PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Community-Clinic Linkages: Qualitative Provider Perspectives on Partnering with Community Health Representatives in Navajo Nation
AUTHORS	Brown, Christian; Lalla, Amber; Curley, Cameron; King, Caroline; Muskett, Olivia; Salt, Shine; Ray, Kathy; Begay, Mae-Gilene; Nelson, Adrianne; Shin, Sonya

VERSION 1 - REVIEW

REVIEWER	Benjamin Oldfield Fair Haven Community Health Care and Yale School of Medicine
REVIEW RETURNED	20-Jun-2019

GENERAL COMMENTS	This is a qualitative study that assesses the perspectives of providers and non-clinical staff of a community-health worker (CHW) program in the Navajo Nation. The authors use grounded theory, reportedly, but also home in on a few certain domains of concepts about which they want more information (e.g. EHR integration, certain educational materials). The study's strengths include its use of qualitative methods to better understand a complex phenomenon, its professionally diverse sample of interviewees, and the longstanding relationship between the study team and the communities impacted by the CHW program. The authors should be commended for conducting a laborious study on an important topic. However, several aspects of the manuscript would need to be modified considerably for publication to be considered: Major comments: The question the study is seeks to answer needs to be explicitly stated. Why are provider perspectives on this program needed, specifically? Were there concerns about buy-in, was there a need to understand how to connect provider to CHW better, or something else entirely? Why was grounded theory chosen as an approach to interview guide construction and data analysis? The questions in the interview guide are quite specific (and seem to focus on program evaluation), and yet grounded theory seeks to explore phenomena at-large and, often, generate new theory. How is new theory generated from this work (or how is existing theory modified or enhanced)?

	Many of the quotes provided are rich and compelling. However, they often lack context, and it is not always immediately clear to the reader how the quote signifies the theme at hand. Please consider shortening the quotes and integrating them into your own text to hand-hold the reader a bit more through your process of generating the themes you did from the quotes. Specific comments: Page 2, lines 16-19: As the focus of this manuscript is qualitative analysis, I would suggest not including a section in the abstract called “intervention” (the intervention in this study is the interview), but would instead describe the CHR program in “setting.” I would recommend substituting out “intervention” and, instead, including “measures” or “instruments” and describing the construction of the interview guide here. Page 2, lines 24-25: Please identify the number of participants in the results section of the abstract. Page 2, lines 32-33: The first sentence of the conclusion in the abstract does not directly emerge from the results presented right before. Page 2, lines 34-35: This is the first mention of CHWs in the abstract, so it comes out of the blue. What is the relationship between CHRs and CHWs? How are they alike and different? If the authors choose to identify this relationship in the abstract, they ought to describe it in the objective section. Page 4, lines 14: What are the “major aspects” of the healthcare system to which CHWs should have access? Please identify. Page 4, lines 29-32: It seems to need explaining why a partnership with a hospital in Boston might help integrate CHRs with local clinic-based teams. What was the Brigham’s role here, and how does the expertise it has fit in with the need the authors identify? Page 4, lines 32-34: What is being defined as “community” here? This reviewer feels that the phrase “community-clinic linkages” is vague and needs clarification regarding the specific avenues of communication and the power dynamics therein. Page 4, line 35: The authors should explicitly state why the perspectives of the clinic-based health care providers is important here. The authors get at this in the Discussion section (e.g. page 14, lines 33-34) but need to identify the gap they’re trying to fill here in the introduction. Page 6, lines 19-20: How was feedback elicited by the CHAP? Please describe. Page 6, lines 37-53: Great description of the research team. Page 7, lines 8-10: This reads as if the themes were not emerging from the data but were pre-identified. Please clarify the relationship between the codes and the themes. Page 7, line 14: What does it mean that “coded material was summarized into paragraphs?”

