PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Cancer rehabilitation support by cancer counselling centres (CARES): Study protocol of a quasi-experimental feasibility study
AUTHORS	Hiltrop, Kati; Heidkamp, Paula; Breidenbach, Clara; Kowalski, Christoph; Bruns, Gudrun; Ernstmann, Nicole

VERSION 1 – REVIEW

REVIEWER	Tremblay, Dominique Université de Sherbrooke, School of Nursing
REVIEW RETURNED	17-Oct-2022

GENERAL COMMENTS	General comments: Retrun to work; retention to work; restoring work ability; reintegration process seems to be used interchangeably. Literature shows that there is specific challenges according to the moment on the trajectory of cancer and work. This should be addressed in the protocol considerint the cancer counselling centres provide services within the first two years after diagnosis. The introduction informs about the services provided by social workers, social pedagogics. However, the reader do not know why the development of the intervention does not describe the coordination with other health providers if physical problems are detected. It is well known that cancer and treatments have clusters of symptoms for which counselling is useful but may not be enough. The reason why this is occulted should be explain. The protocol refers to appropriate conceptual frameworks and generic tools. However, the manner in which they are mobilized to achieve the specific goals of the proposed study lacks specificity. What specific aspects or dimensions are used to understand the development and feasibility of the complex intervention? The method section is weak having only few references to support and justify the methodological choice: sampling method, multiple sources of qualitative data, qualitative content analysis, lack of explanation about how qualitative quality criteria will be managed, no information about integration (or linkages) of qualitative and quantitative results. Considering the aim to examine acceptance, feasibility and implementation conditions, the quasi-experimental pre-post design with a control cohort for quantitative data raises concerns. The distinctive features of a feasibility study are not considered. The authors stated that “The surveys aim to investigate the support needs, experiences through RTW, health status, use of healthcare services, and experiences with the counsellors of the cancer counselling centre”. How this aim align with a feasibility study for which the objective is different? Specific comments: p. 4 INTERVENTION: Intervention description involves a list of

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	generic ingredients to support return and staying at work after a cancer diagnosis. Key features—including provider's profile, duration, dose or intensity (core components and adaptable periphery to align patient preference), mode of delivery, essential processes or counselling approach that can all influence efficacy and replicability need more details. For complex interventions, this information is required for each component of the intervention. How the intervention was developed (aim of the study) during the first project phase is not explicit. Is it an aggregate of intervention components that work from empirical research? Results from a deliberative process? Or from various stakeholder perspective? p. 5, line 6: About 20 out of 200 outpatient cancer counselling centres are recruited to pilot the intervention. Please explain the rational for 20 based on the literature. p. 5, line 19: There are many point of entrée for patient to access the counselling centres. This suggest a type of sampling method. Could you please clarify the type of sampling and describe the potential limits of the sampling considering a feasibility study. p. 5, line 38: How the participants will be selected? What the qualitative interviews seek to describe? Semi-structured interviews suggest an interview grid. The conceptual background for the interview guide is the CFIR, but it is a generic framework lacking specificity to get evidence for replication after the pilot study? What are the interview questions? p. 5, line 48: Same questions as for semi-structured interviews. P. 7, line 3: Same questions as for semi-structured interviews and observation p. 7, line38: Data analysis will perform group comparisons between the participants who received the intervention and those who did not will be performed with descriptive and inferential analyses. There are various type of inferential analysis, a clear analysis plan should be provided. p. 7, line 40-41: Please explain what "process data" and "treatment fidelity" refers to. This seems to be a challenge considering the generic description of the intervention. p. 9, line 27: It would be interesting to make explicit what are the anticipated outcomes of the study and what are the potential original contribution to the knowledge about cancer and work.

