Author's response to reviews

Title: A qualitative Study of the anticipated Barriers and Facilitators to the Implementation of a Lifestyle Intervention in the Dutch Construction Industry

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Author's response to reviews: see over
To the editorial team of BMC Public Health

Regarding: Submission first revision manuscript

Amsterdam, December 11th 2014

Dear editor,

We are grateful for the opportunity to resubmit our manuscript entitled “A qualitative Study of the anticipated Barriers and Facilitators to the Implementation of a Lifestyle Intervention in the Dutch Construction Industry”. We would like to thank the reviewers for their constructive comments. All comments have been addressed in our point-by-point reaction (see below). Corresponding changes have been made to the manuscript.

Sincerely,
also on behalf of all (co-)authors,

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Point-by-point reaction regarding the reviewers’ comments on the manuscript

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to the Implementation of a Lifestyle Intervention in the Dutch Construction Industry”

Dear reviewers,

Thank you very much for your constructive comments. We appreciate the valuable input you gave us and hope that we have adapted the manuscript to your satisfaction. See below our point-by-point reaction to your comments.

Reviewer 1

Comment 1.1
The paper provides new insights into the issues surrounding the implementation of lifestyle interventions within the work setting.
Response
Thank you.

Comment 1.2
My main comment is that the authors need to provide more contextual information in the background section about the occupational health service setting in the Netherlands and the roles of the various health professionals. This is crucial in the reader understanding the study findings, particularly for an international audience. I have given specific examples below where I think this is important.
Response:
We agree that contextual information is important to understanding the findings and have therefore added a new paragraph in the Methods Section “Intervention and Context” where we have included the requested information (line 133-167).

Reviewer 1: Major Compulsory Revisions

Comment 1.3
Title – it is not clear from the title that the interviews were conducted prior to implementation of the program, as such the barriers/facilitators are anticipated perceived barriers/facilitator rather than actual barriers/facilitators experienced during implementation.
Response:
In order to be more clear that it concerns a study to impeding and facilitating factors prior to implementation, we have changed the title into: “A qualitative Study on the anticipated Barriers and Facilitators…”.

Comment 1.4
Results: Risk perception – it is unclear in this section whether participants were responding to their actual (real) CVD risk or imagining they had a high risk. This is confused by the statement ‘Both the opinion of the OP and the PME results contributed to their awareness of the risk’ however in the data collection section it states that participants were told to imagine they had high CVD risk. Whether their risk was real or simulated is important in influencing employees response on whether they would sign up to the program.
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Response:
We agree that this issue could have been clarified. We have adapted the paragraph as follows: “Most employees who were willing to sign up for the intervention first named the hypothetical elevated CVD risk as their reason…” (line 322-323). We have also added the following citation: “Employee A: “I would participate if I really had an elevated risk. See, if the doctor would say that I have an elevated risk, then I would participate.” (line 327-328).

Comment 1.5
Results: It would be useful in the background section to provide more contextual information about how the intervention would be implemented. For example in the results, employees mention practical barriers such as travel time to be an issue. This suggests that the intervention would be conducted outside of the workplace – this is important contextual information to provide for the reader to understand the barriers/facilitators raised.
Response:
To provide more information on the context of the intervention, we have added a new subsection in the methods section titled “Intervention and context”. The following information has been included in this section to provide context for the barriers experienced by employees: “When an employee was referred to a lifestyle counselor, the employee received 2-3 face-to-face consultations and 3-4 phone consultations. The face-to-face consultations took place at the OHS, the participant’s home, or the participant’s work place. Participants chose whether they wanted to change their diet, or increase their physical activity, and how they wanted to achieve those goals. The intervention was thus tailored to the participant’s needs and preferences. The counselor provided guidance on achieving these lifestyle changes if the participant so desired. Participation fees were covered by Arbouw” (line 161-167).

