Author's response to reviews

Title: An international cross-sectional survey, Quality and Costs of Primary Care (QUALICOPC): lessons learned in recruitment and data collection in primary care across Canada

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Author's response to reviews: see over
Dear Ms Eloisa Nolasco on behalf of Dr Zalika Klemenc-Ketis,

Thank-you for your timely review of our manuscript. We have made revisions to our manuscript and provide here a description of how we have addressed the reviewer’s points.

Reviewer: Danica Rotar-Pavlic

Title: the reader cannot find out if the recruitment and data collection lesions came out from physicians level, practice level or patients level. What is the main focus: physician and the recruitment, practice and the recruitment or patient and the recruitment?

Response: We have revised the title to reflect that the main focus of this manuscript is about the places where primary care is delivered: “An international cross-sectional survey on the Quality and Costs of Primary Care (QUALICO-PC): Recruitment and data collection of organizations delivering primary care across Canada” The main focus is that this is the largest study in Canada to collect data from primary care in Canada and internationally. Recruitment necessarily is through family physicians who own (or are owners) organizations that deliver primary care services to patients.

Abstract: It is not clear if the paucity of information is really linked to the payment system (single payer) and organisation of private small businesses or many other factors.

Response: We have made revisions to the abstract to try and clarify the complex nature of performance reporting in primary care.

Do we have any reports that private owners report less on their activities or that big health centres have information of good quality.

Response: In Canada, as is the case elsewhere, there are little to no reports in the area of primary care by these private owners (family physicians). The point about whether the information is of good quality is an interesting one but beyond the scope of this paper.

If there are messages for future large scale studies, than we should know if QUALICOPC-Canada is large scale study.

Response: We have revised the abstract to note that this was a large scale study.

There are three “linguistic” key words named at the end of the abstract: language, English, French. It seems that language is an important factor with respect to data collection and response rate. I wonder why these aspects are not mentioned in the abstract.

Response: We have revised the key words so that there are only 2 linguistic key words.

Background: I do not agree that outside Canada reporting on PHC performance is limited.

Response: We have modified the language to state that ‘Outside Canada, performance reporting in PHC remains challenging’. It would be worthwhile for others to know where PHC reporting is not challenging—perhaps this reviewer would like to write a comment or editorial on this topic?

Citation (14, p.62,15) is unusual.

Response: This citation lists references 14 and 15. We have provided the page number from where the quotation can be found from reference 14. Please advise if you would like us to take out the page number.

What is the definition of acceptable response rate?
Response: Given that this is the first time this kind of large scale study has taken place in Canada, it is not clear what would be considered an acceptable response rate. The purpose of our manuscript was to report the methods used to recruit family physicians who own or are part owners of primary care organizations and their patients across the 10 provinces of Canada.

Canadian provincial principle is not well described in background section. What is the definition of a small province and what of large?
Response: We have added some description of Canada's provinces in the methods section (Line 158-161).

Historical view, i.e. the role of capitation payment versus fee system is not mentioned. Capitation could influence reporting system as well.
Response: Thank-you for this point as it is certainly a valid one. However, it is not the focus for this manuscript. This manuscript is not about how various sources of data (e.g. billing data) could influence performance reporting. Rather, that performance measurement and reporting in PHC is weak. For example, we suggest (line 102-105), “Despite PHC being publicly funded in developed countries, providers have not considered it their role to report on the performance of their practice with the goal of improving the PHC sector or larger health care system.”

It is not clear if the basic approach, written in this article, was to calculate response rates of family physicians or providers or businesses or patients. Methods: Is this section trying to explain an approach to recruitment of individuals (family physicians), businesses, providers, practices? Terminology is not exact.
Response: We have tried to clarify our recruitment approach. In the methods section (line 163-168) we provide our eligibility criteria, “Physicians who were working with a family/general practice (e.g., not specializing in a narrow set of conditions or treatments) were eligible to participate. We maximized recruitment of the variety of practices where family physicians work by having only one physician per practice eligible to participate. A "practice" was defined as one or more physicians that share one of revenue, staff or patients. Only patients of participating family physicians were eligible to take part in the study.” Further, in the methods section (line 254-255), “Response rates were calculated as the number of physicians who signed up to participate in the study divided by the total number of invitations sent out.” Our goal with this manuscript is to report the response rates of family physicians—since they are the main providers of primary care.

Table 1. The same concept or elements of the QUALICOPC study has been published in 2011. I would suggest to skip this table and to use citation. (Willemijn LA Schäfer. QUALICOPC, a multi-country study evaluating quality, costs and equity in primary care).
Response: Editors, we believe this table is useful. This table provides information on the number of questions in each sub-section which provides the reader with an idea of how long the surveys were. Perhaps it can just be considered as supplementary material?

Reviewer: Grant Russell
Strictly speaking I would normally interpret recruitment rate in a paper like this as an outcome, and hence would suggest that the second objective could be reworded to something like “...to describe and interpret patterns of recruitment to the survey...”
Response: We have revised the second objective accordingly (see line 128-129).