REVIEWER	Cecatto, Rebeca Universidade de Sao Paulo
REVIEW RETURNED	17-Oct-2022

GENERAL COMMENTS	1. The author mentions that there is a positive vote by the ethics committee of the University Bonn in favor of the protocol but does not mention a formal number of the committee's approval for carrying out the study. Please include approval number and date as well as the name of the ethics committee responsible by aprovation. 2. The CARES project is a study for a newly developed counselling intervention that is described by author as: needs-based, intensified counselling support program for cancer patients including a psychosocial needs assessment, communicative as well as emotional and organizational support, interventions with a focus on the occupational situation, networking support and companionship within the healthcare, rehabilitation, social legislation, and occupational system. The author described very weel the interviews and Measures of the CARES questionnaires. But the procedures (as emotional and organizational support or

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	networking support) that will be carried out after the interviews are not clearly described. It is suggested in the objectives that the newly developed counselling intervention will be composed by evaluations and some type of action that interferes in the process of re-inclusion of patients in the work activity. If the new tool is only diagnostic, please clarify and improve the methodological description. Moreover the expected outcomes after program are not clearly described. Please clarify.What is expected? Best replacement at work? higher rate of return to work of these patients ? Acceptance and appreciation of the new intense counseling process by users ?

REVIEWER	Sleight , Alix NIH
REVIEW RETURNED	09-Nov-2022

GENERAL COMMENTS	Thank you for the opportunity to review this manuscript. It is certainly inspiring to read about the opportunities afforded to cancer patients in Germany. I have two overarching suggestions. First, I would recommend a full English-language copyedit to ensure that all sentence structures are correct and standardized. Second, the manuscript would benefit from more details about the qualitative methods employed. You mentioned using content analysis. Please elaborate. What is your process for coding? How many team members code each interview/observation? How are discrepancies resolved? How will the final list of codes be determined and agreed upon?

VERSION 1 – AUTHOR RESPONSE

Responses to Reviewer 1 Prof. Dominique Tremblay, Université de Sherbrooke
Retrun to work; retention to work; restoring work ability; reintegration process seems to be used interchangeably.
Response: We gladly explain the differences in the terms we used. We would like to stress that we do not use the terms “return to work” and “retention” interchangeably. On the contrary, we think it is important that research does not only focus on the initial return to work, but also the phase afterwards in which work needs to be retained by the patients with cancer. In the phase after the return to work physical, mental and cognitive long-term effects of the cancer disease can cause difficulties to retain work. Evidence shows that as a consequence, there is a higher risk for early retirement or unemployment. Therefore, our newly developed intervention does not only target oncological patients during their first return to work attempt. To clarify the term “work retention”, we added a description in the introduction (p. 3): “For those affected during working age, return to work (RTW) can be a source of not only financial security and independence but also normalcy and identity [2]. Besides RTW, retention of work is important.”
Restoring the work ability refers to an aim of the rehabilitation programs provided by the German Pension Insurance, see explanation in the manuscript: “Therefore, restoring and maintaining work ability in those affected during the working age is an important aim of the rehabilitation process.” (p. 3).
Progressive reintegration refers to a service offered by the German Pension Insurance describing a plan to increase the working hours progressively to ease return to work for patients. We added a definition in the Intervention section (p. 5): “In cases with lower support needs, the patients receive a minimum of three counselling sessions (e.g. to provide information regarding progressive reintegration into the workplace meaning a plan to progressively increase working hours over an agreed period).”

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Literature shows that there is specific challenges according to the moment on the trajectory of cancer and work. This should be addressed in the protocol considerint the cancer counselling centres provide services within the first two years after diagnosis.
Response: We would like to highlight, that the provision of cancer counselling centres' services is not restricted to the first two years after diagnosis, it happens that the majority of oncological patients seek advice within two years after diagnosis. We agree with the reviewer that challenges depend on the time since diagnosis and added this aspect to the Introduction: "Barriers to RTW or retention of work change over time, with disease- and treatment-related aspects being more pronounced shortly after diagnosis, and personal- and work-related aspects being more pronounced in the long run [7]." (p. 3).