Comment 1.6
Results: It is unclear from 3.1.5 if managers did perceive absence from work to be a problem with implementing the intervention as perceived by employees.
Response:
From our study, we don’t know how employers think about absence from work. The perception about absence from work as a problem is based on the employee’s perceptions. We have made this more explicit by saying: “One employee indicated that he considered participation in a lifestyle intervention to be sensitive information that he would rather keep from his employer. Employee G: “Especially nowadays, where you get sacked for the smallest things. (…) Your employer will know you belong to a risk group that might cost him money. “ (line 415-419).

Comment 1.7
Results: 3.2.1 lack of time – it is difficult to interpret the issue of lack of time for health professionals without further information about the health professionals role, who they were employed by, how they are remunerated and their interaction with construction industry. What is normal practice for them? What is the role of Ops versus medical assistant in screening. This information should be provided in the background section.
Response:
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The section ‘Intervention in its Context’ now provides information about the context in which the professionals of the OHS work: “In the Netherlands, occupational health in the construction sector is financed and coordinated by the national institute Arbouw. This non-profit institute represents construction industry employers and employees and aims to improve working conditions and reduce sickness-related absence in the sector. Employers in the construction sectors pay fees to Arbouw, which Arbouw uses to develop and implement health and safety measures. One of those measures is the periodic medical examination (PME). Every employee in the construction sector has the right, but is not obliged, to participate in one PME every two to four years. At the time of the present study, Arbouw had contracted with 25 commercial OHS to performing these PMEs. The OHS employ OPs, medical assistants and other professionals specialized in occupational health. One of the OHS major task is preventing of sickness-related absence and facilitating employees’ return to work. OHS professionals perform PMEs and follow-up interventions. Most OHS professionals work with employees of several industries, but since the construction industry has one of the largest work forces in the Netherlands, some professionals specialize in the construction sector and have worked with the employees for many years. Arbouw provides the OHS with guidelines on how to perform a PME and monitors their performance. During a PME, the designated OPs and medical assistants perform biomedical assessments, collect and review employee health questionnaire data, and, if necessary, refer employees for follow-up tests or treatment to general practitioners (GPs), medical specialists, or occupational health consultants, such as lifestyle counselors” (line 134-152).

Comment 1.8
Results: 3.2.3 – the issue of cost is raised in one of the quotes by an OP. It would be useful background information for readers to know how the costs of the program are covered, by the employee, employers, health insurance etc. Similarly, lack of continuity of care and time were raised as issue by OP, but again the reader has no contextual information about the normal practice of OP and therefore how the intervention might fit with this.
Response: See our response to comment 1.7.

Comment 1.9
Results: 3.2.4 – please provide more background information about the role and professional background of the lifestyle counselors and how they have been trained.
Response: The section ‘Intervention and Context’ includes information about the recruitment and training of the lifestyle counsellors: “Implementation of the HUC intervention requires that OPs systematically screen employees for an elevated CVD risk and refer those at risk to a trained lifestyle counselor. Prior to implementation, each OHS selected one or more of their employees, preferably with counseling experience, and assigned them to the four-day HUC training organized by Arbouw. The counselors’ professional background of the participants ranged from medical assistants to social workers. The training consisted of four modules: 1) motivational interviewing, 2) the relationship between physical activity, diet, and CVD risk, and 3) the HUC intervention protocol, and 4) data collection for the implementation evaluation” (line 153-160).
Comment 1.10
There is a discrepancy between the results presented in Table 2 and the text. For example ‘Good relationship between OP and other stakeholders’ is presented as a facilitator in the table, however the text (commencing line 376) describes the relationships with GPs and lifestyle counselors acted as a barrier. Similarly fit with perceived task in the text is considered as both a F/B depending on the OP, however the table presents this as a facilitator.
Response:
We recognize that Table 3 was unclear and have changed Table 3 to summarize the description of the themes in the results section. Furthermore, we have added the following description of Table 3: “As can be seen in the table, most themes were related to the implementation level of the target group. One theme was related to the intervention. Most themes were perceived as a barrier by some employees and as a facilitator by others (cells marked as B/F). Only one theme was perceived as a barrier by all respondents (cells marked as B)” (line 313-317).

