Author’s response to reviews

Title: Feasibility, acceptability and effectiveness of young-people specific, integrated out-of-hospital services: A protocol for systematic review

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Response to Reviewer Comments:

We thank the reviewers for their valuable inputs. We have tried to address them, as best as we can, below:

Reviewer #1: The authors present a research protocol for a systematic review of the feasibility, acceptability and effectiveness of young people specific, integrated out-of-hospital services. Given that the need for specific services for young people (i.e. not adults or children) is being increasingly recognised, this review is both timely, relevant and important.

I encourage the authors to submit a modified version after taking into account the comments below:

1. Acknowledgement of the disease burden in young people would add weight to the reasoning behind doing the review: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60512-6/abstract

Response:
We have added a statement on the disease burden. The revised sentence is as follows:
“A systematic analysis report, based on the WHO’s 2004 Global Burden of Disease (GBD) study, recorded 236 million incident DALYs (disability adjusted life years) in young people aged between 10 and 24 years, representing 15.5% of the total DALY burden for all age groups.”
Also, added Reference number 3.

2. I recommend adding more detail in the quality appraisal/strength of cumulative evidence sections - including all studies regardless of their quality assessment is all well and good, but it would be beneficial to include more specific tools used to conduct quality appraisals (Cochrane Risk of Bias tool for RCTs, ROBINS-I for non-randomised evaluations etc). From experience of using the ROBINS-I tool, I would recommend conducting quality appraisals for non-randomised studies in pairs, rather than
two reviewers independently appraising studies and then assessing again after discussion.

Response:
We thank the reviewer for their valuable input. We have revised the section as follows
“For quality assessment of randomised controlled trials, the Cochrane Collaboration’s risk of bias tool for randomised trials will be used (22). The New Castle Ottawa Scale will be used to assess the methodological quality of cohort studies and case-control studies (23). For other non-randomised studies, ROBINS-I tool will be used (24). Quality assessment will be done by both reviewers together with discussion and any disagreement will be resolved by mutual consensus, or discussion with third reviewer (RV). Qualitative studies will be appraised using the Critical Appraisal Skills Programme (CASP) checklist (25).”

3. I would like to see more consideration of the issue of content - the feasibility, acceptability and effectiveness of a particular intervention is surely heavily dependent on the environment in which it is applied. I would anticipate that this review will span many different contexts as it includes studies conducted all over the world, with no exclusion on study country. Moreover, the context that young people (10-24 years of age) have across cultures is highly variable.

Response: We thank the reviewer for their valuable input. We have added consideration to context, by including subgroup analysis, based on the study setting.
We have added this consideration in the data synthesis and analysis section, as follows “The youth specific out of hospital integrated health services may vary according to target age groups, type of health conditions and by settings in which they are delivered. If sufficient data is available for such comparisons, subgroup analysis will be conducted.”

4. In the 'Data Synthesis and Analysis' section use of quantitative data analysis is vague - I understand that the review will undoubtedly generate a range of outcomes, and meta-analyses will not be feasible in many of these cases, but additional detail on what reviewers will use to judge suitability for quantitative data pooling would be beneficial. 'Means and standard deviations' surely does not suffice. This point should be clarified in the abstract too.

Response:
We have revised this section as follows:
“Wherever possible, we will synthesize quantitative data using pooled estimates and forest plots. For outcomes relating to utilization of health services, like participation rate, cure rate and OPD attendance, quantitative data will be pooled and analysed together, wherever, deemed appropriate. Studies reporting similar outcomes will be grouped with each other Eg. Studies describing waiting times, cure rates, relapse rates. Also, data from studies reporting different outcome measures of effectiveness, feasibility and acceptability will be combined.”

5. Some mention of stratification by disease area/health service provider would be beneficial - as alluded to in my earlier comment regarding context, looking at the entire care pathway that young people experience seems huge and difficult to imagine; do you anticipate seeing more studies on particular issues, e.g. mental health, sexual health?