The introduction informs about the services provided by social workers, social pedagogics. However, the reader do not know why the development of the intervention does not describe the coordination with other health providers if physical problems are detected. It is well known that cancer and treatments have clusters of symptoms for which counselling is useful but may not be enough. The reason why this is occulted should be explain.
Response: Thank you for mentioning this important aspect. The cancer counselling centres' regular counselling on social law issues include medical aspects for instance informing about in/out patient aftercare, medical legal questions and rehabilitation programs. Moreover, the cancer counselling centres already assist patients with cancer to get access to services and refer them to other health care providers and partners in general as part of their regular counselling. We added more information on the contents of the social law counselling in the manuscript to enable the reader to understand that also medical aspects are part of the counselling (please see p. 3): "Social law counselling covers the topics of medical and vocational rehabilitation, disability law, (existential) economic security, the range of services of service providers, aftercare, workplace and profession, medical legal questions, and regulations in the event of death [10]."
One part of the new needs-based and intensified intervention is the extension of the network of partners that the counselling centres can refer advice seeking patients to. Besides coordinating patients in the healthcare, rehabilitation, social legislation, and occupational system, the counsellors will now have the timely resources to, for instance, accompany the patients to important appointments with the employer to plan the return to work. This information on the intervention can be found in the Intervention section on p. 5.

The protocol refers to appropriate conceptual frameworks and generic tools. However, the manner in which they are mobilized to achieve the specific goals of the proposed study lacks specificity. What specific aspects or dimensions are used to understand the development and feasibility of the complex intervention?
Response: The conceptual frameworks provided rough guidance for our feasibility study. Regarding the quantitative evaluation, we included aspects of the framework in the surveys (e.g., potential sensitive outcomes see Table 2). Regarding the formative evaluation of the intervention, we evaluated which aspects of the frameworks could be meaningfully integrated in the interview guides. We chose aspects that were suitable for each interviewee group. Depending on the interviewee group, we were able to integrate various aspects of the frameworks and thus obtain the most complete possible picture of the feasibility of the intervention from different perspectives. The aspects of the frameworks that were finally integrated can be found in the interview guides that we added as a Supplementary Material: "The questions in the interview guide are based on the Consolidated Framework for Implementation Research [16] and the objectives of a feasibility study [18]. Aspects of the framework and guidelines have been integrated and can be seen in the interview guides." (pp. 8)

The method section is weak having only few references to support and justify the methodological choice: sampling method, multiple sources of qualitative data, qualitative content analysis, lack of

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explanation about how qualitative quality criteria will be managed, no information about integration (or linkages) of qualitative and quantitative results.
Response: Thank you for pointing out the shortcomings. We extended the explanations of the qualitative sampling, data collection and analysis procedures. Whenever available we added English references to increase transparency for international readers. Please see the changes in the Sampling and recruitment, Measures and Data analysis sections (pp. 5).

Considering the aim to examine acceptance, feasibility and implementation conditions, the quasi-experimental pre-post design with a control cohort for quantitative data raises concerns. The distinctive features of a feasibility study are not considered. The authors stated that "The surveys aim to investigate the support needs, experiences through RTW, health status, use of healthcare services, and experiences with the counsellors of the cancer counselling centre". How this aim align with a feasibility study for which the objective is different?
Response: Thank you for your critical comment. We are happy to explain our approach. Our study investigates the feasibility of the counselling intervention with the help of a formative (semi-structured interviews and observations) and quantitative evaluation (routine data, survey data). The routine data of the counselling centres help us to understand how the developed intervention was applied in practice (e.g., contents of counselling, amount, duration, setting and location of counselling meetings). The quantitative surveys have several purposes. First, the surveys are not only used to evaluate the patients' experiences with the regular counselling or counselling intervention, but also to explore their needs related to work, their health status and use of health services etc. Second, the surveys are used to explore potential outcomes which are sensitive to change as a result of our intervention. This knowledge will be helpful for a potential follow-up effectiveness trial. The approach to incorporate effectiveness aspects in a feasibility study reflects the current state of research since hybrid designs which combine aspects of different phases of the research continuum are increasingly common [2]. Furthermore, this approach is in line with Osmond and Cohn's [3] Objective 2 for a feasibility study (e.g., Question 3b "Do planned outcome measures appear to be sensitive to the effects of the intervention). By applying the described study design with two study groups we will be able to detect differences between the regular counselling that is already offered and the intervention. The chosen design will allow us to understand in how far the components of the intervention have been put into practice. Moreover, we are able to find first evidence for their effectiveness.

