Author's response to reviews

Title: Translating evidence-based interventions for implementation: Experiences from Project HEAL in African American Churches

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Version: 4 Date: 9 January 2014

Author's response to reviews: see over
Denise O’Connor
Implementation Science Editorial Team

January 9, 2014

Dear Dr. O’Connor,

Please consider this revised manuscript, “Translating evidence-based interventions for implementation: Experiences from Project HEAL in African American Churches” for peer review by Implementation Science.

We thank you for your previous careful review of this considerably revised manuscript. We apologize that during the editing process we inadvertently deleted or overlooked a couple of the changes that we had made or intended to make. We hope that by providing the line numbers, at your suggestion, that this has indeed helped to identify the revisions. In the pages that follow, we describe in detail how we have addressed each of the Reviewer comments in this revised version of the paper. We appreciate the opportunity to provide this revised version for consideration.

All human participants were treated in accord with the APA Ethical Principles, gave their informed consent to participate, and the study was approved by the Institutional Review Board. This paper is not currently submitted elsewhere for publication, and has not been published previously. Myself nor any of my team members has any competing interests to report.

Thank you for your consideration. We will look forward to hearing from you soon.

Sincerely,

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Editor’s comments:

Comment:

…page and line numbers relating to where you have made changes in your manuscript in response to peer review comments.

Response:

We now provide line numbers in this revised version.

Comment:

For example, you say there is a statement about ethics approval in the methods section (in your letter dated 14/11) but I cannot locate it. I also cannot see where you have clarified that members of the advisory panel are the same people as community partners etc.

Response:

The information on ethics approval was provided in the revised document, see page 2, line 29. We now additionally provide it in the Method section, page 9, lines 310-311. The clarification on the Advisory Panel is on page 9, line 326. We may have inadvertently deleted this during the team review and editing process, as the paper was heavily rewritten.

Comment:

Also, I noticed that in response to my request to adhere to the relevant reporting guidelines (I provided a link to a document referring to WIDER, Workgroup for Intervention Development and Evaluation Research) your response related to CONSORT. I did not want you to refer to CONSORT but rather to ensure you adhered to WIDER recommendations.

Response:

We now refer to the WIDER recommendations- see below for more detail. I had thought one of the Reviewers suggested that we in addition refer to CONSORT guidelines, but in re-review of the comments, this does not appear to be the case.
Reviewer 2:

Comment:

-the report should adhere to the WIDER guidelines

Response:

We have revised the manuscript as necessary to adhere to the WIDER guidelines: Detailed description of interventions in published papers:

a. Characteristics of those delivering the intervention:
   The CHA eligibility criteria is described on page 15, lines 531-534.

b. Characteristics of the recipients:
   The workshop participants, including eligibility criteria, are described on page 13, lines 477-481.

c. The setting is described on page 13, lines 474-477.

d. The mode of delivery (in-person workshops) is described on page 13, lines 474-475.

e. The intensity (workshops 1.5 hours in length) is described on page 13, line 475.

f. Duration (workshops 1 month post CHA certification and scheduled 1 month apart) is described on page 13, lines 475-477 and page 28, Table 1, line 1290.

g. Adherence/fidelity to delivery protocols is described on page 14, lines 504-512 and page 19, lines 674-676.

h. Detailed description of intervention content provided for each study group:
   i. CHA training content for both conditions is described on pages 11-13, lines 396-419; page 14, lines 495-501; and page 29, Table 2, line 1294.
      1. Traditional CHA training content is described on pages 11-12, lines 396-419.
      2. Online CHA training content is described on pages 12-13, lines 420-470.
   ii. Participant content is described on pages 13-14, lines 471-494.

2. Clarification of assumed change process and design principles:
   a. The intervention development; development of the three interventions that underpin the current study is described in more detail in other papers, which we cite (this includes the theoretical basis). This paper describes the intervention development, which was based on previous interventions. So, this is all available either in the current or in prior publications that we cite.
   b. The change techniques used in the intervention: see “2.a.”
   c. The causal processes targeted by these change techniques: see “2.a.”