Response:
Based on the reviewer comments, we have included subgroup analysis in our data analysis. The studies will be grouped together for analysis, based on context and health issues, if there is sufficient data to do so.
The revised section is as follows: “The youth specific out of hospital integrated health services may vary according to target age groups, type of health conditions and by settings in which they are delivered. If sufficient data is available for such comparisons, subgroup analysis will be conducted.”
6. The review would benefit from additional clarification on what types of intervention the team anticipate - 'outcomes related to effectiveness, feasibility and acceptability of health services' is very broad, and means that the overall focus of the review is somewhat vague.

Response:
We have added some examples of outcomes in Table 1. This list is indicative and not exhaustive and any additional indicators in these domains will be included if reported by studies.

Reviewer #2: The authors have identified a subject related to young people and integrated out-of-hospital services that is topical and of global interest. A few items that would strengthen the manuscript have been identified. Several items outlined below involve minor clarifications, however there are some major issues that need to be addressed as well.

1. Background

   * Lines 47-49: This sentence requires a reference to support the statement
   * Lines 50-53: This sentence requires a reference to support the statement
   * Lines 54-55: This sentence requires a reference to support the statement
   * Lines 56-57: Sentence construction is poor - consider re-wording

Response: References have been added to the three statements mentioned. (References 4-11)

Sentence 56-57 has been revised as follows: "World Health Organization(WHO) defines integrated care as: "Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion”(18). It covers a complex field, with many alternate terms like collaborative care, coordinated care, transmural care, seamless care or comprehensive care.”

2. Methods

   * Table 1: Population - Provide a source for 'young people' as being between 10-24 years of age
   Response: Reference has been added.

   * Table 1: Population - Although different organizations identify 'young people' as large, there is great diversity between a 10 year old and a 24 year old
     - Part of this group would be considered 'children' (pediatrics) and another part would be considered adults. It is critical to acknowledge this in your paper as a there is the question of whether a 10 year old and a 24 year old would have very different needs with regards to integrated services/care - consider outlining strategies for how the review will address/report on this. If these age groups should be grouped together with regards to services, the rationale needs to be clearly outlined and explained in the Background.
   Response: While our review aims to include all youth specific services (age 10-24 years), it is likely that we may encounter studies which include services for specific subgroups (Eg. 10-15 yrs, 15-20 yrs) within this broad range. Such studies shall be included and if there is scope of subgroup analysis, that will be performed for these age groups. On the basis of the data from included studies, such analysis will be considered.

   * Table 1: Study Design - Consider removing 'etc.' with listing of study designs
   Response: This has been removed.
- Rather than saying primary studies (which could include qualitative studies and it does not appear you are including them), you could consider stating something like: 'experimental (randomised controlled trials, quasi-randomised controlled trials, non-randomised clinical trials), quasi-experimental (interrupted time series, controlled before-after studies), observational (cohort, case-control, cross-sectional, case series)'

Response: We thank the reviewer for their valuable input. This has been revised accordingly.

* Table 1: Outcomes - How will you determine effectiveness, feasibility, and acceptability have been measured when assessing eligibility? Is it strictly based on the authors using these terms in the reporting of their studies, or will you be using other strategies to identify them, e.g. if a study measured satisfaction (rather than using the term acceptability) in their outcomes, would this study be included in the systematic review? If so, what source will be used to indicate that these two attributes are similar? Are there other terms for 'effectiveness' or 'feasibility' that would be considered equal - if so, how will this be determined?

Response: We have added a list of outcomes in Table 1 for each of the domains (effectiveness, feasibility and acceptability). An exhaustive list of such outcomes is not available. However, if there is any discrepancy in data extraction between the reviewers, it will be solved by mutual discussion and consensus.

* Search Strategy: Table 1 says the studies will be restricted to English language only - The search strategy indicates there will be no language restrictions. Consider harmonizing these two.

Response: This has been revised by removing section about no language restrictions.

* Search Strategy (Appendix 2):

1) There are some terms not used that would be considered synonyms to integrated care such as, integrated health, comprehensive care, multi-agency care/multiagency care, integrated services.