The reader could have a little more detail on a couple of areas, particularly with an international journal. In particular the concepts: "own patient panel" and "comprehensive community-based practice" could be better defined.
Response: We have revised for clarity (see lines 163-167): “Physicians who were working with a family/general practice (e.g., not specializing in a narrow set of conditions or treatments) were eligible to participate. We maximized recruitment of practices/organizations where family physicians work by having
only one physician per practice/organization eligible to participate. A "practice" was defined as one or more physicians that share one of revenue; staff; or patients.”

The format of the methods could adhere more closely to the STROBE format for cross sectional studies. This may have addressed one of the occasional problems of repetition within the detailing of the methods. This is particularly present in the data collection section between lines 161 and 204

Response: We have revised lines 158-244 which describe data collection. There are now three main sections: Eligibility of participants; Sources and methods of participant selection; and Procedures. We have revised to more closely adhere to the STROBE format and reduce repetition.

There is no justification of the different methods (i.e. random sample) used in Quebec compared to the other included provinces, and little examination of the implications of the different approach. In particular we had minimal additional detail on whether the physicians were randomized – was the person conducting the randomization blinded to the study aims to reduce potential biases? Furthermore this difference in methodology may have attributed to the difference seen in completed physician surveys – with Quebec demonstrating a higher response rates of completed surveys to all other province (table 2, page 29) – this was not explored in the paper.

Response: We have added a short paragraph (lines 390-395) to address the reviewer’s point regarding different recruitment methods across provinces. Given the very low response rate (21% being the highest), we feel it’s important to focus the reader’s attention on this—despite the variation in recruitment methods, the response rates in primary care remain low (lines 281-282). Indeed the cooperation rate (those surveys that were actually returned) is similarly high in BC and Québec (line 288-289).

Although the survey was conducted in 2013 and 2014, we have no idea of the length of time of recruitment – useful in seeking to understand the burden on the provincial teams.

Response: We have added detail here that the length of time for recruitment was 4 months for all provinces except Québec, which was 9 months (lines 212-213).

No detail of the approach taken with missing data

Response: We will address this point in subsequent manuscripts. There was no missing data in terms of the calculations for response, participation, and cooperation rates.

Line 204 Reasons for a re-contact approach of up to 21 times (how close to harassment is this??)

Response: In cases where the numbers are higher, this was due to the “back-and-forth” with the physician’s office (playing telephone tag) or the fact that they were out of the office (e.g. holidays). We have added a sentence to clarify (line 223-226).

Lines 216-217: no description of how sample size estimates were obtained

Response: Line 238-241 explains what we were aiming to collect per province in order to carry out cross-provincial comparisons.

No mention was made of how the authors addressed potential bias

Response: In the methods (lines 197-202) we have revised to state that the working group made up of the provincial team leads met regularly to minimize bias in data collection. We also all worked with the provincial chapters of the Canadian College of Family Physicians and obtained publicly available lists. Through the flow diagram, we show that in all provinces except Québec and Manitoba (outside Winnipeg regional authority), we used a census approach where all family physicians on these publicly available lists were sent an invitation to participate.

Line 266 – mentions the heading “PRISMA diagram” – I don’t think that this is the correct term – I would think that PRISMA is more relevant in a systematic review description.
Response: we have renamed this diagram. It is now relabeled as a Flow diagram.

Some references are missing (i.e. Lines 306 307 325). I don’t think the authors have adequately provided evidence that “greater sums offered would have improved the response rate but not enough to meet the targeted sample size at the provincial level “.
Response: We have revised this sentence (now lines 345-348).

Although the purpose was stated as to identify “lessons learned that could be used in recruitment and data collection for future large-scale pan-Canadian and other cross-cultural studies” (pg. 6, lines 111-114) I don’t think the conclusion reflects this well – there is not mention on what the research provided to answer this question – what was the take home lesson derived?
Response: We have revised this objective so as to not refer to lessons learned. We have also revised the title and abstract.

Although other limitations may have been present which were not discussed – i.e. differences in province study methodologies. As a passing note, the length of the survey is mentioned earlier in the article as a possible challenge to recruitment. This could have been mentioned in the discussion – a shorter survey could be more viable in the real world of pc practice without increasing ethical issues associated with payment to participate in research?
Response: We have revised the limitations section to note that there was variation in province study methodologies (line 390). We also do now mention having short valid surveys (line 412-413) is needed.

I don’t think the 2 lessons, as highlighted in the title, were clear in the discussion / conclusion. There seemed more entreaties towards more resources put to performance measurement in primary care.
Response: As per the other reviewer’s suggestion, we have revised the title and abstract.

I thought that Table 3 would be better as Table 1, with the description of the concepts measured as a box or figure. Editors should note that there is an incomplete sentence in the conclusion (unclear sentence p 15-16 from 328-330; page 18, line 377). In addition, a percentage symbol is missing from data on page 14 line 294.
Response: Editor, what is your preference in terms of Table 1? We have revised the conclusion and added the % symbol that was missing.