3. Access to intervention manuals/protocols:
   These materials can be requested from the authors. We now state this in the paper; see page 14, lines 512-513.

4. Detailed description of active control conditions:
   The description of the comparison (Traditional CHA group) is described on pages 11-12, lines 396-419.
Editor’s comments:

Comment:

-an explicit statement must be added stating that the study has been approved by an ethics committee (state name and study reference of the committee) (see http://www.implementationscience.com/content/6/1/32 )

Response:

We had previously reported this information on p. 2. We now additionally provide this information in the Method section.

page 2, line 29; page 9, lines 310-311

Comment:


Response:

Consistent with the editor’s comment we have completed the changes, as appropriate, to adhere to the CONSORT guidelines for randomized controlled trials (see attached table). We must keep in mind that the current study does not report on randomized controlled trial findings, therefore many of the CONSORT guidelines are not yet applicable for this stage of the reporting. However, they will be applied to subsequent Project HEAL reports of trial data.

See previous page on WIDER.

Comment:

- the report must clarify what contribution it makes to the evidence base in implementation science (see comments by Norton) Implementation Science considers manuscripts describing implementation intervention development in the context of ongoing or subsequent evaluation of the effectiveness of the intervention (and we prefer implementation intervention development reports be submitted/considered for publication prior to reports of the effects of the interventions? see http://www.implementationscience.com/content/7/1/71).

Given you have stated that the developed interventions are being (or will be) evaluated in a cluster randomized trial, the case for publication of the intervention development report would be strengthened if you could provide more details of the ongoing or planned evaluation if available (e.g. trial details, main outcomes, reference to trial protocol etc).

Response:

The present study makes a unique contribution to the implementation science literature specifically in the area of community-based behavioral intervention translation and the application of technology in the training of peer community health advisors. We also appreciate that Reviewers 1, 2 and 3 are supportive of the significant contributions of the paper.
We confirm that the paper is submitted prior to the report of intervention effects. Consistent with Table 1 in the above-mentioned web site, intervention development reports may be acceptable for consideration if they are “Prepared and submitted prior to the reporting of the effectiveness of the intervention.” Finally, upon review of recent tables of contents for Implementation Science, we appreciate that a number of different study formats are published, including intervention development and trial end results.

Consistent with Reviewer 4’s recommendations, we provide additional details of the planned evaluation. To provide trial data would be beyond the scope of the present paper, which as Reviewer 4 notes, is already lengthy.

**page 19, line 654 – page 20, line 691**

Comment:

-journal style confirmation-

Response:

This manuscript was written in accordance with Implementation Science’s guidelines on style and language. Please advise if additional modifications are needed.
Reviewer 1:

Very clearly written manuscript. The goals of the paper are clear, relevant and important to community researchers and implementation scientists. I have just a few minor comments.

Discretionary revisions

Comment:

1. The wording in the abstract session describing the two strategies is a bit unclear. The traditional live with high technical assistance suggests that this is also a technologically enhanced group. I think that high support may make it more clear to the readers that this is a traditional approach with workshops to train the peer health advisors.

Response:

This is a very good point. The language has now been clarified within the abstract.

page 3, lines 43-45

Comment:

2. Are the advisory panel and the community partners (community-based HEAL staff) the same people?

Response:

They were actually separate. This is now clarified in the paper.

page 9, line 326

Comment:

3. How many hours of training did the CHA Training-traditional approach receive? And in how many sessions? What was the attendance at each of the sessions? It seems that 8 hours of training is too long to have in 1 session and that having the flexibility of dividing up the training with the computer based training would be a large benefit.

Response:

The CHAs in the traditional approach received six hours of in-person training over two 3-hour sessions. Additionally, four modules of the Project HEAL curriculum (“leadership skills”, “communication skills”, “documentation”, and “ethical issues”) were presented to the CHAs on a flash drive (as narrated PowerPoints) as self-study modules to be completed at home. Both CHAs attended the two training sessions led by six members of the Project HEAL team and an Advisory Panel member. This is now clarified in the paper.