Specific comments:
p. 4 INTERVENTION: Intervention description involves a list of generic ingredients to support return and staying at work after a cancer diagnosis. Key features—including provider's profile, duration, dose or intensity (core components and adaptable periphery to align patient preference), mode of delivery, essential processes or counselling approach that can all influence efficacy and replicability need more details. For complex interventions, this information is required for each component of the intervention.
How the intervention was developed (aim of the study) during the first project phase is not explicit. Is it an aggregate of intervention components that work from empirical research? Results from a deliberative process? Or from various stakeholder perspective?
Response: Throughout the feasibility study, we aim to develop an intervention that is specifically tailored to the needs of patients with cancer and the cancer counselling centres. Different milestones including the results of the study will be used to adapt and tailor the intervention and its components to increase its feasibility and effectiveness. For example, the results of the feasibility study could show that certain intervention components are not applied in practice and need to be adapted or eliminated from the intervention. Hence, we would like to avoid presenting detailed preliminary versions of the intervention and its components and ask the reviewer for understanding. However, we revised the intervention description to make it easier to understand: "In line with the Template for Intervention Description and Replication (TIDieR) checklist [20], the intervention can be characterised as an intensified needs-based counselling support program for patients with cancer who have employment-

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related questions. The intervention group receives intensified counselling with intervention components focusing on the occupational situation, networking support, and companionship within the healthcare, rehabilitation, social legislation, and occupational systems. The intervention is being delivered from October 2022 to the end of June 2023 in the participating outpatient psychosocial cancer counselling centres by specially trained counsellors (mostly social workers and social education workers with work experience in cancer counselling centres) who have participated in a 2-day training course. Counselling sessions for the intervention are carried out in person (usually in the offices of the cancer counselling centres) or via (video) calls. Moreover, as part of the intervention, the specially trained counsellors can accompany the patients to external appointments (e.g. job centres or workplaces). The duration of the intervention, number of counselling sessions, and contents of the intervention vary depending on the needs and preferences of the patients with cancer. Moreover, the provision of the intervention can be adapted to these needs with the help of facultative components (e.g. accompanying patients to external appointments) in addition to the mandatory components (e.g. establishing a counsellor–patient relationship). The intervention consists of a minimum of three counselling sessions, including a mandatory final session to conclude the counselling process. In cases with lower support needs, the patients receive a minimum of three counselling sessions (e.g. to provide information regarding progressive reintegration into the workplace meaning a plan to progressively increase working hours over an agreed period). In cases with higher support needs, patients can receive more intensive and longer-lasting counselling (e.g. to first organise patients' participation in an inpatient rehabilitation measure and to subsequently organise the RTW during the counselling sessions)." (p. 5)
We agree with the reviewer that the mentioned aspects should be reported for a complex intervention and plan to publish a detailed description of the final intervention and its components after the feasibility study. In addition, we understand the relevance of more details on the intervention development and thus provided more information on the development process of the intervention in the Study Design section (p. 4): "The development process is led by social workers with experience in cancer counselling and is supported by a multidisciplinary research team. The development process incorporates the perspectives of various stakeholders of work after cancer and is theory based. The intervention is piloted in about 20 German outpatient cancer counselling centres."

p. 5, line 6: About 20 out of 200 outpatient cancer counselling centres are recruited to pilot the intervention. Please explain the rational for 20 based on the literature.
Response: Due to the explorative nature of our study we applied a purposive sampling strategy aiming to include around 20 cancer counselling centres. A heterogenous sample regarding region (federal state and urbanity), sponsorship, and size (number of employees and advice seeking persons) is the goal of our purposive sampling strategy. We added the respective information to the manuscript (p. 5): "Applying a purposive sampling approach aiming at a heterogeneous sample, the cancer counselling centres are first chosen on the basis of the criteria of the region (federal state and urbanity), sponsorship, and size (number of employees and advice-seeking persons)."