	Page 7, line 53: Please clarify what the brackets indicate as this appears a non-traditional use of brackets (is this the voice of the interviewer?). Page 8, lines 50-56: Case management seems to come a bit out of the blue here. How does case management interact with CHRs? Is case management thought to be a task of CHRs? Page 13, line 8: What does “in SU with EHR access” mean? Page 15, lines 10-20: Thank you for the thoughtful limitations section. When you say that “we feel that providers were very honest…” what ways of assessing validity were used? What other mechanisms were used to assess rigor/quality of this study? Page 15, lines 26-34: Qualitative studies can generate important hypotheses for future work. What would that future work be in this case, specifically? The authors suggest that the patient perspective would complement the provider perspective, but how? Table 1, row 3: Consider identifying specifically which kinds of providers were interviewed, as the multidisciplinary nature of this sample is a strength of the study.

REVIEWER	J. Lee Hargraves University of Massachusetts Medical School Worcester, Massachusetts USA
REVIEW RETURNED	22-Oct-2019

GENERAL COMMENTS	This paper describes integration of community health workers (CHWs) into healthcare teams as they work to make linkages between clinic-based providers and members of the communities they serve. The population includes people living in Navajo Nation who are working to manage their diabetes. The CHWs are using the job title of Community Health Representatives, who are “a longstanding workforce of community health workers who provide culturally-sensitive outreach in forming an effective patient-centered care team” (p. 4). The authors use a grounded theory approach to analyzing interviews via a qualitative research method in which they interview 13 providers by telephone, email, or in person. They do not state how many interviews were conducted in each mode. The purpose of the study is an evaluation of the Community Outreach and Patient Empowerment (COPE) Project. Specifically, they are examining provider views related to integration of CHRs in direct patient care supporting patients living with diabetes. CHRs provide information, education about health risks, and work to provide patients with support of their chronic condition. CHRs also are enabled to document their efforts in electronic health records (EHRs). The ability to directly document their interactions with patients in the EHR is a key aspect of their integration into the health care team. The paper is timely for clinics and organizations that are using community health workers to provide direct support to patients with chronic conditions. Understanding the experiences of providers

	having CHWs working on their teams is extremely important. In order to work collaboratively with providers in clinics, CHWs need to be recognized as a team member and providers will need to respect the skills and cultural knowledge that CHWs bring to improving patient care. This paper documents some of the views of providers and organizes their experiences using themes derived from transcriptions of the interviews. They appropriately discovered these themes as they emerged in the data, rather than having predetermined themes. They used independent coding of transcripts and examined inter-rater reliability, which was adequate (.46 to 49 Kappa statistics). One key disconnect is between their description of the 4 main themes in their codebook and the presentation of results that describes three main themes. The codebook identified the following themes: general interaction with COPE, implementation of COPE, impact of COPE, and improvement of COPE. The presentation of results describes 3 main themes: acknowledging the importance of community-clinic linkages, endorsement of COPE training, and appreciation of CHR access to EHR. It would be helpful to describe this apparent discrepancy in the themes that emerged during the analysis. How are the 4 themes in the codebook and 3 themes in the results related? Specific comments (page numbers from PDF): Pg 6, 2nd paragraph. How many interviews via phone, email, or in-person? The interviewer has an effect on responses and since interviewers were known among providers, one wonders about the candid response to some questions. In my review, I noted that there seemed to be no negative comments about CHRs working on the team. I have had some providers who adamantly opposed integration of CHWs on teams. Was integration really that smooth? Pg. 2nd paragraph. You discuss saturation before presenting your grounded theory approach. Saturation is a tricky concept in qualitative work. Please tell us what you mean. In a traditional approach, one keeps interviewing new participants until no new themes emerge. Is this what occurred? Did the research team continually modify the interview guide based on new information from participants? I wanted to know more than “Sampling ended when saturation was achieved.” You can also reference “more about our qualitative methods" is presented in the Data Analyses section, see page 7. Page 7, 5th paragraph. The subheading really doesn’t match the key finding, “importance of the CHR role.” Page 8, general comment. I have two points. First, I don’t think that the quotes need to be exactly verbatim. I find the use of ‘um’ and ‘uh’ distracting. These filler expressions do not add any value. Second, I believe that some of the quotes are too long. On the one hand, having some direct quotes is invaluable and on the other hand, pages 8 and 9 are 90 % direct quotes. Page 8, general comment. It might be helpful to identify the speakers for these quotes. I’m guessing that you are using several from the same participant. Perhaps identifying them as Provider 1, Provider 2, et cetera will help readers get a flavor for who said what. I wonder about the dominance of some voices.