Pages 11-12, lines 396-412; page 16, lines 567-572

Comment:

4. I think that creating a CHA module for the breast cancer intervention may have also contributed to the
increased time of the translation process and could me mentioned in the discussion.

Response:

Excellent point. We have added this to the Discussion section.

page 21, line 738-740
Reviewer 2:

Thank you for the opportunity to review this manuscript. I enjoyed reading about the process of implementing your interventions in a community-based setting. Reporting the experiential aspects of creating the intervention, conducting pilot testing, and lessons learned throughout this process are invaluable to enhancing your current and future interventions and for other researchers undertaking this work. More manuscripts of this nature should be published to guide future intervention design and implementation.

Major Compulsory Revisions:

Comment:

My main comment to the authors is related to intervention conceptualization. It is unclear why the integration of three distinct interventions would be considered a process of translation rather than a process of intervention development.

It is also unclear why the training of the peer community health advisors is not considered an intervention. This type of training (i.e., ‘train the trainer’) is integral to the cancer prevention/screening education sessions and would need to be included in order to replicate your study. This means that the ‘train the trainer’ aspect should be justified, supported by the literature, and described in detail.

Outcome measures to determine the effectiveness of the peer community health advisor training overall and the effectiveness of each mode of delivery are also an important component of understanding whether or not this intervention could be improved/refined in future studies.

Response:

These are all highly insightful points, and we will address them one by one.

To address the first: This is an outstanding point and one to which we have given significant reflection. Project HEAL was designed to take a series of three highly related evidence-based cancer communication interventions, merge them and brand them together, and test two delivery modes for CHA training in an implementation trial. It is not an efficacy trial, in that the three evidence-based interventions were each tested in their own previous randomized efficacy trials to establish their evidence base.

That being said, we believe the current study describes intervention “translation” (minor adaptations, in an implementation trial context) rather than intervention “development” (e.g., from scratch, in an efficacy trial context). Intervention (new materials) development activities were conducted for the web portal, health ministry guide, and breast cancer module, but mainly the process was working with existing materials.

In a clinical context, translation is often defined as “bench to bedside” [Woolf, 2008], however the definition provided by Dankwa-Mullan and colleagues [Dankwa-Mullan, et al., 2010] more fully emphasizes the broader applications of research targeting health disparities as “research that links or translates basic science (biological, genetic, social, political, and environmental) discoveries to practical, applicable strategies and effective policies to improve health outcomes in health disparity populations (p. S20). The four domains include “(1) basic science discovery, (2) testing and applications in developmental stages, (3) outreach and dissemination of findings, and (4) adoption and implementation” [Woolf, 2008] (p. S20).

More relevant to the present study is a behavioral science perspective on translation, which involves translating research into practice (Glasgow, et al., 2003; Glasgow, et al., In Press; Estabrooks, et al., 2003). Stated more specifically, this model of how to translate research into practice involves developing
disseminable interventions that progress from efficacy studies to effectiveness trials to dissemination projects (Glasgow, et al., 2003). However, it is acknowledged that this process does not flow evenly due to lack of attention to setting and contextual factors. The RE-AIM Framework is suggested as one way to address these factors, and Project HEAL is using this framework in its evaluation plan.

A definition of “translation” in the behavioral science context is now provided in the manuscript, and we have now taken more care with our use of the term throughout the paper.


[THROUGHOUT PAPER]

To the second point, we DO consider the CHA training part of the overall intervention, and have now included supporting citations and a general write-up on the use of CHAs. This also helps to provide background for this critical part of the intervention.

page 10, line 353 – page 11, line 378

To the third point, we agree wholeheartedly with the importance of outcome measures. Project HEAL has a multi-level evaluation plan aligned with the RE-AIM Framework as well as informed by health behavior change theory. This also includes a detailed process evaluation that will utilize data provided by multiple perspectives (e.g., participants, CHAs, pastors, team member observations). This information is now described in the Implementation Trial section of the manuscript.

page 19, line 654 – pge 20, line 691

Comment:

1. The target population for the present study is not clearly defined. Specific areas that require clarity: 1) in the ‘background’ sections the target population appears to be church attendees; 2) in the ‘present study’ section the target population appears to be peer community health advisors; and 3) in the ‘implementation trial’ section the target population is unclear. In relation to my above comments, there may be two target populations; however, this is not explicitly stated.