p. 5, line 19: There are many point of entrée for patient to access the counselling centres. This suggest a type of sampling method. Could you please clarify the type of sampling and describe the potential limits of the sampling considering a feasibility study.
Response: During the study period, every person seeking for advice is screened for eligibility in the participating cancer counselling centres, therefore it is an exhaustive screening for the setting of participating cancer counselling centres. However, we are aware patients with cancer who visit a cancer counselling centre can be different from those who do not visit (e.g., health status, health literacy, motivation). Our results will be generalizable to patients with cancer who visit the cancer counselling centres. No generalizations of results will be made for the larger group of all patients with cancer. This limitation will be discussed in all study-related publications.
As described, the advice seeking cancer patients contact the cancer counselling centres themselves or are assigned by allocators from the cancer counselling centres' networks. In the first survey, the

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participating patients are asked how they found their way to the cancer counselling centre. In the quantitative analyses, we can therefore control for differences based on the allocation. Moreover, this knowledge on the allocation could be a sampling criterion for the qualitative interviews with participating patients with cancer.

p. 5, line 38: How the participants will be selected? What the qualitative interviews seek to describe? Semi-structured interviews suggest an interview grid. The conceptual background for the interview guide is the CFIR, but it is a generic framework lacking specificity to get evidence for replication after the pilot study? What are the interview questions?
Response: Thank you for your questions. We added more information on the selection of participants in the Recruitment and sample section. The qualitative interviews are used to explore aspects of feasibility in the different interviewee groups (patients with cancer, counsellors etc.). The Measures section contains information on the contents of the interviews "The interviews with patients focus on acceptance, attractiveness, feasibility, effectiveness, and burden of the counselling, as well as their relationship with the counsellor" (p. 8.) Since the interviews are semi-structured, an interview guide (=interview grid) was developed "Owing to their semi-structured characteristic, interview guides with open-ended stimulus questions and further narrative-generating questions have been developed [22]" (p. 8) Based on frameworks such as the CFIR, questions for the interview guide were developed - a procedure that has been applied successfully before in research [4]. For example, as part of the Orsmond and Cohn's Objective 3 it should be examined how acceptable and appealing the intervention is and if it creates a burden. Hence, questions on the appeal and burden were added to the interview guide for patients. The questions in interview guides contain references to respective aspects of the frameworks and were added the interview guides as Supplementary Material.

p. 5, line 48: Same questions as for semi-structured interviews.
Response: Please see above

P. 7, line 3: Same questions as for semi-structured interviews and observation
Response: Please see above

p. 7, line38: Data analysis will perform group comparisons between the participants who received the intervention and those who did not will be performed with descriptive and inferential analyses. There are various type of inferential analysis, a clear analysis plan should be provided.
Response: Thank you for your comment. Since the main goal of the study is gaining explorative insight into the feasibility of the intervention and only first indications regarding the intervention's effectiveness are examines, group comparisons will be based on descriptive analyses. We have adapted the sentence: "For potential primary outcomes (see Table 2, section Occupation Situation), we will follow a stepwise procedure by first describing the change between measurement time points per study group, analysing the effect sizes, and, in case of at least medium effect sizes, finally testing for significant differences between the two study groups. The analyses will be carried out using SPSS Statistics, R, and Stata." (p. 9)

p. 7, line 40-41: Please explain what "process data" and "treatment fidelity" refers to. This seems to be a challenge considering the generic description of the intervention.
Response: Process data refers to the routine data. We changed the wording consistently to routine data and apologize for the confusion. The routine data and its collection were explained throughout the manuscript e.g. "The routine data collected during the counselling process by the counsellors comprise information on the amount, duration, setting, and location of counselling meetings as well as the form of contact (i.e. personally or via [video] call) and contents. The counsellors also report particularities and adverse events. Moreover, the diagnoses of the participants and information regarding the qualifications of the counsellors are included" (p. 8). With the help of these data we can understand which components of the intervention were applied in the counselling process and to what