	Page 9, 3rd paragraph. I encourage interviewers to provide neutral comments during their interviews. In the middle of quotes are bracketed comments. I interpreted this as the interviewer voice. Please confirm and add something in the paper. A comment of "Oh good!" from an interviewer implies a value judgment from the interviewer. The authors mention that COPE team members conducted the interviews in the limitations section (see page 15). Given that the paper shows some of the encouraging words of the COPE team member conducting the interviews, I think some acknowledgment of the difficulty of COPE team members asking providers about their opinions is warranted. Did the interviewers explicitly ask about "things that aren't going well"? P12, 5th paragraph. This quote, "I mean obviously….." is an example of one that can be trimmed to just present the point about CHRs talking about difficult topics. All of the "um, so, um" can be trimmed. Pg 13, 3rd paragraph. This quote seems very duplicative to the 1st paragraph. Maybe that's intentional. But the main point is that ability to use EHR is so crucial to integration of CHRs, especially the back and forth dialogue among team members about patients. Pg 14, Discussion: Please provide a bit more on "quadruple aim" and the "triple aim" these seem like esoteric terms, although one can argue that everyone should know these aims.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:
This is a qualitative study that assesses the perspectives of providers and non-clinical staff of a community-health worker (CHW) program in the Navajo Nation. The authors use grounded theory, reportedly, but also home in on a few certain domains of concepts about which they want more information (e.g. EHR integration, certain educational materials). The study's strengths include its use of qualitative methods to better understand a complex phenomenon, its professionally diverse sample of interviewees, and the longstanding relationship between the study team and the communities impacted by the CHW program. The authors should be commended for conducting a laborious study on an important topic.

We appreciate the reviewer's feedback on the strengths of this manuscript. We have also sought to respond to the comments below.

The question the study is seeks to answer needs to be explicitly stated. Why are provider perspectives on this program needed, specifically? Were there concerns about buy-in, was there a need to understand how to connect provider to CHW better, or something else entirely?

This overarching study was designed to evaluate stakeholder perspectives including CHRs, providers, and patients. We did not have specific concerns about buy-in but rather have sought stakeholder perspectives to inform ongoing quality improvement and to assess impact and potential for sustainability. We have expanded the last paragraph of the introduction to better explain this rationale.
Why was grounded theory chosen as an approach to interview guide construction and data analysis? The questions in the interview guide are quite specific (and seem to focus on program evaluation), and yet grounded theory seeks to explore phenomena at-large and, often, generate new theory. How is new theory generated from this work (or how is existing theory modified or enhanced)?

Thank you for this important question. We discussed this feedback among authors and agree with the reviewer's point. We have changed the method to thematic analysis to better reflect the analytic approach.

Many of the quotes provided are rich and compelling. However, they often lack context, and it is not always immediately clear to the reader how the quote signifies the theme at hand. Please consider shortening the quotes and integrating them into your own text to hand-hold the reader a bit more through your process of generating the themes you did from the quotes.

Thank you. We have followed this suggestion.

Specific comments:

Page 2, lines 16-19: As the focus of this manuscript is qualitative analysis, I would suggest not including a section in the abstract called "intervention" (the intervention in this study is the interview), but would instead describe the CHR program in "setting." I would recommend substituting out "intervention" and, instead, including "measures" or "instruments" and describing the construction of the interview guide.

Thank you. We have moved the program description to Setting. The BMJ Open Structured Abstract states that outcome measures should be used for quantitative studies only, and "instruments" is not included as an option for the abstract format. We hope that the abstract reflects the intent of the reviewer while still adhering to BMJ Open guidelines.

Page 2, lines 24-25: Please identify the number of participants in the results section of the abstract.

We have added these numbers to the abstract (and where lacking to the results).

Page 2, lines 32-33: The first sentence of the conclusion in the abstract does not directly emerge from the results presented right before.
We have addressed this by adding a sentence to the results section summarizing the first theme of community-clinic linkages.
Page 2, lines 34-35: This is the first mention of CHWs in the abstract, so it comes out of the blue. What is the relationship between CHRs and CHWs? How are they alike and different? If the authors choose to identify this relationship in the abstract, they ought to describe it in the objective section.

