Author’s response to reviews

Title: The Health Equity Implementation Framework: Proposal and Preliminary Study of Hepatitis C Virus Treatment

Authors:

Eva Woodward (eva.woodward2@va.gov)
Monica Matthieu (mmmatthie@slu.edu)
Uchenna Uchendu (uuchendu@healthmanagement.com)
Shari Rogal (rogalls@upmc.edu)
JoAnn Kirchner (joann.kirchner@va.gov)

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Author’s response to reviews:

Dear Drs. Wilson, Sales, and Wensing,

We are excited to submit revisions to our manuscript for your consideration.

I have revised the manuscript to include tables in separate files.

In addition to consulting with our authorship team, I also presented a poster on this framework and its pilot to a scientific audience at the AcademyHealth Annual Conference on Dissemination & Implementation (D&I) in Washington, DC, December 2018. Feedback from this forum is also incorporated into our revision. One of the biggest changes we made in the manuscript was to rename the framework from the Health Care Disparities Implementation framework to the Health Equity Implementation framework based on feedback from Reviewer #2 and the D&I conference.

A point-by-point response is below, and the changes we made to ensure the article is updated with most current references and feedback from the D&I conference are listed last.
If I can answer any questions, I would be happy to.

Sincerely,

Eva

Reviewer reports:

☐ Associate Editor's comment: could you please attend in detail to outlining what the framework adds and contributes over and above existing implementation frameworks

Response: We addressed this point that another reviewer also brought up and have added a significant addition, with examples (e.g., Theoretical Domains Framework), to strengthen our argument.

> Reviewer #1: In general

> I find the paper both interesting and contributive. However before making the final decision I think the editor should consider the level of engagement with existing literature implementation of health care frameworks.

> Some proofreading is necessary

Response: We proofread this and edited some typos and hope this improves readability.

> Apart from the below statements I think the paper presents a thorough description of the field of study, theoretical background, methodological approach, analytical results and discussion.
Abstract:

partially mixed sequential dominant status mixed methods design = semistructured interviews with purposeful sampling?

Response: While we realize this may be viewed as “jargon” – we are using terminology consistent with recommendations for taxonomy of mixed methods research. In this case, we used quantitative information from 1) the medical record and then 2) phone screenings to collect data to identify the correct population for qualitative interviews (purposive sampling). The language related to the partially mixed sequential dominant status design came from Leech and Onwuegbuzie (2009), and refers to these dimensions: “A content analysis of the various available mixed research designs has led us to conceptualize that these designs can be represented as a function of the following three dimensions: (a) level of mixing (partially mixed versus fully mixed); (b) time orientation (concurrent versus sequential), and (c) emphasis of approaches (equal status versus dominant status).” (p. 267-268) The full text is: Leech NL, Onwuegbuzie AJ. A typology of mixed methods research designs. Quality & Quantity: International Journal of Methodology. 2009;43:265–75.

If after reviewing this rationale, the reviewers still find it unnecessary or distracting, we’d be happy to alter the taxonomy further.

Does it make sense to talk about percentages when N is so low? 12 persons, it does not in my opinion contribute to anything but politicize the results. In my opinion we should be careful not to use frameworks to bypass normal standards for good scientific practice.

Response: We agree that the topic of equitable treatment (especially with a small sample size for a preliminary study) is very political. To this end, before we submitted this manuscript, we consulted with the VA program office charged with helping to provide HCV care to Veterans, the VA Office of HIV, Hepatitis, and Related Concerns, and they reviewed the manuscript to address any information they felt might incorrectly politicize the results. Therefore, we retained the percentages on key demographics and information related to HCV treatment in the manuscript. However, to respond more conservatively to this critique, we also omitted the percentage of Veterans who had heard of or received HCV treatment from the abstract.
> Introduction:

> There is a good interaction with literature on implementation science and its impacts on health research and implementation of health strategies.

> I would like even more specific details on the number of people suffering from health disparities and the outcome of this on their health statistics compared to people not suffering this social difference. This would further underline the importance of handling this important issue.

Response: We’ve expanded the second paragraph with several sentences to provide a general overview of this topic. The precise number of people suffering a disparity depends on the health condition and the specific subgroup – because there is so much variation and the purpose of this paper is not to provide a comprehensive scope of US disparities, we attempted to provide a general overview instead.

> Integrating the two frameworks:

> A great effort is spent on explaining the benefits of applying the integrated i-PARIHS and Health Care Disparities Framework. I would however appreciate if you could specify some of the exact differences from other frameworks. So that it becomes exactly clear what this integration of concepts adds.

> Response: We numerated and expanded them in “key differences for implementation scientists”

> Reviewer #2: Thank you for the opportunity to review.

> This paper highlights a composite framework to address this shortcoming. Specifically, two conceptual frameworks from implementation science and healthcare disparities research were combined to create one that would consider health disparities. The researchers tested this new framework on a study exploring barriers to the uptake of seeking hepatitis treatment in a population that experiences health disparities.
> Strengths

> The researchers recognized the need for an implementation framework that considers health disparities. Applying a social justice lens to implementation practices and research is important to promote inclusivity and equity. It is important to consider how health disparities may impact implementations and whether this field is being inclusive or reinforcing biases

> Opportunities for improvement

> General:

> The authors could consider broadening references on 'disparities' (an U.S.-specific term) to literature about equity.

Response: We agree – thank you for pointing this out. We have changed the text and added literature, in addition to changing the name of this framework, to incorporate equity.

> The authors could consider broadening the discussion to identify how this fits with or might help with the literature on culturally tailored interventions.

