Author’s response to reviews

Title: Explaining experiences of community-dwelling older adults with a pro-active comprehensive geriatric assessment program – a thorough evaluation by interviews

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Response to reviewers’ comments on

"Explaining experiences of community-dwelling older adults with a pro-active comprehensive geriatric assessment program – a thorough evaluation by interviews" (BGTC-D-18-00701)

Dear Editor,

Thank you for your consideration of our manuscript and opportunity to resubmit our paper. We carefully addressed all the reviewers’ remarks. Below, we respond to each of the remarks.

We also took note of the reference checking results. All references which were not checked or could not be validated were corrected to the requested format. Expectantly, the citations can now be fully linked with CrossRef.

We hope that our manuscript is now suitable for publication in BMC Geriatrics.

Kind regards, on behalf of all authors,
Dear colleagues,

Thank you for submitting your paper to BMC Geriatrics.

I´ve the following remarks:

1. Please report in the abstract the mean ± SD age of your study participants and the gender proportion.

Our response:

The following text in the abstract was added: “The participants’ mean age was 78.5 (SD 6.9) and 56% was female.”

2. Please correct the whole paper including the abstract for correct capitalization.

Our response:

In the abstract we removed all capitals from the themes. For improved recognition and readability the themes have now been written in italics. We checked the whole paper for appropriate capitalization.

3. The last sentence of the abstract conclusion should be explained more in the main text, espec. the case that you perform a CGA without following interventions.

Our response:

We now added the following text:
Abstract, Line 48:

Conclusion – Older adults’ need for a holistic view is covered by this outpatient assessment program. However, their engagement and the correct timing of the program are hampered by the pro-active recruitment and the limited integration of the program within existing care. Furthermore, satisfaction seems an insufficient guiding factor when evaluating CGA programs for older adults because it does not reflect the impact of the program.

Discussion, Line 335:

Similar to our findings, Darby et al. reported that satisfaction applied to the contact with the geriatrician within an in-patient CGA program, but it also appeared concurrently with a lack of understanding regarding the meaning of the intervention [25]. For out-patient CGA programs, both with and without subsequent interventions, the discrepancy between satisfaction and efficacy has been underlined before [26].

Conclusion, Line 408:

This study underlines that satisfaction seems an insufficient guiding factor when evaluating care programs for older adults as it appears to have no link with the experienced effects of the assessment program.

4. After introducing CGA as an abbreviation please use this throughout the text.

Our response:

Indeed, the word assessment was used throughout the text, sometimes to refer to CGA, sometimes to refer to the whole program.

We now corrected this. Every time the assessment part of the program is addressed, it is referred to with ‘cga’. Every time we refer to the complete Sage-atAge program (including pro-active population screening, the cga, and recommendations), it is referred to with ‘outpatient assessment program’.

5. You report that additional dentist and pharmacy assessment were offered but not how often it was used. The same is true for physiotherapy, dietitian and psychology.
Our response:

In Table 1 we now note the interview participants’ utilization of additional allied health care professionals in a separate column.

6. Please report the CGA domains and instruments used in your study.

Our response:

The CGA consisted of a consultation with a geriatric nurse or elderly care physician and focused on multiple domains (physical, functional, psychological, social and living).” By protocol the assessor was advised to extend the assessment with measurement instruments for psychological, social or functional needs. For example, the mini-mental state examination was administered when cognitive complaints were expressed, and when depressive complaints were mentioned, the HADS was administered.

We added some extra information about the content of the CGA:

Method section, line 93: “The CGA consisted of a consultation with a geriatric nurse or elderly care physician [15] and focused on multiple domains (physical, functional, psychological, social and living).” ). By protocol, the assessor was advised to extend the assessment with measurement instruments for psychological, social or functional needs. For example, when cognitive complaints or depressive feelings were expressed .”

For each study participant the domain of recommendations is noted in Table 1.

7. Explain more how you find and attract the study participants for participation. E.g. what is the Sage-atAgeprogram. How many persons are contacted, how many agreed?

Our response:

We added several figures about the contacted and reached population of the Sage-atAge program:
“The Sage-atAge program is an outpatient assessment program offered to home-dwelling older adults (65+) by seven general practices in a rural area in the north of the Netherlands. A postal questionnaire was distributed among 3004 older adults and completed by 1455 of them. This questionnaire captured frailty, care complexity and health-related issues. Frailty was assessed using the Groningen Frailty Indicator (GFI). GFI comprises 15 items, covering four domains: physical, social, cognitive and psychological. The total score ranges from 0 to 15; a higher score indicates higher level of frailty [14]. All older adults with a substantial frailty level (GFI >2) were invited for a CGA (n=708).”

Further details about the program population and the delivered program components will be described in a second, currently submitted, manuscript about the effects of the program.

8. Please don’t use different abbreviations (MS or MF) for the same author.

Our response:

In the Method section, Line 130 we corrected MFS into MS

The abbreviation MS is now used throughout the whole manuscript for this author.

