Author’s response to reviews

Title: Cross sectional survey to inform the development of a telehealth support model: a feasibility study for women undergoing breast cancer surgery

Authors:

Natasha Noble (natasha.noble@newcastle.edu.au)
Lisa Mackenzie (Lisa.Mackenzie@newcastle.edu.au)
Mariko Carey (Mariko.Carey@newcastle.edu.au)
Anthony Proietto (Anthony.Proietto@hnehealth.nsw.gov.au)
Robert Sanson-Fisher (Rob.Sanson-Fisher@newcastle.edu.au)
Gail Walker (gail@thebec.com.au)
Judith Silcock (judith@thebec.com.au)

Version: 1 Date: 18 Feb 2019

Author’s response to reviews:

19 February 2019

Sameer Parpia
Pilot and Feasibility Studies

Dear Dr Parpia,

Re: PAFS-D-18-00133

Many thanks to the editor and reviewer for providing feedback and comments on our manuscript, and for the opportunity to submit a revised version. Please find below our responses to each of the concerns raised. Changes to the manuscript are indicated in the text using highlighting.

Assigned Editor:

1. As a pilot/feasibility study of 50 patients, statistical comparisons (p-values) should be avoided. The study was not designed for this purpose.
We agree that the small sample size precludes making a meaningful statistical comparison, and have removed reference to the p-values comparing telehealth preferences (page 13 para 1).

2. The sample size of 50 was based on precision of a prevalence rate. Please clarify what outcome is this referring to

Precision was based on the estimated prevalence rate of having at least one unmet information or preparation need on the MiPrep tool. We have clarified this in the Analysis section of the manuscript (page 11 para 1).

3. Can you justify why two difference cut-off were used for the VAS score?

A range of cut-off scores for the VAS have been reported in the literature. For clarity, we have revised our reporting and use of the cut-off scores according to those reported by Paul et al 2005 (mild pain: 1–4; moderate pain: >4–7; severe pain: >7–10), given that these are the more recently reported optimal cut-off scores for cancer pain (page 9 para 3). The results have also been modified to reflect these cut-off scores (page 14-15).

4. Details on the pre-specified criteria to determine feasibility are lacking. Please provide details

We have added details regarding the following criteria for acceptability and feasibility to the introduction section: 75% of respondents indicating access to equipment suitable for a teleconsultation (including internet access and an internet connected device with a camera and speakers), 50% indicating willingness to accept a post-operative teleconsult, and 50% of respondents indicating at least one unmet informational or preparation need related to (page 6 para 1). These criteria are based on sample size considerations for the planned future randomised controlled trial.

5. Provide details on missing data in the results for each measure, and how this may have effect the results

Missing data for pain scores (1 value) has been added to the results section (page 14-15). Missing values on the STAI-S (2 participants with missing values at T1; 1 participant with missing values at T2) and FACT-B (no missing data) are already reported in this section of the results. Given that the amount of missing data was small (at around 2% of all data), we have not discussed the effect of missing data on the results.

6. There appears to be a disconnect between the results and discussion. A large part of the discussion is based on the pre-operative approach, and the usefulness of the teleconsultation, however, the results don't support this or the study was not designed for it. I believe the discussion needs to be re-written
We have substantially revised the discussion to focus less on the pre-operative stage of surgery, and align more closely with the study results, in terms of acceptability and feasibility of telehealth consultations, and the implications of the reported unmet informational needs and levels of pain and anxiety for the planned telehealth support model (page 15-18).

Reviewer reports:

Reviewer #1: Page 7, Line 42: Define NSW

This change has been made (page 6 para 2).

Page 10, Line 12: Consider defining what 27 means as far as the MiPrep tool score.

As noted by the reviewer, we agree that the total of 27 items on the MiPrep tool makes an overall unmet needs score difficult to interpret. Upon reflection, we have decided to remove reporting on the overall scoring of the MiPrep tool from our manuscript (page 9 para 2; page 11 para 1). The MiPrep tool was designed to help identify areas for improvement and areas of excellence in patients’ preparation for medical interventions, including surgery. As such, reporting on the specific items or areas where a significant proportion of respondents indicated an unmet need is more meaningful than reporting a total and mean unmet needs scores.

Page 13, Line 50: Preferences for teleconsultation, it appears the yes and not sure responses were grouped together. Is this the case? If so, why lump them together?

The prevalence of preferences for teleconsultations are reported separately for those who responded ‘yes’ (15%), ‘not sure’ (20%) and ‘no’ (65%) regarding whether they would have accepted a teleconsultation if it had been offered to them. The analysis in which ‘yes’ and ‘not sure’ responses were grouped together has now been removed in response to point 1. from the assigned editor (above; page 13, para 1)

Page 14, Line 14: The first sentence in the paragraph is awkward grammatically, particularly with the placement of the word "about".

This sentence has been revised (including removal of the words ‘those’ and ‘about’) (page 13 para 2).

Page 17, Line 45: The word "be" is used twice and one needs to be deleted for it to make sense.

This change has been made in the revised discussion.

Why were only a subset of participants given a description of a teleconsultation? Bias to the answering.

Apologies, this was not clearly explained in the original manuscript. Only a subset of participants were asked the series of questions relevant to the provision of a telehealth support model (n =
20), including being given a description of a teleconsultation. All participants asked about telehealth were given the description of a teleconsultation prior to being asked if they would have accepted this (n = 20), not just a subset of participants. We have revised the methods to clarify this (page 8 para 1).

How many scores needed to be prorated? A minor portion or the majority of your sample? May want to clarify on how much data was imputed, more than 10% should be justified in some way.

We have included the number of scores which needed to be prorated in the results section (pages 13-15). This ranged from 14-18% of participants requiring their scores to be prorated across the different measures. We have not added a specific justification for this level of imputation, given that the STAI-S and FACT-B allow for prorated scores where ≤10%, and ≤50% of subscale responses, respectively, are missing.

We hope that we have addressed the issues and concerns raised by the editor and reviewer, and that our manuscript can now be reconsidered for publication.

Kind regards,

Dr Natasha Noble (corresponding author)
Research Assistant
Health Behaviour Research Collaborative
University of Newcastle; Callaghan NSW 2308