Comment 1.11
Table 2: what does the F and B stand for in the table?
Response:
See our response to Comment 1.10.

Comment 1.12
Table 2: It is unclear why an individuals’ risk perception is considered the level of ‘socio-political’ context – surely this is at the individual level. Please clarify.
Response:
Although the article by Fleuren et al. (2004) indeed states that the characteristics of the individual members of the target group are defined as part of the ‘socio-political level’, we agree with the reviewer that this is confusing. We therefore have adapted the model by splitting this category into ‘Socio-political context at the societal level’ and ‘Characteristics of members of the target group’. We have changed section 4.1 accordingly: “During the course of the analyses, we found it confusing that the category ‘socio-political level’ includes factors that are located at the societal level, as well as at the individual level. We therefore adapted the model by splitting the category ‘socio-political level’ into ‘Socio-political context at the societal level’ and ‘Characteristics of members of the target group’ (see Table 3)” (line 653-656).

Comment 1.13
Quotes for individual interviews should be followed by (health professional 1 etc) so the reader can see that quotes came from a range of participants not just one or two,
Response:
We have added the respondent group and number to each quote, e.g.: “OP 1: And then there are the small companies…” (line 483).

Comment 1.14
Discussion: The discussion states that “An important barrier for employees to sign up for the intervention was a low level of risk” however this isn’t actually reported in the results – in fact the reader is unaware of the actual or perceived CVD risk of participants.
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Response:
The employees’ risk perception became apparent from their reactions. Even though this was a hypothetical risk, there were marked differences in the reactions of the employees to this hypothetical risk, allowing for a distinction between employees with different levels of risk perception. This was not described clearly in the results section. We have added the following sentence: “Most employees who were willing to sign up for the intervention first named the hypothetical elevated CVD risk as their reason, while employees who did not feel at risk were much less inclined to participate” (line 322-324).

Comment 1.15
Discussion: The authors need to put the study findings in the context of the broader literature on factors influencing implementation of lifestyle interventions in routine practice, particularly the work setting, highlighting the unique contribution to knowledge made by this study.
Response:
In order to broaden the scope of the literature review, we put our study findings in the context of the results of two studies on prevention in the occupational health (van Berkel et al., 2013, Verweij et al., 2012), as well as two studies on prevention in general practice (Geense et al., 2004; van Steenkiste et al., 2004) (references no. 37, no. 46, no. 21, no. 38).

Comment 1.16
Conclusion: The conclusion states “The implementation was facilitated and hampered by a combination of factors” – this is written in past tense and makes it sound like the implementation of the intervention has already occurred however the results were about anticipated barriers/facilitators prior to implementation. This needs to be made very clear in the title, abstract and conclusion.
Response:
We have reformulated the conclusion into: “Employees and professionals named a combination of factors that they thought would hamper or facilitate the implementation” (line 706-707). We have also added the words “anticipated” and “hypothetical” in the abstract (line 38 and line 41).

Comment 1.17
Conclusion: It is unclear what this conclusion means “OPs can be motivated to invest their time into the lifestyle agenda by placing lifestyle into the center of their goal setting strategy”. Does this mean OP need to make lifestyle more of a priority?
Response:
We meant that based on the barriers ‘lack of time’ and ‘fit intervention with task OP’, OPs lack incentives for working on the promotion of a healthy lifestyle. We have reformulated: “OPs can be motivated to invest their time in the lifestyle agenda by making lifestyle an OP’s priority” (line 715-716).

Reviewer 1: Minor Essential Revisions

Comment 1.18
Abstract: Methods not clear who participated in focus groups versus interviews. Please clarify
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Response:
In accordance with the reviewer’s comment, we have clarified this and have changed the text into: “Prior to implementation, focus groups were held with eight lifestyle counselors and semi-structured interviews with 20 employees of the construction industry, four occupational physicians, four medical assistants, and one manager of an occupational health service” (line 33-35). We have also added Table 1 which describes the method used for each respondent group (line 931).