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extent the counselling in the intervention group actually differed from the counselling in the regular counselling group. We referred to this as “treatment fidelity”, meaning the “fidelity to the intervention manual”. We changed the wording in the manuscript (p. 9).

p. 9, line 27: It would be interesting to make explicit what are the anticipated outcomes of the study and what are the potential original contribution to the knowledge about cancer and work.
Response: We added the following information to the manuscript: “The main goal of the CARES study is to gain an insight into the feasibility of implementing the developed intervention in existing oncological health care structures in German outpatient cancer counselling centres. Expected outcomes are explorative and are anticipated to contribute to tailoring and implementing the intervention. Furthermore, the first indications of the effectiveness of the interventions will be examined. We expect that the participants in the intervention group will report better outcomes at T1 than participants in the control group. Thus, the project’s potential original contribution will be knowledge on the needs of patients with cancer regarding work after cancer and on the manner in which support and counselling need to be designed to fit patients’ needs and the structure of the German health care system.” (p. 10)

Responses to Reviewer 2 Dr. Rebeca Cecatto
1. The author mentions that there is a positive vote by the ethics committee of the University Bonn in favor of the protocol but does not mention a formal number of the committee's approval for carrying out the study. Please include approval number and date as well as the name of the ethics committee responsible by aprovation.
Response: Thank you for your comment. We added the number of approval, date of the approval, and the name of the respective ethics committee, e.g., “The ethics committee of the Medical Faculty of the University of Bonn has provided approval (061-22; 09.04.2022)” (p. 10).

2. The CARES project is a study for a newly developed counselling intervention that is described by author as: needs-based, intensified counselling support program for cancer patients including a psychosocial needs assessment, communicative as well as emotional and organizational support, interventions with a
focus on the occupational situation, networking support and companionship within the healthcare, rehabilitation, social legislation, and occupational system. The author described very weel the interviews and Measures of the CARES questionnaires. But the procedures (as emotional and organizational support or networking support) that will be carried out after the interviews are not clearly described. It is suggested in the objectives that the newly developed counselling intervention will be composed by evaluations and some type of action that interferes in the process of re-inclusion of patients in the work activity. If the new tool is only diagnostic, please clarify and improve the methodological description. Moreover the expected outcomes after program are not clearly described. Please clarify.What is expected? Best replacement at work? higher rate of return to work of these patients ? Acceptance and appreciation of the new intense counseling process by users ?
Response: Thank you for your comment and questions. Our CARES study consists of two parts: 1) development of the intervention and 2) evaluation of its feasibility.
1) We aim to develop an intervention that is specifically tailored to the needs of patients with cancer and the cancer counselling centres. Different milestones including the results of the study will be used to adapt and tailor the intervention and its components to increase its feasibility and effectiveness. For example, the results of the feasibility study could show that certain intervention components are not applied in practice and need to be adapted or eliminated from the intervention. Hence, we would like to avoid presenting detailed preliminary versions of the intervention and its components and ask the reviewer for understanding. However, we revised the intervention description to make it easier to understand. We agree with the reviewer that the mentioned aspects should be reported for a complex intervention and plan to publish a detailed description of the final intervention and its components after the feasibility study. In addition, we understand the relevance of more details on the intervention