Thank you for this observation. We have added a sentence to the settings to describe how CHRs are a tribal subset of CHWs. We have also reworded the conclusion sentence to be more precise.

Page 4, lines 14: What are the "major aspects" of the healthcare system to which CHWs should have access? Please identify.

Thank you for this observation. We have added specifics and citations.

Page 4, lines 29-32: It seems to need explaining why a partnership with a hospital in Boston might help integrate CHRs with local clinic-based teams. What was the Brigham's role here, and how does the expertise it has fit in with the need the authors identify?

We have added a sentence in the COPE Intervention section of the methods which provides more context to the BWH team's role and why they were even relevant.

Page 4, lines 32-34: What is being defined as “community” here? This reviewer feels that the phrase “community-clinic linkages” is vague and needs clarification regarding the specific avenues of communication and the power dynamics therein.

We have provided more information about the phrase community-clinic linkages. We have chosen to add this in the methods section under “choice of terminology,” but if desired, can introduce the terminology earlier in the introduction.

Page 4, line 35: The authors should explicitly state why the perspectives of the clinic-based health care providers is important here. The authors get at this in the Discussion section (e.g. page 14, lines 33-34) but need to identify the gap they’re trying to fill here in the introduction.

We have added provided more context in the last paragraph of the introduction section to explain why provider perspectives were considered important. The over-arching study was designed not only to evaluate health outcomes, but also key stakeholder perspectives including CHRs, providers, and patients. We feel that stakeholder perspectives – including provider input – are critical to inform ongoing quality improvement and to assess impact and potential for sustainability.

Page 6, lines 19-20: How was feedback elicited by the CHAP? Please describe.

We have provided more details on how feedback was elicited from the CHAP.

Page 6, lines 37-53: Great description of the research team.

Thank you!

Page 7, lines 8-10: This reads as if the themes were not emerging from the data but were pre-identified. Please clarify the relationship between the codes and the themes.

We have provided more details on the methods section regarding how the data were analyzed.

Page 7, line 14: What does it mean that “coded material was summarized into paragraphs?”

We have tried to clarify this step as follows: A brief synopsis for each code was them generated, describing the number of respondents endorsing each code, as well as patterns of concordance and contrasts among respondents.

Page 7, line 53: Please clarify what the brackets indicate as this appears a non-traditional use of brackets (is this the voice of the interviewer?).

You are correct that this the interviewer. I have addressed multiple feedback regarding quotes in the revised version.

Page 8, lines 50-56: Case management seems to come a bit out of the blue here. How does case management interact with CHRs? Is case management thought to be a task of CHRs?

We have referenced case management in the methods section. Case management was not previously considered to be a task of CHRs.

Page 13, line 8: What does “in SU with EHR access” mean?

We have defined SU as Service Unit.

Page 15, lines 10-20: Thank you for the thoughtful limitations section. When you say that “we feel that providers were very honest…” what ways of assessing validity were used? What other mechanisms were used to assess rigor/quality of this study?

We have added in the limitation section that providers did give many suggestions for improvement – this is one of the reasons we felt providers were honest in their feedback. We also added in the methods section that coded results were further triangulated with field observation from our COPE staff and shared with the CHAP to determine if findings were consistent with their own perspectives.

Page 15, lines 26-34: Qualitative studies can generate important hypotheses for future work. What would that future work be in this case, specifically? The authors suggest that the patient perspective would complement the provider perspective, but how?

We have provided additional detail including how patient data may complement provider perspectives to inform whether and how CHW integration in healthcare teams also improves the patient experience of care.

Table 1, row 3: Consider identifying specifically which kinds of providers were interviewed, as the multidisciplinary nature of this sample is a strength of the study.

We have added more detailed descriptions of job titles; however, note that some participants held more than one title; however providing specific titles (e.g. “nurse midwife and diabetes educator”) for each person could jeopardize confidentiality as it could be clear who some individuals are for local readers.