Comment 1.19
Abstract: line 50-51 doesn’t make sense, suggest re-wording.
Response:
We have decided to remove this sentence.

Comment 1.20
Introduction: Would be good to provide the reader further context about the barriers and facilitators to implementation identified in the trial
Response:
The manuscript indeed suggested that barriers and facilitators were assessed alongside the trial; this is not the case. To clarify this, we have changed the text into: “Although the process evaluation alongside trial indicated several ways to improve the implementation of the intervention, a comprehensive assessment of the implementation barriers and facilitators was still lacking” (line 93-95).

Comment 1.21
Methods: Focus group is not a setting but a method
Response:
We have reformulated: “Focus groups were generally the preferred method...” (line 123).

Comment 1.22
Methods: Data collection – did the 2 occupational health services also participant in the trial or have previous experience implementing the program?
Response:
Yes, the two occupational health services were indeed involved both in the trial and the current implementation. We have made this more explicit in the revised manuscript: “These two OHS had also participated in the earlier trial of HUC intervention in 2006-2010” (line 195-196).

Comment 1.23
Method: Sample - sample characteristics and response rates are typically presented in the results section. It would be useful to include employee age and CVD risk profile in the sample characteristics if this was collected.
Response:
The text and table about the sample characteristics have now been moved to the results section (line 229). Table 2 shows the sample size, response rate, and gender per respondent group (line 933). No data was collected on the age and CVD risk profile of the respondents.
Comment 1.24
Method: Did interviews with employees occur in work time?
Response:
Indeed, the interviews with the employees took place in their work time. We have added this information: “Employees have the right to take paid leave for their PME, therefore the PME usually takes place during the employees’ work time” (line 203-204).

Comment 1.25
More detail about the content of periodic assessment would be useful.
Response:
See our response to comment 1.7.

Comment 1.26
Method: It would be useful if the authors could provide a rationale for why the employees real risk profile wasn’t used as the basis for interview
Response:
Unfortunately, it was not feasible to select employees based on their risk profile, because the OPs who did the recruitment were concerned that this might violate the privacy of medical data of the employees. We have now described this more clearly in the manuscript: “It was not possible to select respondents according to their CVD risk level; the OPs who recruited employees for the interviews did not consent to providing information about the employees’ CVD risk assessment due to privacy issues. Consequently, respondents were recruited regardless of their CVD risk” (line 204-208).

Comment 1.27
Method: It would be useful to provide further background information about the occupational physicians, medical assistant and managers and their usual role. For example do they work for occupational health service, What is their usual contact with construction industry and employees.
Response:
See our response to comment 1.7.

Comment 1.28
It is not clear who the manager was, manager of occupational health service or manager at construction industry?
Response:
This formulation was unclear indeed, and has been changed into: “The OHS managers were approached directly for an interview” (line 234-235).

Comment 1.29
Line 187 should this be ‘counsellors’ or ‘consultants’
Response:
We have changed ‘consultants’ into ‘counselors’.
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Comment 1.30
Line 200 “3) motivating participants to complete the trajectory “ – what does this mean?
Response:
In the revision, we have explained this by: “…motivating participants to maintain their behavioral change and attend counseling” (line 261-262).

Comment 1.31
Please provide rationale for the different coding process used for employees and Ops compared to other participants.
Response:
In the revised manuscript, we have explained why two different coding processes were used and made more explicit how the coding was done: “The interviews with the employees and the OPs were coded by two coders (ST and ES). The interviews with the manager, the medical assistants and the counselors rendered less codes, which is why they were coded by one coder (ES). The second coder (ST) read the coded transcripts and checked the codes. The coders had several meetings to reach consensus on codes where discrepancies had arisen” (line 272-277).

