Statistical analysis plan for The Health And Performance Promotion in Youth (Happy) study: A hybrid effectiveness-implementation study investigating the effectiveness of an implementation-supported injury prevention exercise program in Danish youth handball

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Statistical analyses plan – HAPPY.

Section 1: Administrative information

Trial and trial registration

- 1.a: Title: The Health and Performance Promotion in youth (Happy) study. Happy is a hybrid effectiveness-implementation study evaluating if the combination of access to the Happy Injury Prevention Exercise Program and the Happy implementation strategy (intervention group) is superior to a strategy of access to the Happy Injury Prevention Exercise Program only (control group) in improving team adherence and in reducing shoulder, knee and ankle injuries in young handball players aged 11-17 years.
- 1.b: Trial registration number: ClinicalTrials.gov ID: NCT05294237

SAP version

- 2: Version 2.0, Date: 01.03.2023

Protocol version

- 3: This statistical analysis plan (SAP) has been written based on the PhD protocol approved by the Graduate School of Health, University of Southern Denmark, entitled “Injury prevention in Danish youth handball – a hybrid effectiveness-implementation study”. This SAP adheres to the Guidelines for the Content of Statistical analysis plans in Clinical trials (1). The SAP was made publicly available at before any outcome analyses commenced and before unblinding the data.

SAP revisions

- 4a: Revision history
- 4b: Justification for revision
- 4c: Timing of revision

Two versions of this SAP are available, one with and one without tracked changes.
Roles and responsibilities

• 5: Names, affiliations, and roles of SAP contributors

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Signatures

- 6a: SAP author: Merete Møller
  Date: 01.03.2023

- 6b: Statistician signature:
  Date: 01.03.2023

- 6c: Primary investigator signature
  Date: 01.03.2023
Section 2: Introduction

Background

• 7: Synopsis of trial background

Background and rationale

Handball is one of the most popular organised sports in Denmark, but also a sport with some of the highest injury rates (2-4). According to a recent report on sports injuries among 3,498 adults and 3,221 children, Danish youth and senior handball players reported the highest prevalence of injuries in the past 12 months compared to 49 other sports (3). Fifty percent of these injuries are in the ankle, knee and shoulder joint (4). Injuries can lead to absence from sport for more extended periods or complete discontinuance with the sport, leading to risk of social isolation and inactivity with the consequences of poor mental and physical health (5). In the long term, injuries can lead to chronic pain, decreased function, and early development of osteoarthritis (6-8) with associated reduction of quality of life.

Injury prevention exercise programs (IPEPs) can reduce the risk of injury in the ankle and knee by up to 68% in both youth and senior players in soccer, handball, basketball, and volleyball (9-14). Studies have demonstrated that, in youth and senior handball, the risk of knee, ankle, and shoulder injuries can be reduced by up to 50% under ideal conditions in randomised controlled trials (9, 15-17). While these programs have been shown to be effective under controlled conditions, the effectiveness of IPEPs in a real-world setting is lacking in handball (18). A proposed reason for the lack of translation is that interventions shown to be efficacious in trials have had a biomedical focus and failed to systematically examine and address the influence critical contextual components have on real-world implementation (19). To successfully translate the genuine knowledge of injury prevention from research to a real-world practice context, it is essential to understand the contextual and facilitating factors that might help bridge the gap from research to practice (20).

Happy is an end-user, evidence-based and context-specific injury prevention initiative co-developed in a Danish youth handball setting. Guided by intervention mapping (21) as a theoretical framework, we have in previous steps investigated existing knowledge on the
effectiveness and implementation of injury prevention initiatives. We have collected data on injury prevention perspectives from players, coaches, clubs, and other relevant stakeholders from the handball environment through workshops, questionnaires, and interviews. While other studies in handball generally have developed and evaluated an Injury Prevention Exercise Program (IPEP) only, our acquisition of knowledge this far has resulted in a multifaceted intervention featuring an IPEP (Happy IPEP) and a Happy implementation strategy. Our multifaceted Happy intervention is based on behavioral and social science theories which addresses the barriers we have identified in Danish youth handball environments to a widespread, sustained, and high-fidelity use of injury prevention training.

