Reviewer's report

Title: Is Your Health Promotion Program Making the GRAID? A New Methodology for Creating Inclusive, Evidence-Based Obesity Prevention Strategies for Youths and Young Adults with Disabilities

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Reviewer: Paula Brauer

Reviewer's report:

Major Compulsory Revisions

Is the question posed by the authors new and well defined?

1. The purpose of the work is new and relatively well defined. The focus on creation of a formal consensus-based process to create adapted clinical guidelines for the disabled population when evidence is lacking is the main purpose of the paper. The purpose could be improved by clearly separating the methods development aspects from the obesity prevention focus.

The fact the method was applied to obesity prevention in young people – where the evidence is very weak – is secondary. The evidence and methods for the obesity prevention strategies are provided at: Laura Kettel Khan, Kathleen Sobush, Dana Keener, Kenneth Goodman, Amy Lowry, Jakub Kakietek, Susan Zaro. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. MMWR July 24, 2009 / 58(RR07);1-26. http://www.cdc.gov/MMWR/preview/mmwrhtml/rr5807a1.htm

2. The purpose will also be more clear if the "disabled" population is better defined for each kind of adaptation being considered. Definition of disabled is needed in the background (page 3) and may be a useful addition to the Conceptual Framework (figure 1), as I expect the target population may differ by guideline. For example, with playground equipment, no modification for autism might be needed, but it might be impossible to adapt climbing equipment for the wheel-chair bound. In that case, a different approach to promoting physical fitness might be better.

Are the methods appropriate and well described, and are sufficient details provided to replicate the work?

The decision algorithm and consensus methods used for developing the "disability adapted strategies" or GRAIDS in Figures 1 and 3 were clear. In general other methods were clear.

3. The development of the criteria to assess the process of development of the "disability adapted strategies" was apparently based on the AGREE II tool for assessing the process of clinical guideline development. However, many of the items from the AGREE II tool have been substantially changed to the point that the criteria are now quite different. This is not a problem, except there is no
description of the methodological development of the criteria, as I would expect in a methods paper. For example, editorial independence as one of six major domains of criteria in AGREE has been removed altogether with no explanation. AGREE itself was developed through several rounds of consensus processes. I would have expected the authors to confirm the face validity of the criteria. Some of the criteria currently seem very weak, in my opinion—e.g. barriers and costs only need only to be “discussed”, not “addressed” or even “assessed”. Having the expert panel who worked on obesity prevention review the criteria would an excellent way to assess the face validity of the criteria.

Are the data sound and well controlled?
The process of developing GRAIDS is well described. The process has not been evaluated in any way. At a basic level, were participants satisfied with the consensus process?

Does the manuscript adhere to the relevant standards for reporting and data deposition?
Yes—few standards in this area.

Are the discussion and conclusions well balanced and adequately supported by the data?
4. There is insufficient discussion and reflection on the methods developed in the process. The discussion and conclusions should focus on the development of the consensus methods used and lessons learned in the process of using with this particular topic. Additional questions or commentary on the following would be most helpful.

• It is not clear why only 11 most promising strategies were chosen for GRAID development. I assume the expert panel used the Figure 1 algorithm.
• Were any revisions needed after development of the criteria?
• Did any problems with different views come up with different disabilities?
• Phase III. Step 1. Diverse stakeholders, including community leadership, potentially could provide input at this stage. Since it would be local communities/states that would be expected to deliver community strategies, this input is important. Does a web-based survey offer sufficient opportunity to discuss competing community priorities within this defined context?
• In Phase III, Step 3. Consensus had to be achieved before a GRAID content or wording could proceed. Consensus can be challenging to achieve in diverse groups. What happens when there might not be consensus in future? This should be discussed.

Do the title and abstract accurately convey what has been found?
5. The abstract needs to be more focused on the discussion of the development and lessons learned with using the methods. There is currently too much focus on obesity prevention.
Discretionary Revisions

6. Calling the adapted guidelines GRAIDS was a problem for me as it was too much like GRADE which is a well regarded methodology for reviewing the totality of evidence in the process of developing clinical practice guidelines.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.