Comment 1.32
Given the large number of theoretical models published around implementation, please provide the rationale for the choice of implementation model used (Fleuren, Wiefferink and Paulussen). It doesn’t seem to be a natural fit with the data presented.
Response:
The model fits the data in the sense that all factors could be categorized in one of the implementation levels. We used the model in a separate step of the analysis, and as sensitizing concepts during the coding process, which is why the model only had a minor influence on themes that were found. The rationale for choosing the model has now been explained as follows: “The model was chosen because it was developed to analyze implementation processes in large health care organization as opposed to implementation by individual health professionals” (line 170-172).

Comment 1.33
Results: 3.2.3 should read ‘Relationship between occupational physicians and other stakeholders.
Response:
We have changed the heading as suggested (line 436).

Comment 1.34
Overall the manuscript should be proof read by a native English speaker to improve the written English.
Response:
The revised manuscript was edited by a native speaker, who made substantial revisions.

Reviewer 1: Discretionary
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Comment 1.32
It might be helpful to include a table summarizing the interview schedule for each group of participants
Response:
We have added Table 1 as suggested (line 931).

Reviewer 2: Major Compulsory Revisions

Comment 2.1
In the introduction, we can read that there is already a process evaluation performed for this intervention (reference 18. Groeneveld IF, et al. 2011). Can the authors in the research question at the end of the introduction, state more clear what the added value is of their research (other target group? Other methodology?)? Or can the authors indicate more clear in which phase their research is situated compared with the previous process evaluation (f.e. process evaluation situated in ideal situation in the evaluation phase of the intervention, this research in real life situation)?
Response:
To accentuate the added value of this study, we have added the following information: “Although the process evaluation alongside trial indicated several ways to improve the implementation of the intervention, a comprehensive assessment of the implementation barriers and facilitators was still lacking” (line 93-95) and “The current study provides new insights, because the implementation process under study takes place in a real-life setting. During the trial, the implementation process was coordinated by a research team. During the current study, coordination was taken over by the OHS, thus making the results more relevant for implementation processes outside a controlled setting. Furthermore, the process evaluation had focused exclusively on the role of the counselors and the employees, while during the present study, interviews were held with all key stakeholders of the implementation process, namely employees, OPs, medical assistants, counselors, and an OHS manager” (106-115).

Comment 2.2
Methods lines 119-120: there is research on barriers and facilitators to participation and implementation of lifestyle interventions. There is even a whole journal dedicated to this topic (see Implementation Science). When not much research is found, researchers can also use theory as basis for their study (see f.e. Downey AM & Sharp DJ, Health Promotion International, 22(2), 2007 using the Theory of Planned Behaviour). This is something I miss in this paper: theory, what is already know about barriers and facilitators, …
Response:
We have added a section with the title ‘Theoretical Framework’ which describes the theory that was used. Also, we have changed the reason for the qualitative approach as follows: “In order to obtain in-depth information on the factors that influence the willingness and ability to participate
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and implement a lifestyle intervention in this specific context, a qualitative design was chosen” (line 221-123).

Comment 2.3
Methods lines 156-158: Same remark as 2. Here is stated that previous research already revealed some barriers and facilitators (mentioned by professionals and by employees). Was theory used in this research to capture these determinants? How can you be sure that there are no barriers or facilitators missing?
Response:
There was theory used; we now have made this more explicit by adding the section ‘Theoretical Framework’ (line 169-190). (See also our response to comment 2.2.)

Comment 2.4
Methods lines 174-175: What was the basis for the topic list?
Response:
Theory was used in this study, but not to formulate the topic lists. We have explained this in the revised version as follows: “The topic lists were based on the research question. The concepts in the framework served as sensitizing concepts during the coding of the data. In a later step in the analysis, the data was structured according to the framework” (line 187-190).

Comment 2.5
Discussion: limitations: Was there saturation of information in the interviews of the employees, OP’s and medical assistants? Did this research succeed to capture most of the barriers and facilitators?
Response:
We agree that saturation is an important issue to determine how complete the results are. In the revised version, we have added the following: “For some groups (assistants, counselors), saturation was reached, after which no further interviews took place. For other groups (OPs, employees, manager), the number of participants was too small and did not result in saturation. The interviews were performed during the six months prior to actual implementation. Once implementation had started, no further interviews could be performed, because the results would not have been comparable to the results generated before implementation” (line 680-685).