The Happy IPEP will be available online via the Happysport webpage (www.happysport.dk) and via a booklet emailed to all coaches. It consists of 7 warm-up components and 4 resistance training components to be completed after handball practice. The warm-up program has three to four exercise variations for each of the seven components and can be completed with no equipment other than handballs. A modified warm-up program with the same focus areas will be available when the warm-up must take place in a confined space e.g., a hallway where balls are not allowed.

The coaches may deliver the four resistance training components in the field or in the gym. The resistance training components in the field and the gym targets the same four body areas but differs in that the components in the gym are performed with equipment, while the components in the field can be performed without equipment. The four focus areas of the Happy resistance training program are exercises targeting the 1) quadriceps, 2) hamstrings, 3) external shoulder rotators and 4) core and posterior shoulder muscles. Each resistance training component has three levels.

The Happy implementation strategy involves:

- "Train-the-trainer” workshop (3 hours).
- Coach support via phone (1 hour)
- On-field supervision midseason (2.5 hours)
- Online support via Teams or msn group with all involved coaches in the club (2.5 hours)
The Happy implementation strategy is delivered by Happy ambassadors (health professionals and physical trainers with a handball background) who oversee the train-the-train workshop and provide the coach support in the intervention group during the full handball season. The Happy ambassadors was educated at a seminar at the University of Southern Denmark (SDU) in late August 2021. In the beginning of the season, the ambassadors will carry out the train-the-trainer workshop for coaches in each of their allocated clubs. All members of the club will be invited to participate in the workshop, e.g., coaches of other than teams in the target age-group, management, parents, players, and other interested club members are welcome. The ambassadors will re-visit the clubs and support the coaches in delivering the new exercises as intended during midseason.

In this study, we aim to evaluate the effectiveness of our multifaceted intervention, featuring the Happy IPEP and the Happy implementation strategy, on implementation and injury outcomes. This SAP describes the objectives and corresponding analyses for the primary report of the study.

Objectives and hypotheses

- 8: Description of specific objectives and hypotheses

**Primary objectives**

**Implementation**

The primary implementation objective is to evaluate if access to the Happy IPEP in combination with applying the Happy implementation strategy (intervention group) is superior to a strategy of only getting access to the Happy IPEP (control group) on improving adherence to the Happy IPEP at team level during one season.

**Effectiveness**

The primary effectiveness objective is to evaluate if access to the Happy IPEP in combination with applying the Happy implementation strategy (intervention group) is superior to a strategy of only getting access to the Happy IPEP (control group) in reducing shoulder, knee and ankle injuries among young Danish handball players aged 11-17 years old during one season.
Primary hypotheses
We hypothesize that access to the Happy IPEP plus the Happy implementation strategy delivered and overseen by Happy ambassadors is more successful in terms of team adherence and in terms of reducing shoulder, knee and ankle injuries during a season compared to access to the Happy IPEP only.

Secondary objectives
Implementation
Secondary implementation objectives are to evaluate if access to the Happy IPEP in combination with applying the Happy implementation strategy (intervention group) is superior to a strategy of only getting access to the Happy IPEP (control group) in improving:
- adherence to the warm-up part of the Happy IPEP at team level
- adherence to the resistance training part of the Happy IPEP at team level
- adherence to the resistance training part of the Happy IPEP at player level

Effectiveness
Secondary effectiveness objectives are to evaluate if access to the Happy IPEP in combination with applying the Happy implementation strategy (intervention group) is superior to a strategy of only getting access to the Happy IPEP (control group) in:
- reducing substantial handball related ankle, knee and shoulder injuries in young handball players aged 11-17 years old during one season

Section 3: Trial methods

Trial design

- 9.0 Brief description of design

This study is a pragmatic hybrid effectiveness-implementation cluster randomised type 2 (RCT) study. Participating clubs were allocated (1:1 ratio) to either an intervention group receiving the Happy implementation strategy in combination with access to the Happy IPEP or to control group getting access to the Happy IPEP only. The study involves Danish handball clubs with teams at
the youth level (age groups under (u) 13, u15, u17) during one full season from October 2021 to May 2022 (plus recruitment period).