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development and thus provided more information on the development process of the intervention in the Study Design section (p. 4): “The development process is led by social workers with experience in cancer counselling and is supported by a multidisciplinary research team. The development process incorporates the perspectives of various stakeholders of work after cancer and is theory based. The intervention is piloted in about 20 German outpatient cancer counselling centres.”
2) The feasibility study will accompany the implementation of the intervention. The qualitative part of the feasibility study consists of semi-structured interviews with different stakeholders of the intervention (patients with cancer seeking advice, the counsellors etc) and observations of the counselling appointments in order to understand how the developed intervention was put into practice. The quantitative part of the study includes routine data from the counselling appointments (contents of the counselling, duration etc.) and survey data from the patients with cancer. In the survey, we include various potential outcomes that could be sensitive to change as a result of the counselling intervention. Table 2 provides an overview over the instruments that are potential outcomes. Since the main aim of our study is to first explore the feasibility of the intervention, we do not intent to proof effectiveness of the intervention for one specific outcome in the first place but rather explore outcomes potentially sensitive to change. We added the results that we expect to the manuscript (p. 10): “The main goal of the CARES study is to gain an insight into the feasibility of implementing the developed intervention in existing oncological health care structures in German outpatient cancer counselling centres. Expected outcomes are explorative and are anticipated to contribute to tailoring and implementing the intervention. Furthermore, the first indications of the effectiveness of the interventions will be examined. We expect that the participants in the intervention group will report better outcomes at T1 than participants in the control group. Thus, the project’s potential original contribution will be knowledge on the needs of patients with cancer regarding work after cancer and on the manner in which support and counselling need to be designed to fit patients’ needs and the structure of the German health care system.”

Responses to Reviewer 3 Alix Sleight , NIH
Thank you for the opportunity to review this manuscript. It is certainly inspiring to read about the opportunities afforded to cancer patients in Germany.
Response: We appreciate the positive feedback on our study.

I have two overarching suggestions. First, I would recommend a full English-language copyedit to ensure that all sentence structures are correct and standardized.
Response: The manuscript was edited by a professional copyediting service to improve the quality of the English.

Second, the manuscript would benefit from more details about the qualitative methods employed. You mentioned using content analysis. Please elaborate. What is your process for coding? How many team members code each interview/observation? How are discrepancies resolved? How will the final list of codes be determined and agreed upon?
Response: Thank you for your questions. We added the requested information in the Recruitment and sample, Measures, Data analysis sections of the manuscript.

References
1 Hoffmann TC, Glasziou PP, Boutron I, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ 2014;348:g1687. doi:10.1136/bmj.g1687 [published Online First: 7 March 2014].
2 Curran GM, Bauer M, Mittman B, et al. Effectiveness-implementation hybrid designs: combining elements of clinical effectiveness and implementation research to enhance public health impact. Med Care 2012;50(3):217–26.
3 Orsmond GI, Cohn ES. The Distinctive Features of a Feasibility Study: Objectives and Guiding Questions. OTJR (Thorofare N J) 2015;35(3):169–77.

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4 Dittmer K, Hower KI, Beckmann M, et al. A qualitative study of the adoption of Value Stream Mapping in breast cancer centers. Eur J Oncol Nurs 2021;54:102037. doi:10.1016/j.ejon.2021.102037 [published Online First: 17 September 2021].

VERSION 2 – REVIEW

REVIEWER	Cecatto, Rebeca Universidade de Sao Paulo
REVIEW RETURNED	10-Feb-2023

GENERAL COMMENTS	The author has considerably improved his manuscript. There are still small questions to be answered: 1. In relation to table 2 which contains the measures of the CARES questionnaire: what does the column entitled "Use for evaluation" and its completion mean? 2. To identify suitable outcome variables for this feasibility study, the author mentions several chosen outcomes. Why the outcomes analyzed with NCCN Distress Thermometer; 24, quality of life (EORTC-QLQ C30; 25), role conflicts, life satisfaction (adapted from ESS; 27), current work situation, job changes , the need for occupation-related treatments (SIBAR; 29), working intention (self-developed; adapted from SOEP; 30), experienced pressure to RTW, RTW literacy, RTW self-efficacy (RTW-SE, 31), experienced burden through RTW, quality of working life (QWLQ-CS), satisfaction with the employment situation (adapted from ESS; 27), were used to assess the feasibility of the study ? Are these outcomes related to this? Please explain better. 3. Please describe the control group used. What are the measures used in the control group?

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