Response: Although we are not experts on culturally tailored interventions, we absolutely want to acknowledge this important field’s contribution to implementation and how this manuscript extends that work. Thus, we’ve added several sentences in the introduction, starting with, “There is an entire literature on culturally tailored or adapted interventions…” We do not, unfortunately, have the expertise to further discuss how this implementation framework might help with cultural adaptations to interventions, but we do reference that this implementation framework might help with cultural adaptations to implementation strategies.

> New frameworks can be helpful, but implementation science is replete with them. The paper could be strengthened by adding more of an argument about where other commonly used implementation science frameworks fall short of considering health disparities. For example, the Consolidated Framework for Implementation Research (CFIR) considers many contexts, including patient needs and resources and knowledge and beliefs about the intervention. Although CFIR may not address health disparities specifically, would the construct of
Knowledge and Beliefs About the Intervention (I.e. "Individual attitudes toward and value placed on the intervention as well as familiarity with facts, truths, and principles related to the intervention"

retrieved from: https://urldefense.proofpoint.com/v2/url?u=https-3A__cfirguide.org Constructs knowledge and beliefs about the intervention

be a more general category that would encapsulate health disparities? Another example could examining the Theoretical Domains Framework…

Response: We understand this concern and in this response and in the manuscript (see paragraph 4), have explained and expanded our justification. Although implementation science frameworks sometimes have domains that address patient or even provider knowledge or beliefs about the intervention, they do not explicitly address issues of concern to populations who experience health disparities. I hypothesize that if implementation factors specific to a healthcare disparity problem are not assessed, they are unlikely to be identified, and thus, cannot be intervened upon by implementation strategies. The preliminary study reported in this manuscript showcases this as an example – we identified an entire category of barriers and facilitators that are likely unique to VA Black and African American patients (e.g., peer testimonials of racial discrimination, personal experience with perceived racial discrimination). Although we did not identify any barriers at the innovation level for this group, I can imagine a scenario for other populations and health problems where this might be the case – e.g., Latinos accessing mental health interventions due to stigma and thus, lack of acceptability from Latino/a patients. Perhaps in those cases, the mental health intervention would need to be re-marketed as behavioral health or stress management. Colloquially, if implementation researchers do not look for healthcare disparity barriers, they will not find them (even if they exist) — and down the line in analyses, increase chances of type II error.

> A discussion about how this proposed approach could be adapted to suit the needs of other individuals who face health disparities might strengthen the paper. For example, would this framework be easily adaptable to other groups or individuals who face barriers to accessing care such as people without homes? What might be a challenge - if any - with this?

Response: we’ve added this to the discussion section – this is an excellent point.
Specific:

> Abstract

> The objective could be more clear. Is it to test the new framework? Discover the barriers and facilitators to using this new framework? To determine whether using this framework is feasible? Having a clear objective would strengthen the abstract.

Response: we attempted to clarify this.

> Page 4, line 95

> Too general of statement. Could there be cases where this does not apply? Implementation Science methods are not all one and the same.

Response: We changed the objective sentence to read differently to reflect that there are certain methods that are better suited for implementation, not to imply that implementation research needs to use prescribed methods: “Implementation research has benefitted from comprehensive reviews of implementation theories and conceptual frameworks,[5,6] research designs that are well-suited for implementation research,[7–9] more rigorous selection of measures,[10–12] and precise terminology for and categorization of its tools.[13,14]”

> Page 5, line 132

> The points in this paragraph are strong. Perhaps some could be incorporated into the abstract to emphasize the importance and why what your team is doing is different.

Response: Thank you – we took your guidance.

> Page 7, line 162

> Perhaps an example of why health care disparities are so complex would help illustrate your point.
Response: We inserted more examples throughout the paper of the intersection between health equity problems and implementation to highlight more of the factors for different groups and different health conditions.

> Page 7, line 179-181

> I am reading this as a euphemism for prejudiced clinical decision-making. If my interpretation is correct, I think this is an important point to emphasize. Perhaps making this point a bit clearer would strengthen the paper.

Response: We added more text to clarify this point and showcase how combining health care disparities factors (like biased clinical decision making) with implementation factors is a strength of this integrated framework.

> Page 8, line 187

> I wonder if this statement is too conclusive for the current state of the framework, if your team is testing it at the moment. Perhaps rewording this or removing "fully" would add some clarity.

Response: We agree and have reworded to ensure it’s more of a suggestion, a hypothesis, rather than a confirmed fact.

> Page 9, line 218-220

> Adding an example could help to clarify your point. In the current state this sentence is too vague to be meaningful.

Response: In the paragraph immediately after this sentence on importance of clinical encounters for health equity, we discuss examples in details (see “key differences for implementation scientists”).

> Pages 10-11, lines 249-252
Excellent point, but I think it could be strengthened by making it a bit more clear. As it is currently written, it seems as though the electronic health record would identify only those patients who are transgendered who also experience healthcare disparities.

Response: We edited this to reflect that transgender individuals, as a group, experience healthcare disparities, rather than the system can identify only transgender patients with healthcare disparities.

Page 13, lines 298-302

Very clear! Having this type of information in the abstract would add clarity.

Response: We incorporated your recommendations and appreciate your perspective.

Reviewer #3: Well-written and an important topic.

Response: Thank you for sharing your feedback.

MANUSCRIPT IMPROVEMENTS FROM THE ACADEMYHEALTH CONFERENCE ON DISSEMINATION AND IMPLEMENTATION IN HEALTH

1. We reflected that the most recent AcademyHealth Annual Conference on Dissemination & Implementation in Health (11th annual) also featured a health equity track, since it has occurred between the decision on this manuscript and resubmission.

2. We altered the figure to represent more specific examples of societal influence on context, including structural violence in the form of economies, policies, and sociopolitical forces.
3. We renamed the framework to Health Equity Implementation Framework

4. We added a paragraph at the beginning of the section, “Key Differences for Implementation Scientists” to showcase ways and rationale for using the framework.