The primary endpoints are:

- the between-group difference in team adherence between the group randomised to receive the Happy IPEP plus HAPPY Implementation strategy and the group randomised to receive the Happy IPEP over one season.
- the between-group difference in shoulder, knee and ankle injuries between the group randomised to receive the Happy IPEP plus the HAPPY implementation strategy and the group randomised to receive the Happy IPEP only over one season.

Randomization

- 10: Randomization details
The clubs were randomly assigned to either the control or intervention group at a 1:1 allocation ratio, using a computer-generated cluster randomisation schedule, taking difference in cluster size into account. The randomisation was performed by a statistician, who received a blinded list of participating clubs and the number of players participating in each club.

Sample size

- 11. Full sample size calculation
  Adherence
The sample size calculation for adherence outcomes is based on a recent report using a similar approach with a mean team adherence to an IPEP in the group receiving access to an IPEP via a webpage of 55% and a mean team adherence in the group receiving IPEP + workshop in the beginning of the season of 75% (22). We expect a standard deviation of 1.0, a cluster size of 4 teams and cluster variation of 1.5. To detect a difference in adherence between groups at a 0.05 significance level, and with power 0.80, a sample size of 9.1 clubs in each arm are necessary. To allow for 10% dropouts, 10 clubs with a minimum of 4 teams in each arm are necessary.
Effectiveness

The sample size calculation for the primary effectiveness outcomes follows the formula suggested by Jahn-Eimermacher et al. (23). When considering time to first injury of interest (shoulder, knee, or ankle) in our balanced clustered design with an expected cluster size of 40 players, assuming data to follow a proportional hazards model and an overall 50% probability of censoring due to other injuries or lost to follow up before end of season, we derived that 6 or more clubs per arm would be needed to detect a hazard ratio of 0.5 at the significance level of 5% and power of 80% with a presumed cluster variation of 0.3.

Framework

- 12. Description of hypothesis testing framework

Both primary and secondary outcomes will be assessed using a superiority framework, expecting that teams in the intervention group receiving the Happy IPEP plus the Happy implementation strategy will have a higher adherence compared to teams in the control receiving the Happy IPEP only. Similarly, we expect players in intervention group will have a lower risk of shoulder, knee and ankle injury compared to players in control group.

Statistical interim analysis and stopping rules

- 13. Statistical interim analysis and stopping guidance

No stopping rules or statistical interim analyses were applied.

Timing of outcome assessments

- 14. Timing of final analysis

The follow-up period extends for 7 months after season start (October 1st, 2021) and all primary and secondary outcomes will be analyzed collectively by an independent statistician. Data from baseline and the weekly reports collected during the 7-months season will be included in the analyses.
• 15. Timing of outcome assessments

Table 1 presents an overview of baseline characteristics and outcomes assessed and their timing. The inclusion period started from end of August 2021 until the first week in October 2021. At inclusion, coaches for each team received access to the level 1 resistance training exercises, and players and coaches were asked to answer an online baseline questionnaire. The randomization was conducted by a blinded statistician last week of September 2021, when all teams had accepted to participate. The weekly reports of adherence, injury and handball exposure started at inclusion to the study, however, only reports from October 1st (the official study start) will be included in the analyses. On October 1st all coaches from each team received access to the full Happy IPEP.