Response:

This is an excellent point. We have now specified the target populations for both 1) the intervention; and 2) the community health advisor training.

1) The target population for the workshops is described on page 13, lines 477-481.
2) The target population for the community health advisor training is described on page 15, lines 531-
Comment:
2. The intervention conceptualization and development is not clearly described (see above comments).

Response:
See above.

Comment:
3. The outcomes/outcome measures of the present study are not clearly identified and described. It is unclear whether the post-workshop survey (p. 16) is intended to evaluate the peer community health advisor training or church attendees’ post-workshop cancer screening knowledge. If the effectiveness of peer community health advisor training is not assessed, this should be explicitly stated and justified.

Response:
These are excellent points related to outcomes on several levels:

Related to the present paper, we have added that a method used to evaluate the CHA training is through the certification process, where each CHA must pass a knowledge exam on the core content in order to move forward to conduct their workshops. Other evaluations of the CHA training could come through its impact on the workshop participants’ knowledge and screening outcomes, as well as process evaluation measures.

page 20, line 688-691

Related to Project HEAL overall, we have also added a section on evaluation (see “Implementation Trial”) that outlines our evaluation structure, which is based on the RE-AIM Framework. We had previously not included this due to the length of the paper and its focus on intervention development.

page 19, line 667 – page 20, line 691

We have also clarified the role of the post-workshop survey. Though this data will be used primarily in the trial phase, we did pilot the procedure in the pilot study.

page 19, lines 669-671

Comment:
4. Please include a statement regarding research ethics approval for the study.

Response:
We had previously reported this information on p. 2. We now additionally provide this information in the Method section.

page 2, line 29; page 9, lines 310-311
Minor Essential Revisions:

Comment:
1. Please define the term ‘translation’ and cite relevant literature to support the definition. The term translation is used in the manuscript multiple ways, which hampers clear understanding of the intended meaning (i.e., “translational field” (p. 6); “translating our series of three evidence-based interventions into one” (p. 8); “interventions require minimal translation to put into real world practice” (p.9); “materials had to be translated for the new setting” (p. 18)).

Response:
This is an outstanding point. We have now addressed use of terminology, consistent with a previous comment. We have addressed each place in the manuscript in which the term “translation” is used, and cleared up inconsistencies.

[THROUGHOUT PAPER]

Comment:
2. The following passages would be greatly strengthened by referencing supporting literature:

a. “Furthermore, African Americans suffer a disproportionate burden due to variety of factors including disparities in early detection” (p. 4).

Response:
Modified sentence and added supporting citation.

page 4, line 85-87

b. “However, more often than not, such interventions are tested in randomized trials, become evidence-based, and then fail to reach further implementation” (p. 4).

Response:
Modified sentence. We can provide additional support if needed.

page 4, line 93-94

c. “The current evidence base in dissemination/implementation research mainly focuses on provider-based interventions and settings” (p. 6).

Response:
This material was cut in response to Reviewer 4’s recommendation to condense the Introduction section.

page 6, line 163

d. “Simultaneous with the growing need to bridge the gap between research and sustainable practice is the
push for the field of public health to keep pace with the rapid development of technology” (p. 7).

Response:

This material was cut in response to Reviewer 4’s recommendation to condense the Introduction section.

page 7, line 217

Discretionary Revisions:

Comment:

1. The application of an intervention categorization framework, such as the EPOC Taxonomy from the Cochrane Effective Practice and Organisation of Care Review Group, or a descriptive framework, such as the WIDER Recommendations to Improve the Reporting of Behaviour Change Interventions, would standardize intervention terminology/descriptions making the interventions of your study easier to understand and compare.