One key disconnect is between their description of the 4 main themes in their codebook and the presentation of results that describes three main themes. The codebook identified the following themes: general interaction with COPE, implementation of COPE, impact of COPE, and improvement of COPE. The presentation of results describes 3 main themes: acknowledging the importance of community-clinic linkages, endorsement of COPE training, and appreciation of CHR access to EHR. It would be helpful to describe this apparent discrepancy in the themes that emerged during the analysis. How are the 4 themes in the codebook and 3 themes in the results related?

Thank you for raising this point. We have added more details in the methods section. We initially drafted the manuscript organized by the four themes that were coded (i.e. interaction, implementation, impact, improvement). However, the narrative was redundant at time, returning to topics such as training or electronic health records. Therefore, the team discussed an overarching conceptual framework on how providers viewed the most salient aspects of COPE and derived the 3 topics, which were used to re-organize the manuscript. We have attempted to describe these “transverse” themes in the Data analysis subsection of the Methods section.

Pg 6, 2nd paragraph. How many interviews via phone, email, or in-person? The interviewer has an effect on responses and since interviewers were known among providers, one wonders about the candid response to some questions. In my review, I noted that there seemed to be no negative comments about CHRs working on the team. I have had some providers who adamantly opposed integration of CHWs on teams. Was integration really that smooth?

We wish to clarify that recruitment happened by phone, email or in person, but interviews took place by phone or in person. We have provided data on how many interviews took place by phone versus in person.

We have added in the limitation section that we interviewed providers who had already participated in this initiative, and therefore, were more likely to be the champions for such a program, rather than reflecting the predominant attitudes among providers across these healthcare facilities.

Pg. 2nd paragraph. You discuss saturation before presenting your grounded theory approach. Saturation is a tricky concept in qualitative work. Please tell us what you mean. In a traditional approach, one keeps interviewing new participants until no new themes emerge. Is this what occurred? Did the research team continually modify the interview guide based on new information from participants? I wanted to know more than “Sampling ended when saturation was achieved.” You can also reference “more about our qualitative methods" is presented in the Data Analyses section, see page 7.

We have added more details in the methods section on how we determined saturation.

Page 7, 5th paragraph. The subheading really doesn’t match the key finding, “importance of the CHR role.”

Thank you. We have edited this paragraph to align with the subheading.

Page 8, general comment. I have two points. First, I don’t think that the quotes need to be exactly verbatim. I find the use of ‘um’ and ‘uh’ distracting. These filler expressions do not add any value. Second, I believe that some of the quotes are too long. On the one hand, having some direct quotes is invaluable and on the other hand, pages 8 and 9 are 90 % direct quotes.

Thank you, we have edited the quotes to be more succinct.
Page 8, general comment. It might be helpful to identify the speakers for these quotes. I’m guessing that you are using several from the same participant. Perhaps identifying them as Provider 1, Provider 2, et cetera will help readers get a flavor for who said what. I wonder about the dominance of some voices.

We have also added the speaker identifies for the quotes.

Page 9, 3rd paragraph. I encourage interviewers to provide neutral comments during their interviews. In the middle of quotes are bracketed comments. I interpreted this as the interviewer voice. Please confirm and add something in the paper. A comment of “Oh good!” from an interviewer implies a value judgment from the interviewer. The authors mention that COPE team members conducted the interviews in the limitations section (see page 15). Given that the paper shows some of the encouraging words of the COPE team member conducting the interviews, I think some acknowledgment of the difficulty of COPE team members asking providers about their opinions is warranted. Did the interviewers explicitly ask about “things that aren’t going well”?

We acknowledge the challenge of neutrality among the interviewers. We have added a comment in the limitation section pointing out that the structured interview guide included several questions explicitly asking about challenges and areas for improvement.

P12, 5th paragraph. This quote, “I mean obviously…..” is an example of one that can be trimmed to just present the point about CHRs talking about difficult topics. All of the “um, so, um” can be trimmed.

Thank you, we have trimmed verbiage which contributes to distraction and/or does not add to the data.