Comment 2.6
Discussion lines 581-582: The authors indicate that one of the limitation is that the sample of employees was not selected based on their CVD risk. Besides that this makes your group more heterogeneous in risk perception and lifestyle, I also see another limitation. When people got the diagnosis of being at risk for something, they can react differently compared with when they are in the hypothetical situation of being diagnosed (like in this study). They can fight or they can flee. This is something that is not captured in this study. Other barriers and facilitators can pop up when they are actually in this (sometimes life threatening) situation. For the other stakeholders, this hypothetical situation is less important as they are not/less emotionally involved.
Response:
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Based on this comment and the comments 1.4 and 1.14, we have stated more clearly in the results section as well as in the discussion that the elevated risk was indeed a hypothetical situation. We have also added our interpretation for the results of this study: “Furthermore, the employees’ response might differ from respondents who are confronted with an actual elevated CVD risk. Literature indicates that perceived susceptibility and perceived severity of a threat influences the intention to adopt protective behavior, although the influence is smaller and less consistent than that of the perceived response efficacy and perceived self-efficacy regarding the offered protective measure” (line 695-670).

Reviewer 2: Minor Essential Revisions

Comment 2.7
Is Arbouw a commercial institute or is it a governmental institute (like a general institute coordinating all occupation health services)? If it is the first, it would be better to make this institute anonymous.
Response:
Arbouw is a non-profit organization. The revised manuscript states: “In the Netherlands, occupational health in the construction sector is financed and coordinated by the national institute Arbouw. This non-profit institute represents construction industry employers and employees and aims to improve working conditions and reduce sickness-related absence in the sector. Employers in the construction sectors pay fees to Arbouw, which Arbouw uses to develop and implement health and safety measures” (line 134-138).

Comment 2.8
Methods line 127-128: Did the Medical Ethics Committee give a reason why ethical approval is not necessary?
Response:
The Medical Ethics Committee gave no explicit reasons, but our argumentation before the committee was that 1) this study was no medical study, as the implementation process was the central issue, and not the health of the participants, and 2) respondents were not required to undergo any kind of treatment or follow any behavioral rules that deviate from reality outside the study.

Comment 2.9
Table 2: Indicate in the footnote: F = facilitator, B = barrier; instead of with numbers. Or put footnote 3 at the first barrier and not at the second.
Response:
We have changed the footnote as suggested (line 936-938).

Comment 2.10
Attachment: See comment 1, minor essential revisions.
Response:
See also our response to Comment 2.7.
Reviewer 2: Discretionary Revisions

Comment 2.11
Line 182: The interviews with the medical assistants lasted on average 25 minutes; ...
Response:
We have reformulated the phrase as suggested (line 225-226).

Comment 2.12
Line 302: weighing scale.
Response:
We have reformulated the phrase as suggested (line 385).

Reviewer 3: Major compulsory revisions

Comment 3.1
The fact that probably more than half of the participants that were employees had no risk factors for cardiovascular disorders (according to previous studies in the introduction) most likely affected their responses. Five employees said that they were not willing to sign up for the intervention, which might have been due to that they already were engaged in similar activities or that they believed they had no risk factors. It is self-evident that those who wanted to sign up thought they had an elevated risk. A more interesting question is whatever those that were at risk actually were aware of this and were willing to participate. It is difficult just to imagine that you are at risk if you never considered it before. In line with this I do not fully follow the authors in the first part of the discussion. If the interviewees had no or small risk factors, how could they be aware of them? Were questions asked about knowledge of risk factors?
Response:
Indeed, we meant the awareness of the perceived risk. Some employees reported having risk factors, and still were not motivated to participate. In the discussion, we have now distinguished between these groups: “Some employees reported they were physically active and felt healthy, which made it hard for them to imagine having an elevated CVD risk. But even employees who reported having CVD risk factors, such as being overweight or having high blood pressure tended to evaluate their lifestyle as healthy, and they were not compelled to take action until they developed actual health complaints” (line 551-555).