**Table 1: Baseline characteristics and outcomes of the Happy-study**

<table>
<thead>
<tr>
<th>Coaches</th>
<th>Baseline</th>
<th>Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gender (male, female, binary/non-binary, other, prefer not to answer)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Postal code (4 digits)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Educational level (elementary school, high school, vocational education, higher education (short), higher education (middle), higher education (long))</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Club (string)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Experience as handball coach for youth players (years)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Experience as handball coach for senior players (years)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Handball experience as player (years)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Coach education (yes/within DHF*, yes/not within DHF*, no)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Knowledge of IPEP** (yes, no, don’t know)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Team they are coaching the following season (string)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Number of times per week they have planned to train handball in the next season (n)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Number of times per week they have planned to do resistance training in the next season (n)</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

| **Adherence** | | |
| Number of times they have performed each Happy IPEP** component in the past 7 days | X | |

| Players | | |
| **Baseline characteristics** | | |
| Date of birth (8 digits) | X | |
| Gender (male, female, binary/non-binary, other, prefer not to answer) | X | |
| Height (cm) | X | |
| Weight (kg) | X | |
| Club (string) | X | |
| Team (string) | X | |
| Player position (keeper, wing, back, playmaker, streg, no permanent position, don’t know) | X | |
| Preferred throwing arm (right, left, both) | X | |
| Handball experience (years) | X | |
### Statistical analyses plan – HAPPY.

<table>
<thead>
<tr>
<th>Expected number of handball training sessions per week (1, 2, 3, &gt;3)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation on other handball teams (talent training, national teams, senior team, elderly teams, younger teams, other, none of the above)</td>
<td>X</td>
</tr>
<tr>
<td>Participation in other sports (yes, no)</td>
<td>X</td>
</tr>
<tr>
<td>If yes:</td>
<td>X</td>
</tr>
<tr>
<td>What other sports (string)</td>
<td></td>
</tr>
<tr>
<td>How many times a week (1 every other week, 1, 2, &gt;2, don’t know)</td>
<td>X</td>
</tr>
<tr>
<td>Resistance training (times per week) in the last season (1 every other week, 1, 2, &gt;2, don’t know)</td>
<td>X</td>
</tr>
<tr>
<td>Knowledge on IPEP** (yes, no)</td>
<td>X</td>
</tr>
<tr>
<td>If yes:</td>
<td>X</td>
</tr>
<tr>
<td>Name of program(s) (string)</td>
<td>X</td>
</tr>
<tr>
<td>How many times a week in the last season (1 every other week, 1, 2, &gt;2, don’t know)</td>
<td>X</td>
</tr>
<tr>
<td>Injuries within the past year (have had an injury, body regions and body side)</td>
<td>X</td>
</tr>
<tr>
<td>Current injuries within the last two weeks (OSTRC-H2 responses (24))</td>
<td>X</td>
</tr>
</tbody>
</table>

### Adherence

| Happy resistance training exercises times per week | X |

### Health problems (injuries and illnesses), and handball exposure (training and match)

| Any health problems during the past 7 days based on the OSTRC-H2 questionnaire (24) | X |
| If players report anything but “full participation without any health problems” to the first question in the OSTRC-H2 questionnaire: |  |
| Modified training/competition |  |
| Affected performance |  |
| Extent of experienced pain |  |
| New or previously reported health problem within the past 14 days |  |
| Injury or illness |  |
| If injury, body region for injury |  |
| Number of training hours the past 7 days (hours) | X |
| Number of match minutes the past 7 days (minutes) | X |

*DHF=Danish Handball Federation, **IPEP= Injury Prevention Exercise Program

### Section 4: Statistical principals

**Confidence intervals and p values**

- 16. Level of statistical significance and confidence intervals
  
  A significance level of 5% is chosen.

- 17. Adjustment for multiplicity
  
  No adjustment for multiplicity will be performed

- 18. Confidence intervals
  
  Confidence intervals will be presented.
Adherence and protocol deviations

- 19a. Definition of adherence to the intervention
Optimal adherence to the Happy implementation strategy is defined as when minimum one coach from each team in the intervention group participate in the train-the-trainer workshop and in the mid-season supervision.
Sub-optimal adherence to the Happy implementation strategy is defined as when minimum one coach from each team in the intervention group participate in the train-the-trainer workshop but not in the mid-season supervision.
Poor adherence to the Happy implementation strategy is when no coaches from teams in the intervention group participate in the train-the-trainer workshop and the mid-season supervision.