Response:

We have carefully reviewed these frameworks. In general, we provide the details of our study consistent with the recommendations. However, as this paper does not report trial data, not all areas are applicable as of yet. If there is specific information that is not covered in the present writeup, we are happy to include it as appropriate.

See previous

Comment:

2. The manuscript refers to “process evaluation” (p. 17) that will take place in the future. This is a great idea and detailed description of the intended process evaluation methods, outcomes, and timing would add clarity about the purpose and the feasibility of the intervention. This information may also generate interest in a follow-up paper about the process evaluation.

Response:

This is an excellent point. We have now added an elaboration on our planned evaluation methodologies.

page 19, line 654 – page 20, line 691

Comment:

3. Practical examples of branding, workshop materials, and the web-based training portal referred to in the manuscript would be of great interest and may be used to inform future interventions.

Response:

Excellent idea. Four examples have now been added as figures.
Reviewer 3:

General Comments:

This manuscript is well-written and it serves to extend the dissemination and church-based health promotion literature. There is a need to clarify how evidence-based programs get translated, disseminated and ultimately adopted by communities they are intended to serve but often is glossed over in literature about how researchers actually do this. An additional strength of this work is the translation of several evidence-based cancer communication interventions into one coherent, branded strategy. Finally, the use of technology to expand dissemination efforts has good potential for improving reach to targeted populations and is important strategy to test.

The authors could provide additional details to enhance the reader’s understanding of potential challenges, current evaluation methods, and provide some process details (see detailed comments below) to further strengthen this report.

Major Compulsory Revisions:

Comment:

• Examples from the PRAISE project presented on pgs 6-7 are listed regarding approaches for designing with institutionalization and sustainability including determining organizational capacity for the program. The authors say that all the example strategies listed were incorporated into Project Heal. How was organizational capacity determined?

Response:

This is a very good point. We have added additional information describing the inclusion of organizational factors to assess their impact on implementation, in the evaluation section of Project HEAL.

page 20, lines 686-688

Comment:

• Pg. 12 web-based CHA training portal: It would be beneficial to add some detail about the comparison to the print materials. Given that these are different mediums, how, if at all, did layout change, were there any interactive features? What there features that allowed for more engagement?

Response:

The CHAs received the CHA Training Manual, Health Ministry Guide, and Cancer Resource Guide in it’s original print form. All other materials delivered through the web-based portal were exact replicas of the print materials used in the traditional approach with the exception of the PowerPoint slides that had added narrations. This has now been clarified in the paper.

page 12, lines 421-430

Comment:

• Pg. 15. Pilot workshop-traditional approach: While the CHAs were the focus of the evaluation, it would be helpful to know more about who received the training, how many etc?
Response:

We have now added the number of participants that were in each pilot condition as well as their gender and mean age.

Page 17, lines 597-599; pages 17-18, lines 612-630

Comment:

Why was the entire series of trainings not evaluated and only the first? It is likely that CHAs increased confidence in their training and improved over time or diminished in the quality of their training. Also, given that each module in the series was focused on a different content area, challenges and ease of presenting each topic area could have varied. But there is no report about whether CHAs followed the protocol for each of these sessions.

Response:

Thank you for these comments. We piloted each study condition (traditional and technology) with two CHAs each in two separate churches. Both churches’ CHAs received the entire CHA training curriculum. To keep the overall study timeline moving, the traditional condition church was only asked to deliver the breast/prostate cancer workshop, and the technology condition church was asked to deliver the colorectal cancer workshop. In this way, all materials were piloted prior to the main trial (next phase). This pilot test was designed as a protocol “dry run” only. The randomized trial will provide an opportunity to address the above issue.

With regards to adherence to protocol, both sets of CHAs followed the prescribed protocol for each workshop session. This is now reported in the manuscript.