Comment 3.2
The statements used in the interviews on barriers and facilitators derived from interviews with professionals. Did they derive from the interviews that are included in the present study?
Response:
Yes, some statements were derived from the interviews that were used in this study. This has been included in the revised manuscript: “The statements operationalized barriers and facilitators
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that were derived from the interviews with the professionals who were included in the present study…” (line 222-223).

Comment 3.3
They [the statements] do not seem like professionals opinions more like participants. If they derived from participants in the previous study were those participants involved in the intervention program?
Response:
Some statements were derived from interviews with employees before the intervention had been designed. We have explained this more clearly by the following statement: “…as well as interviews with employees in the construction industry that had been held in 2006 in preparation for designing the HUC intervention” (line 223-225).

Comment 3.4
Some of the statements looks somewhat strange – how can a person react to a statement like “my wife think it is important I participate” if they had not been able to discuss it with their wife?
Response:
In the actual implementation, employees also may need to decide whether or not they want to participate in the intervention without being able to discuss it with their wife. It is not the actual opinion of the spouse that will influence their decision, but their perceived opinion. In this case, the hypothetical nature of the question is actually realistic.

Comment 3.3
Focus groups and individual interviews are two techniques that result in very different information. It is stated that focus groups was preferred but that this was not feasible. Different techniques were now used in different groups making it very difficult to compare the results and summarize them together. This needs to be discussed.
Response:
We agree that the different methods of data collection need to be taken into account. In the discussion, we have added the following sentence: “Distinct methods of data collection were used for the counselors and the other respondent groups, which limits comparability of the results. This limitation should be taken into account when interpreting the results” (line 677-679).

Comment 3.4
One of the conclusions is that occupational physicians should place lifestyle into the center of their goal setting strategy. This actually might be the task for other professionals, which are better educated for this.
Response:
We agree and have reformulated the text: “OPs might benefit from clear policy statements and OHS management targets that integrate the promotion of a healthy lifestyle within their organization. Guideline developers should clarify if and how consultation and collaboration with an employee’s GP is advisable. They should strive for coherence with existing GP guidelines and consider the adverse effects that the implementation of a guideline could have on the relationship
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between the OP and GP. Decision makers within OHS and OP interest groups need to employ strategies on how to implement those guidelines” (line 638-644).

Comment 3.5
*The Op-s did not consent to make a risk assessment. This is important information on barriers to implement the program. Why did they not consent? Some of them seemed to believe that prevention was important.*

Response:
This sentence refers to the OPs who recruited PME participants for the interviews of the present study, not for the intervention. We have made this more clear by saying: “It was not possible to select interview respondents according to their CVD risk level; the OPs who recruited employees for the interviews did not consent to providing information about the employees’ CVD risk assessment due to privacy issues” (line 204-207).

Comment 3.6
*The gathered information is based on persons with entirely different experience of the intervention program. The counselors have previously been involved and all the others have not. Thus it is difficult for the other groups to have opinions on for example the importance of training in motivational interviewing. Are those counselors that have previous experience of the program going to be involved in the implementation? Did this affect their answers?*

Response:
It is indeed the case that most professionals who participated in the interviews were also involved in the implementation. We decided to include this information under ‘Limitations of the study’: “All professionals who participated in the interviews knew they might be involved in the implementation of the HUC intervention and this might have influenced their responses during the interview“ (line 687-689).

Comment 3.7
*How can the conclusion be that the implementation was hampered? As I understand it the implementation is not yet done and that this study was done to design it.*

Response:
We also find that it must be clearly stated that this study was performed prior to implementation. We therefore changed the wording as follows: “Employees and professionals named a combination of factors that they thought would hamper or facilitate the future implementation of the intervention” (line 706-707).