9. Please refer to Table 1, Table 2, Figure 1 instead of "listed in a table"…

Our response:

The text in the method section was adjusted accordingly (Line 152-160).

10. Please check for missing blank keys, e.g. in "embedding in literature".

Our response:

We checked the whole manuscript for the correct reference citations. We added the requested blanks (in discussion section, Line 338 and 340).

11. As you refer to CGA I wonder that you not discuss the results of the Cochrane Review.

Our response:
Thank you for the recommendation of relevant literature.

We are aware of the Cochrane review for outpatient assessment services of which the protocol was published in 2017 by Briggs et al. We are looking forward to the publication of the results of this review.

Other Cochrane reviews about CGA (Ellis et al., 2017; and Eamer et al., 2018) both focus on inpatient assessment services. Because the effects of inpatient assessment services are markedly different (mostly larger) compared to the effects of outpatient assessment services, we do not refer to these or other literature about inpatient assessment services.

12. Don’t use the term screening when you mean assessment.

Our response:

We adjusted the terminology. We only use the word ‘screening’ when it applies to the triage instrument.

In results section line 224 and 284 we changed ‘screening’ into ‘assessment’.

13. Please check the reference section for correct (non-)capitalization and full citation data, espec. no 2,5,6,8,911,15,17,20,22,47,52

Our response:

The complete reference list was now checked in detail against the recommended reference style of BMC Geriatrics. Citation data and capitalization was corrected accordingly.

We expect that all citations can now be linked with CrossRef.

14. Tables: Please provide a table with baseline data of participants and CGA results.

Our response:

We added detailed information about the domains of the assessment and the needs of the interview participants to Table 1.

We did consider the possibility that the reviewer wants us to report on the sample of our effect study. This will be addressed in a different paper which is presently submitted.
Reviewer: 2 - Li-Mei Chen

1. Line 106 Conducting 20 interviews for enough "information power" requires an explanation. I understand that the COREQ list was presented to detail the qualitative process, but how is that specific number satisfy a scientific study? How has data saturation been achieved?

Our response:

We added the following sentence to the method section, Line 111.

"We planned for more than 20 interviews to provide enough “information power”. Following Malterud et al., the sufficiency of the sample size was concluded from a diverse range of dimensions of our study: a small subject but with a heterogeneous sample, no predefined theory and a cross-case analysis technique [17]. We stopped interviewing when we reached data saturation."

In the supplementary file we added this sentence:

22. Data saturation; Was data saturation discussed?; The research group discussed findings and data saturation multiple times. Data saturation was reached after 25 interviews. This is mentioned in the manuscript as well.

2. Line 129 Inconsistent methodology raises a question about the quality of the data. In the COREQ list, it suggested that the question topics derived from a pilot study of 25 participants. Is the study submitted the same study? Please make that clear.

Our response:

The study reported in the manuscript is not the same study as the pilot study mentioned in the COREQ list. The pilot study was executed by medical students and focused mainly on the experienced effects after Sage-atAge.

After the pilot study, we adjusted the topic list mainly to improve appropriate wording.
The following text in the Supplement was added to diminish this possible inconsistency:

“The interview topic list was pilot tested by 2 students who carried out a pilot study among 25 participants. This pilot study focused on the experienced effects after Sage-atAge. After this pilot study, the topic list was adapted for the current study:”

3. Line 180 and 327 Beside the "need for a holistic view" and "unexpected help" the themes are mainly related to the problems of the CGA program. The problems delineated are interesting but since they exceed the good so the findings "dilute" the participants' satisfaction and raises questions whether CGA is any good. Elaborating the explanation and the discussion on the latter (unexpected help) can more helpful to view CGA as a preventive strategy design since that is the direction we are going with the health care in aging societies

Our response:

Thank you for your thoughtful consideration on the results of our analysis. We now added the following text, to improve the visibility of these positive results.

Discussion section, line 324

In this article we described the experience of older adults with an outpatient assessment program and aimed to explain the coherence between this experience and program components. Although older adults expressed satisfaction this did not cover their whole experience with the program; they also expressed a lack of ownership in the program, experienced problems with the timing of the program, were uncertain about the scope of the CGA and their views on problems seemed to differ with the care workers. Importantly, the program seemed to address their need for a holistic view and delivered unexpected help. In aiming to explain this this broad range of experiences we found coherence with three program components: multi-domain approach, pro-active sampling and integration in usual care. By connecting the experiences to the program components, we gained insight into potentially relevant factors for improving care for older adults.

Discussion section, Line 398

An outpatient assessment program fits into person-centred care, as it is able to meet the older adults’ need for a holistic view. Next to that, with its’ pro-active approach it is able to deliver unexpected help to some of the participants. However, the correct timing and engagement of older adults is hampered by pro-active recruitment and limited integration of the program within
existing care. More attention needs to be paid to these program components and implementation strategies when designing and evaluating pro-active and person-centred care for older adults.