Page 16, lines 562-566; page 18, lines 633-634

Comment:

How were the CHAs evaluated to determine their ability to conduct the workshop? This information is critical to understanding whether there is evidence to support them as primary point of dissemination.

Response:

After completion of the CHA training, CHAs in both conditions complete a certification process consisting of a knowledge exam that must be passed with a score of 85% or better. The exam covers material on breast, prostate, and colorectal cancer (e.g., symptoms, risk factors, screening methods). We have elaborated on this process within the manuscript. We have added the above point to the limitations section of the Discussion.

Page 12, lines 413-419; page 13, lines 465-470; page 24, lines 847-857

Comment:

• Pg 20: Does the suggestion that churches with health ministries are more likely to focus on disease management than on prevention and control pose a challenge or an opportunity for working with churches that have health ministries? It would be helpful to readers to understand what potential characteristics of faith-based institutions that might hinder or facilitate health promotion of this kind.
Response:

It may be premature to draw conclusions in this area particularly based on a web site review. We have therefore softened the sentence being referenced. We also add to this section that “because so little is known about health ministry development, structure and function, and how health priorities are identified in faith-based organizations, this is an area that has potential for future research.” We believe that characteristics of faith-based organizations will play an important role in Project HEAL outcomes, and will assess the role of these characteristics in study outcomes in the next phase.

page 23, lines 825-827

Minor Essential Revisions

Comment:
• Pg 18: Missing word in second sentence of second paragraph.

Response:
We have corrected this error.

Page 21, lines 743-745

Comment:
• Pg 17. Authors say that they wanted to determine if the intervention “could be implemented and sustained in African American church settings”. This statement reflects the next phases of the project and not the current study so should be removed as they are discussing the current study.

Response:
In light of another Reviewer’s strong interest in discussion of the next phase of the study (e.g., implementation trial), we have retained this content. However, we have aimed to clarify what is reported in the context of the current paper and what is in the scope of the next phase.

page 19, lines 655-658; page 8, lines 268-272

Discretionary Revisions:

Comment:
• Is the technical assistance (TA) provided to web-based CHAs done by telephone or email? Given that CHAs can take this training at any time, if they encounter issues after hours, would this be a barrier to continuing the training? Are they ways that the authors have thought of to provide more structured technical assistance rather than self-initiated by CHAs? From previous experience working with churches, TA may be needed but churches hesitate to initiate contact on a regular (or needed basis) to allow for this. Perhaps the revised protocol of including a face-to-face overview prior to the web-based training may help to mitigate any potential issues with asking for TA.

Response:
These are excellent points. Technical assistance provided to web-based CHAs was done via both telephone and email. In the event that assistance was needed outside business hours, project team staff would return CHAs’ calls or emails as soon as possible. Including an FAQ section in the web-based training portal is something that the authors have considered adding in future iterations of the program. We agree that providing a face-to-face technical assistance session prior to the web-based training would be helpful and have added these ideas to the Discussion section.

**Comment:**

- Pg. 15: The authors have determined that an in-person orientation is needed for the CHA training technology approach, who would be responsible for providing this service in the next phases of a larger program roll-out where researcher involvement is removed?

**Response:**

This is a very good point. This determination was based on a single church. As we progress through the study, we will consider the different technical assistance needs for CHAs to complete this type of program. A few ideas have been to include an FAQ section in the web-based training portal or to utilize a peer-supported approach where existing trained CHAs support each other.

**Comment:**

- Pg. 16. Authors were responsive to the church’s need by adding the survivorship module thus enhancing fit of the intervention. This was a good strategy of responding to needs of the target population/institution.

**Response:**

Thank you. This also illustrates the need for flexibility in conducting this type of work.

**Comment:**

- Pg 20: Any considerations of including a FAQ section (if not already done) about any issues that may come up with using the technology approach to help with TA provision?

**Response:**

This is an excellent idea (also see above). The project team has considered this and plans to use this approach in future iterations of the web-based training portal.