Pg 13, 3rd paragraph. This quote seems very duplicative to the 1st paragraph. Maybe that's intentional. But the main point is that ability to use EHR is so crucial to integration of CHRs, especially the back and forth dialogue among team members about patients.

Thank you. Also responding to the overall feedback on quotes, we have eliminated excess quotes which do no contribute additional insight.

Pg 14, Discussion: Please provide a bit more on "quadruple aim" and the "triple aim" these seem like esoteric terms, although one can argue that everyone should know these aims.

Thank you, we have provided more details on the quadruple and triple aims, and linked them more clearly to the study.

VERSION 2 – REVIEW

REVIEWER	Benjamin Oldfield Yale School of Medicine, United States
REVIEW RETURNED	01-Dec-2019

GENERAL COMMENTS	Thank you for the opportunity to review this manuscript again. It is a much improved manuscript and I think the authors have thoughtfully responded to my previous comments as well as those by the other reviewer. I have a few considerations for further improvement based on the revised manuscript. In the abstract, on page 2, What is "prospective" about the qualitative process? Generally, qualitative research is cross-sectional in nature, although sometimes it is longitudinal—with multiple observations/interviews/focus groups of the same participants over time. It seems that the word "prospective" can be left out here. In the abstract, on page 2, I would recommend naming the qualitative approach (thematic analysis) you used in the analysis section as this is a foundational component of the analysis. In the abstract, on page 2, I would recommend avoiding documenting the number of respondents whose data was concurrent with each theme, as this type of numerical data is rarely useful in most qualitative studies. I would, however, express the total number of interviews conducted. I would also recommend against documenting the number of respondents who made mention of each theme in the results and discussions section of the text. In the abstract, on page 2, space allowing, I would recommend mentioning that the study design and instrument construction were guided by the CHAP, as this is a strength of the study. In the introduction, on page 4, in the paragraph starting on line 24, please clarify that you are speaking about tribal communities in the US (and the Indian Health Services in the US, later in the paragraph), as terms like "tribal" and "Indian" carry different meanings elsewhere.

	In the methods, on page 8, I appreciate that the authors now describe their process as thematic analysis, not grounded theory. In the text here, could the authors offer a phrase or a sentence to explain while they chose this qualitative approach in particular for this project? In the results section, I would suggest not including the first names of the respondents, but instead just the professional role and, as the other reviewer suggested, number (e.g. physician 1, physician 2, etc.).

REVIEWER	Lee Hargraves University of Massachusetts, USA
REVIEW RETURNED	10-Dec-2019

GENERAL COMMENTS	This revised paper shows how community health workers, who work as Community Health Representatives (CHRs) in Navajo Nation, can be key members of health care teams. The paper uses interviews with health care providers following implementation of CHRs to support people living with diabetes. The finding that having standardized teaching materials and access to electronic health records can improve coordination of care and patient education is a valuable contribution to the community health worker literature. The ability of CHRs to access electronic records allows providers to know more about community health workers contact with clients and to provide the back-and-forth communication that is essential to quality, continuous relationships with patients. Thank you for the opportunity to review this paper. Specific comments: Abstract: What does the (n=) represent. If it's to show consensus or the number acknowledging, enthusiasm, and support, I'm not sure that 4 out of 13 is evidence of support. I think it may show the denominator for activity, e.g., CHRs with access to EHRs. I would consider not showing the n, as it might be misinterpreted. Page 5, line 18. Is this the title of the program, "CHR, Tuberculosis and Sexually Transmitted Disease Prevention Programs". It seems cumbersome. Necessary? Page 6, line 25. Were any providers asked to interview and declined? P 6, line 44. Do you mean after the first 3 of 13 interviews? P 7. lines 18, 19. Something seems amiss with the sentence that ends with "and specifically," which is followed by a fragment. BTW. I don't think Research study staff is a proper noun. "research study staff" Page 8. Are these pseudonyms for people interviewed? Did all research subjects consent to use of their first names. I'm guessing that there aren't too many Catherine, nurse practitioners working in Navajo Nation. I do like the ability to track individuals and know

	their role. These quotes are much improved from the first version of the paper. Thank you for taking the time to edit the quotes and provide more context.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 1
In the abstract, on page 2, What is “prospective” about the qualitative process? Generally, qualitative research is cross-sectional in nature, although sometimes it is longitudinal—with multiple observations/interviews/focus groups of the same participants over time. It seems that the word “prospective” can be left out here.

