Author's response to reviews

Title: Dissemination of the nurse-administered Tobacco Tactics intervention versus usual care in six Trinity community hospitals

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Author's response to reviews: see over
Thank you for these comments. Below, please find our responses.

Major compulsory revisions

1. When dealing with participants not responding to the mail survey, the authors suggested on P.10 that they would offer them the opportunity to complete the survey by phone. Knowing the discrepancy in the reliability and validity between mail survey and phone survey, and the potential of over-reporting and under-reporting behavioral in either one of the methods, I am concerned that why the authors would offer to complete the survey over the phone with majority of the participants completing it by mail. Please address this issue.

   Yes, we agree that two methods of data collection are not ideal. Our primary method of data collection is through mailed surveys using the Dillman technique. However, in our prior similar VA study and other studies of inpatient hospitalized smokers, response rates are low as these individuals are very sick. So in our prior study, our DSMB suggested that we do telephone surveys to those participants that did not respond to the surveys to obtain missing data with a high emphasis on the dependent variable (quit versus not quit) and this did increase the response rate. Our statisticians tell us that this is better than having missing data. So we are proposing this again for this study. This has been added to the paper.

2. Would you be able to provided data to support that collecting specimens for cotinine test during follow-up is feasible? What specimens you are going to collect? Will the participants need to come in to the clinic? And if so, those who have hard time responding to the mail survey are even less likely to provide the specimen.

   Yes, we can provide data on our method of collecting cotinine. The NicAlert urinary test strip is mailed with the survey and the participant can mail it back with the survey. In our prior similar VA study, 90% of the 645 respondents that returned the 6-month survey also returned the urinary cotinine test strip. Only two returned the cotinine test and not the survey (paper under review). This has been added to the paper.
3. With the revised Table 1, I understand the design of the study better. My question is, which doesn't seem to be addressed in the proposal, how is the pre-intervention quit rate going to be determined? You showed three observations in Table 1. And then with the intervention being 2-6 months long, how long is the full implementation before the post-intervention surveys? And will the post-intervention quit rate be determined? Will that be at the same time of the year as the pre-intervention surveys? If not, how are you going to control for seasonal effect of quitting?

Throughout the entire study, smokers are surveyed at baseline, 30-days, 6-months, and 1-year after discharge. In this way, quit rates at 3 time points for all patients are determined during intervention (of less interest), and post-intervention in both the Tobacco Tactics and usual care groups. There are two sources of control. The first source of control is pre- versus post-intervention changes within hospitals; this source of control will NOT control for seasonal changes. The second source of control is changes in the Tobacco Tactics sites compared to the usual care sites; this source of control WILL control for seasonal changes and any other historical events that may influence quit rates across sites. This has been added to the paper.

Discretionary revisions

1. I appreciate the explanation on why a true randomization is not preferred in this case. I believe readers will be interested in knowing the rationales behind your decision too.

The rationale for why true randomization is not preferred has been added to the paper.