**Comment:**

- Pg. 24, lines 854-857; p. 24, lines 854-857; page 21, lines 751-756; p. 24, lines 854-857
Reviewer 4:

This manuscript reports on the process of translating evidence-based cancer-focused interventions into community settings. The authors describe their process in detail and provide lessons learned for others interested in pursuing this type of approach.

Although interesting and informative, I do not think that this manuscript is suitable for publication in the journal Implementation Science. The description of the process presented herein is not particularly innovative; much has been written on processes for translating evidence-based interventions into community settings. I recommend that the authors consider the suggestions outlined below, revise as they see appropriate, and consider submitting the manuscript to a more specialty journal in public health/community engagement (e.g., Evaluation and Program Planning; cancer prevention/education specialty journal).

Major Compulsory Revisions

Comment:

• The contribution of this article to the evidence base in implementation science is unclear. The authors should consider significantly reducing the introductory text; most readers in this field are familiar with the problem of lack of dissemination and implementation of evidence-based interventions, confusion over use of various terms, and efforts to reduce the research-to-practice gap.

Response:

We have reduced Introduction section as recommended. We have also emphasized the contribution to the evidence base that the article makes, which is to advance the literature in implementation science through describing a novel way to extend the reach of an intervention that may have broader implications for other implementation methodologies. More specifically, the technology-based holds promise and could be adapted and considered for broader use in implementation/dissemination research. This is also the first contribution that we are aware of that describes a technology-based approach for training community (lay) health advisors. See also our response to the Editor’s comments regarding this issue.

Introduction section

Comment:

• The authors should explicate their rationale for using in-person vs. web-based training approaches, and hypothesize which approach they believe to be more effective at changing CHAs’ behavior (e.g., increased fidelity to intervention components?). Has this type of manipulation been conducted already in the field? What are the results and how do those findings inform predictions in the present study? The approach needs to be situated within the context of other published findings that may manipulate the type of technical assistance and training provided to community health workers.

Response:

These are all excellent points and addressing them has caused us to more clearly make the case for the current contribution, which we appreciate. We have now provided a rationale for the technology condition and comparing it to the traditional approach. We also provide study hypotheses from the overall HEAL trial, under the “Implementation Trial” section, so as not to confuse readers about the purpose of the present paper, which is not hypotheses-testing in nature. We note that there is limited literature on use of technology to
train community health advisors, which is an innovative contribution of the current study. There is also limited published research on manipulating training approaches for community health advisors/workers, which is also now noted in the paper.

p. 19, lines 658-666; p. 7, lines 227-230; p. 7, line 216-233

Comment:

• Unclear what results are actually being presented in this manuscript. Might consider waiting for outcomes of the full trial and then report whether or not differences were found between the two training conditions.

Response:

In the Abstract and “The present study” section of the Introduction, we state that:

This article describes a community-engaged process of translating three evidence-based cancer communication interventions into one coherent, branded strategy for training community health advisors with these two delivery mechanisms. We describe the translation process, outline the intervention components, report on the pilot test, and conclude with lessons learned from each of these phases.

To provide trial data would be beyond the scope of the present paper, which is as noted, already lengthy.

Comment:

• Unclear what contribution this manuscript makes to the evidence base in implementation science. The lessons learned approach is helpful, but there are many such articles already published that speak to these same issues. The authors need to demonstrate—via review of the literature—that their lessons learned and their approach is different, unique and makes an important contribution to our collective knowledge on how to translate interventions into real-world settings. How is this approach different than others? How is it unique? How does it differ from other articles on lessons learned?

Response:

As discussed above, we note that there is limited literature on use of technology to train community health advisors or comparing multiple approaches. These are areas in which the present paper makes an innovative contribution. We also set the study context in terms of implications of technology for broader reach/dissemination in an implementation research framework.

Minor Essential Revisions

Comment:

• The manuscript could be significantly shorter. Much of the information presented in the introduction is unnecessary.

Response:

This point is well-taken. We have streamlined the Introduction section in terms of the literature review in implementation research and made it more specific to the current paper.

Introduction section