- 19b. Description of how adherence to the intervention will be presented
Adherence to the intervention will be presented as the number and percentage of coaches that have optimal, sub-optimal and poor adherence to the intervention.

- 19c & 19d. Definition of protocol deviations and how they will be reported
A major protocol deviation is a protocol deviation that might significantly affect the results. All major protocol deviations will be reported in the primary report.

Analysis population

- 20. Definition of analysis population

Intention to Treat Analysis
In the primary analyses of the trial outcomes, all coaches and players will be included according to the group they were randomized, following the Intention-To-Treat (ITT) principle. This is the full analysis set, defined as an analysis set being as complete and as close to the ITT principle of including all randomized individuals as possible (25).

Per protocol analysis
In addition, a per protocol analysis will be performed. The as treated population excludes players and coaches from teams in the intervention group where no coaches from the team attended the train-the-trainer workshop and the mid-season supervision.
It is not possible that players/coaches in the control have received the workshops and ambassador guidance received in the intervention group, therefore the control group will remain the same in the per protocol analysis as in the intention to treat analysis.

Section 5: Trial population

Screening data

21. Reporting of screening data
The duration of the recruitment period (start and end date) and the total number of subjects screened for eligibility throughout the recruitment period will be reported. See also item 23 & 24.

Eligibility

22. Summary of eligibility criteria
This injury prevention initiative's primary beneficiaries are young handball players aged 11-17 years. All players irrespective of current or previous injuries were eligible for participation in the study. The study's target group also includes handball coaches as primary program deliverers. The desired teams are youth teams from the age groups under (u)13, u15, and u17. Handball clubs with at least four teams in the desired age groups, regardless of playing level, will be eligible for participation in the study. We aim to have clubs participating in all five regions of Denmark and include clubs from different municipalities in terms of economic resources to make sure that the participating groups are broadly representative of the Danish handball community. Also, we aim to obtain an equal distribution of female and male players included in the study.

Recruitment and withdrawals

23+24. Information to be included in the CONSORT flow diagram

The CONSORT flow diagram will consist of the following:
We invited clubs that meet the eligibility criteria to participate in the study via the Danish Handball Federation (DHF). The recruitment period started May 2021. During the inclusion period introduction meetings for coaches, players, parents, and club management was held online by the principal investigator (MM) with the duration of 30 minutes to inform the potential participants on the study, data collection and data management. Hereafter, a link was sent out to all parents with eligible players to collect consent from the parents or legal guardians. The eligible coaches received a link to collect consent and baseline data. In August, the research group visited all the included clubs to ensure the following: 1) baseline data collection on players, 2) introduction to weekly data collection by players 3) baseline data collection on coaches 4) introduction to data collection by coaches.

Baseline patient characteristics

- 25a. List of baseline characteristics to be summarized
  Table 1 presents an overview of baseline characteristics that will be presented in the primary report.
- 25b. Details on descriptive summary of baseline characteristics
  Categorical and binary data will be summarized by absolute and relative frequencies. Continuous data will be summarized by mean (SD) if data are normally distributed and median.
Section 6: Analysis

Outcome definitions

- 26: Specification of outcomes and timing

**Primary implementation outcome measure**

Team adherence will be evaluated as the number of Happy components delivered per week at team level over the full season.

Reports of Happy program usage will be recorded electronically on a weekly basis by the head coach of each team using the web application REDcap. Each Sunday evening the head coach of each team will be asked to report how many times he or she has used each Happy component during the past 7 days.

