Title: Patient perspectives on continuity of medication management: Results of a qualitative study

Authors:

Corrine I Voils (voils001@mc.duke.edu)
Betsy Sleath (betsy_sleath@unc.edu)
Matthew Maciejewski (matthew.maciejewski@va.gov)

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Author's response to reviews: see over
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Dear Editor:

We thank the reviewers for their constructive critique of our article entitled, “Patient perspectives on continuity of medication management: Results of a qualitative study,” which we have retitled to “Patient perspectives on having multiple versus single prescribers of chronic disease medications: Results of a qualitative study in the veteran population,” per Reviewer 1’s suggestion. We have revised the manuscript according to the reviewers’ suggestions. Below, please find each reviewer comment followed by our response in bold. Changes to the manuscript are shown via tracked changes.

**Reviewer 1**
Major compulsory revision:
1. Indicate the population in the title

**Done.**

2. indicate if ethics approval was gained and from where

**Ethics approval was obtained at the Durham Veterans Affairs Medical Center, Duke University Medical Center, and University of North Carolina at Chapel Hill (p.5).**

3. replace, some and all by % out of total sample

**Whether to count in qualitative inquiry is debatable; the decision is driven by consideration of the research goals (Sandelowski, M. (2001). Real qualitative researchers do not count: The use of numbers in qualitative research. *Research in Nursing & Health, 24*, 230-240.) In our approach, a response that is generated by only one participant is considered important. We believe that counting in this context could mislead the reader about the relative importance of each finding (e.g., a finding that is generated by only one participant would seem less prevalent or important than a finding generated by several participants—now stated on p. 14). This is consistent with our sampling imperative, which was purposeful sampling to sample for possibility (Wood & Christy, 1999). Follow-up quantitative studies that employ probability sampling would be needed to draw conclusions about the prevalence of each theme suggested by this study.**
4. exclude the one women data as it does not represent female population, when trending by gender

Done.

5. exclude specialists data as it is recommended that people with chronic diseases see specialists at least once a year, globally

Respectfully, discussion about specialists is relevant to our research question concerning multiple prescribers. Although patients in some health care systems may see specialists at least once a year, this is not universal. Anecdotally, many VA primary care physicians feel capable of managing patients with comorbidities and may only refer to specialists if clinical outcomes continue to be elevated.

6. conclusion need to reflect the objective, i.e. no mention to adherence to therapy or patient outcomes

We have added a sentence in the Conclusion section stating that interventions to reduce numbers of prescribers would need to be evaluated by their effect on patient adherence, utilization, and outcomes (p. 15).

Minor essential revision: see attached scanned copy

Thank you for the handwritten edits. We have made all recommended changes.

Reviewer 2

MAJOR COMPULSORY REVISIONS

INTRODUCTION
The introduction and title both give the impression of a very broad examination of medication management, whereas in fact this manuscript really on examines the impact on medication supply. Please amend generally to focus more on the results presented. In fact, only the first quote and related text are at all directly relevant to more general management of medicines beyond the supply issue. Previous literature examining general med management have a number of important themes not identified here. Consider changing the title to ‘continuity of medication access/supply’ or similar.

We agree with the reviewer and have changed the title and Introduction (pp. 4-5).

The first line of the introduction discusses the issue of medication management with relation to multimorbidity. However, Table 1 suggests a relatively ‘straightforward’ group of patients, with only 30% with three or more conditions. If
diabetes, HT and HF are included in these figures, I think it is important to identify that most participants have consistent co-morbidities (i.e. with reinforcing therapeutic principles), which is overall less complicated wrt coordination and decision-making than situations where competing clinical priorities exist. Some comments on this would be welcomed in the discussion.

We agree with the reviewer that coordination is likely to be better with “concordant conditions” (as coined by Piette and Kerr), which is why we selected these particular conditions. We have added a sentence to the Methods explaining this (p.5). We reasoned that if greater healthcare utilization and worse health outcomes were associated with increasing prescribers in patients with multiple concordant conditions, then the problem might be even worse in patients with discordant conditions. This possibility will need to be examined in future research. We have amended the Discussion accordingly (p. 15).

DISCUSSION
Affordability was obviously a huge issue in the Results section, and I think this has not been considered adequately in the Discussion with reference to previous literature. Consider also the competing effects on adherence of less coordinated care vs increased affordability/access with increasing numbers of prescribers.

We have added sentences to the Discussion to this effect (p. 14).

MINOR ESSENTIAL REVISIONS
INTRODUCTION
‘We were interested in veterans’ experiences with having multiple prescribers of cardiometabolic medications as well as their perceptions of advantages and disadvantages of having multiple prescribers.’ Be more specific in stating this aim, relate it specifically to supply.

We have restated the aim to address medication supply in the Abstract and Introduction (p. 5).

METHODS
‘addressing other study aims (results not presented herein). From the 1,999 veterans who were sent surveys, 300 veterans were randomly selected to receive a recruitment letter for this focus group study.’ Please clarify in the results section if the 23 participants represented all of the respondents – this is the impression I get but it is ambiguous.

We clarified that the random sample of 300 veterans invited to participate in the focus groups included both responders and nonresponders to the survey that was administered to 1999 veterans as part of a different study aim (p. 6).
After all focus groups were conducted, the transcripts were content-analyzed by the social psychologist and health economist. Clarify whether or not the data was coded independently by these parties, or together. If not independently, please explain why.

**We have clarified our coding process (p. 7).**

‘These emergent codes were refined by a systematic process of consensus among the two coders.’ Were there any contingency plans in place for a situation where consensus between the two coders was not possible.

Lack of consensus was addressed in development of the coding scheme by discussing the relevant text and revising the coding scheme as necessary. The coding scheme was then applied by a single person. This has been explained more clearly on p.7.

‘Analyses were conducted with Atlas.ti ‘ Please reference Atlas.ti

**Done (p.7).**

**DISCUSSION**

This is a US-centric discussion of a global issue. Consider reference to other health systems with respect to external validity, so readers can judge its relevance locally. I am mindful of the large number of issues identified in these results that would potentially be less pertinent in many other countries (e.g. varying cost of a prescription depending on prescriber, use of multiple health systems as opposed to prescribers, 90 day supplies, phone based automatic refills). With respect to internal/US validity, it would be useful to see any empirical evidence regarding prevalence of people with both VA and non-VA insurance, and generally how relevant it is to other groups not in this situation. For example, non-veterans, the uninsured etc.

In the introduction, we now note that fragmentation of medication management may not be an issue in non-US single payer systems or integrated US-based systems (e.g., Kaiser Permanente), but it is an issue due to the lack of a single payer system for most Americans (p. 4). We have expanded our limitations to explain that the findings may not generalize to single-payer systems (which may be present inside or outside the US) and to the uninsured (p. 15).

On behalf of the authors,

[Signature]

Corrine I. Voils, Ph.D.