2) The search for a systematic review must be exhaustive - there are no variations on spellings, e.g., co-ordinated care, care co-ordination

3) No wildcards are used in the 'integrated care' portion of the search that would ensure a comprehensive search.

4) For MEDLINE/Cochrane: MeSH (Medical Subject Headings) need to be added to the 'young people' portion of the search, e.g., Adolescent/, Young Adult/, Child/.

5) For EMBASE/CINAHL: Subject Headings need to be added to the 'young people' portion of the search; as well, the search terms used have been restricted to Abstracts only and should include searching titles for this portion of the search.

* Consider searching the grey literature - One strategy would be to identify a list of websites that focus on 'young people', e.g., WHO, PRB, UN and search their sites for relevant studies

Response on Search Strategy Comments:

Based on reviewer comments, we have revised our search strategy and added terms integrated health, comprehensive care, multi-agency care, integrated services to our search strategy. We have also included variations in spellings as suggested, co-ordinated care & care co-ordination. Wild card for integrated care has been added. MeSH headngs Adolescent/, Young Adult/, Child/ have been added accordingly. EMBASE search has been revised to include titles as well. Although we have not included grey literature in our search strategy, to expand our search, we will do a comprehensive search of references of included studies to identify articles/reports which could identify studies relevant to the
review.

* Line 94: Provide more information about how the data extraction forms will be piloted, e.g., how many records will be used to pilot the forms, what level of agreement will be needed before moving to extraction of all eligible studies
Response:
Based on reviewer comments, section on data extraction has been modified as below:
"Data extraction forms will be piloted on a sample of included studies (25%) to ensure that all the relevant information is captured and there is consistency in data extraction. The consistency of data extracted will be assessed to ensure >95% agreement. The exporting, analysis and outputs of the data extraction forms will also be pilot tested, on 25% subsample of included studies."

* Lines 100-101:
1) The reference is not to the primary research on the Newcastle-Ottawa Scale;
2) The reference used does not look at the Modified Newcastle-Ottawa Scale;
3) The Newcastle-Ottawa Scale is only relevant for nonrandomized studies - Scales for other study types, e.g., trials, need to be identified
Response: Scales for all types of studies have been added. The revised section is as follows:
"Two reviewers (AP & AA) will extract the data and conduct quality assessment. For quality assessment of randomised controlled trials, the Cochrane Collaboration’s risk of bias tool for randomised trials will be used. For cohort and case control studies, New Castle Ottawa checklist will be used. For non-randomised studies, ROBINS-I tool will be used. Qualitative studies will be appraised using the Critical Appraisal Skills Programme (CASP) checklist. Quality assessment will be done by both reviewers together with discussion and any disagreement will be resolved by mutual consensus, or discussion with third reviewer (RV). Quality assessment would aid in interpretation of results, but will not be used to determine inclusion.

4) If a Modified Newcastle-Ottawa Scale is being used, indicate why the modified version is preferred over the original version
Response:
Based on reviewer suggestion, we shall use New Castle Ottawa Scale only for cohort and case control studies. Hence, we shall no longer use the modified version.

* Lines 104-106 and Lines 112-113: It is not possible to know the results of your systematic review before conducting it, therefore this speculation should not be included in the protocol - If trials are included in the study types accepted into the systematic review, provisions for handling them within the systematic review must be made
Response: We have deleted both these sentences. Quality assessment criteria for trials have been added, as stated above.

3. Discussion
* Line 120-121: It is challenging to declare that evidence will be provided before the review is done as it is possible there may be no studies that fulfill the eligibility criteria.
Response:
We have deleted this sentence from the discussion.
5. References
* Please review all of your References and ensure they are listed in the correct format - e.g., include website links where appropriate and follow NLM reference style
Response: This has been corrected in the revised manuscript.

6. Other
* Author Contributions: Line 147 - 'AP was the lead reviewer' - Given this is the protocol, no reviewing would have taken place yet
Response: Author contributions has been revised to ‘AP created the study design and search strategy, and wrote the first draft of the protocol manuscript.’