Reviewer’s report

Title: Longitudinal Assessment of the Association Between Implementation Strategy Use and the Uptake of Hepatitis C Treatment: Year Two

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Reviewer: Courtney Balentine

Reviewer’s report:

I enjoyed reading the authors’ evaluation of the association between various implementation strategies and the uptake of hepatitis C treatment in VA. The paper is thoughtful, well-written, and certainly interesting to anyone interested in changing treatment in VA. I have a few questions regarding their approach and conclusions:

1. The primary endpoint is the number of Veterans started on HCV treatment per year at each site. Is this truly a raw number as stated in their methods, or is it a proportion of eligible patients who are treated? If the dependent variable is the number of treatments that occur, and each VA has a somewhat limited population of eligible Veterans with HCV who could initiate treatment, then I worry that a VA which is successful in delivering HCV care in year 1, could show a falsely low number of treatments in year 2. In other words, if a VA has 10,000 Veterans with HCV in the VISN and they treat 6,000 in the first year, then there will only be 4,000 potentially treatable patients in the next year and the correlation between implementation strategy and the number treated will falsely show a decline. Similarly, if a VA is more effective than another (prior to implementation) then there may be less ground for improvement. Can the authors control for prior levels of treatment at each facility before evaluating the correlation between implementation strategies and the number treated?

2. Related to 1, it would be nice to see the actual number/proportion of treated Veterans and the changes over time. It's useful to know that a given implementation strategy correlates with the number treated, but it is hard to assess the importance without a sense of the magnitude of change (I don't recall seeing an actual number of increase/decrease in treatment over the study period).

3. Given the large number of implementation strategies being tested, was there a statistical correction for multiple comparisons?

4. How did the authors verify that the individuals at each hospital understood the different implementation strategies and how to differentiate them? I realize they developed a survey for this purpose, but am worried that conceptually similar strategies may bleed together in peoples' minds so that if they feel strategy A was used by the institution, then they are more likely to also say that strategy B was used because they seem somewhat similar.
5. As far as strategies attributed to the HIT collaborative, is there a sense that these are being appropriately attributed? In other words, did the collaborative deliberately emphasize and support the strategies attributed to them more than others that were not?

6. I was also curious if the authors were able to look at treatment success rates across VA's? This is certainly not necessary for publication but might be interesting to see if there's a relationship between implementation strategies and success as well as treatment initiation.

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