Thank you for this suggestion. We have removed the work prospective.

In the abstract, on page 2, I would recommend naming the qualitative approach (thematic analysis) you used in the analysis section as this is a foundational component of the analysis.

Thank you, we have incorporated this suggestion.

In the abstract, on page 2, I would recommend avoiding documenting the number of respondents whose data was concurrent with each theme, as this type of numerical data is rarely useful in most qualitative studies. I would, however, express the total number of interviews conducted. I would also recommend against documenting the number of respondents who made mention of each theme in the results and discussions section of the text.

Thank you, we have incorporated this suggestion.

In the abstract, on page 2, space allowing, I would recommend mentioning that the study design and instrument construction were guided by the CHAP, as this is a strength of the study.

Thank you, we have incorporated this suggestion.

In the introduction, on page 4, in the paragraph starting on line 24, please clarify that you are speaking about tribal communities in the US (and the Indian Health Services in the US, later in the paragraph), as terms like “tribal” and “Indian” carry different meanings elsewhere.

We have started paragraph 3 with “In the United States” to specify that we are referring to te U.S. setting.

In the methods, on page 8, I appreciate that the authors now describe their process as thematic analysis, not grounded theory. In the text here, could the authors offer a phrase or a sentence to explain while they chose this qualitative approach in particular for this project?

We have added more context to this choice of qualitative approach: “Thematic analysis was used to analyze qualitative data, in order to respond to themes emerging from the providers themselves.”

In the results section, I would suggest not including the first names of the respondents, but instead just the professional role and, as the other reviewer suggested, number (e.g. physician 1, physician 2, etc.).

We have clarified that these are pseudonyms. We are happy to change to “physician 1, etc.” but would like to clarify that anonymity has been preserved while allowing readers to attribute different quotes to the same person.

Reviewer: 2

Abstract: What does the (n=) represent. If it's to show consensus or the number acknowledging, enthusiasm, and support, I'm not sure that 4 out of 13 is evidence of support. I think it may show the denominator for activity, e.g., CHRs with access to EHRs. I would consider not showing the n, as it might be misinterpreted.

We have removed the counts as per both reviewer suggestions.

Page 5, line 18. Is this the title of the program, "CHR, Tuberculosis and Sexually Transmitted Disease Prevention Programs". It seems cumbersome. Necessary?

Thank you, we have simplified.

Page 6, line 25. Were any providers asked to interview and declined?

None of the providers declined interviews.

P 6, line 44. Do you mean after the first 3 of 13 interviews?

We have clarified as follows: The study team determined that saturation was achieved when no new information about the impact of the COPE Program on provider care surfaced after three consecutive interviews. Specifically, after ten interviews, our team observed that three additional interviews did not contribute new information, resulting in 13 interviews total.

P 7. lines 18, 19. Something seems amiss with the sentence that ends with "and specifically," which is followed by a fragment. BTW. I don't think Research study staff is a proper noun. "research study staff"

Thank you for noting this error. We have corrected as follows: Prior to the study initiation, the CHAP provided feedback to define the overall study objectives, and specifically endorse this qualitative study of provider perspectives. We have changed “Research study staff” to “study staff.”

Page 8. Are these pseudonyms for people interviewed? Did all research subjects consent to use of their first names. I'm guessing that there aren't too many Catherine, nurse practitioners working in Navajo Nation. I do like the ability to track individuals and know their role. These quotes are much improved from the first version of the paper. Thank you for taking the time to edit the quotes and provide more context.

We apologize for not clarifying that pseudonyms were used, although the role was correct.

VERSION 3 - REVIEW

REVIEWER	Benjamin Oldfield Yale School of Medicine
REVIEW RETURNED	28-Dec-2019

GENERAL COMMENTS	Thank you for another opportunity to review this interesting manuscript. I believe that the authors have satisfactorily responded to the comments made by myself and the other reviewer. I look forward to seeing continued work in this space by the authors.