**Primary effectiveness outcome measure**

For evaluation of effectiveness on injury outcomes, the primary outcome will be time to any new handball related ankle, knee and shoulder injuries defined as any tissue damage or other derangement of normal physical function due to participation in handball, resulting from rapid or repetitive transfer of kinetic energy, following a recent consensus statement from the International Olympic Committee (27).

Each week during the handball season, players will be asked to complete the updated version of the Oslo Sports Trauma Research Centre Questionnaire on Health Problems (OSTRC-H2) via SMS messages (24). We have previously demonstrated this approach to be a feasible and valid option for injury surveillance in youth handball players (28, 29). OSTRC-H is translated into Danish and has been validated and reliability tested among Danish athletes (30).

Players reporting anything but “full participation without any health problems” to the first question in the OSTRC-H2 questionnaire (24), and further classify the health problem as a new shoulder, knee or ankle injury is included as primary outcome.
Secondary implementation outcome measures
Secondary implementation outcome measures will be:
• number of Happy warm-up components delivered per week at team level over the full season.
• number of Happy resistance training components delivered per week at team level over the full season.
• number of Happy resistance training components completed per week at player level over the full season.

Secondary effectiveness outcome measure
Secondary effectiveness outcome will be time to any substantial handball related ankle, knee and shoulder injuries. Players reporting at least a moderate reduction in training volume or performance due to a health problem with the OSTRC-H2 questionnaire (24) and further classify the health problem as a new shoulder, knee or ankle injury is included defined as a substantial injury.

Analysis methods
• 27: What analysis methods will be used
The longitudinal continuous adherence measure (both for coaches and for players) is modelled as linear combinations of intervention groups, sex and calendar time using mixed effects linear regressions to account for the between subject variation including a random intercept for each cluster (club). If normality assumptions of residuals or random effects are not fulfilled, bootstrapping with 1000 repetitions will be performed to construct more robust confidence intervals and p-values. Moreover, adherence will be presented graphically as adherence level over calendar time.

The recurrent time-to-injury data is analysed with multistate models considering injuries of interests and other injuries as events while adjusting for sex and calendar time and taking into account club by clustered standard errors to study effects across intervention groups. Time scale in these time-to-event analyses will be the cumulative time of play (training and matches together). Players will be censored if the player stops responding to the weekly questionnaires, drops out during the season, or by the end of 7 months follow-up, whichever comes first.
Players will be allowed to return to the at-risk set after an injury, hence allowing for repeated injury events. The main analyses will be performed by estimating pseudo-values, and a Cox regression will be applied as a sensitivity analysis. Injuries different from the main outcome (ankle, knee, shoulder) will be taken into account as competing events. If data allows, we will as a secondary analyses, investigate shoulder, knee and ankle injuries separately in the analyses.

In sensitivity analyses we will repeat both the longitudinal continuous adherence measure analyses as well as recurrent time-to-injury analyses adjusting for player sex, age group and team size.

Missing data

- 28: Handling of missing data

No imputation methods will be applied with respect to adherence, as the repeated measures mixed model allows inclusion of all subjects if there is at least a baseline measurement, or one follow up measurement (31). In a sensitivity analyses, we will impute missing adherence data as 0 performed components, to investigate to which this changes the results.

With respect to injuries, we will interpret missing injury answers as no injury in the corresponding week (but still censoring after the player’s last week of answers as stated above in 27).

Play time will be multiply imputed by predictive mean matching separately for training and match time clustered by club. As match time > 3.0 hours and training time > 8 hours in a week, are unrealistic in this setting, such measurements will be replaced with missing before imputation.

- 29: Additional analyses

Other outcome measures at ClinicalTrials.gov (ID: NCT05294237) will be reported in subsequent, secondary reports. We have planned the following subsequent, secondary reports with the following aims:
1) to evaluate if applying the Happy implementation strategy in combination with access to the Happy IPEP is superior to a strategy of only getting access to the Happy IPEP on improving behavioural constructs like intentions, outcome expectancies, self-efficacy, social influences, action planning and coping planning among coaches.

2) To evaluate team and player adherence with the Happy IPEP and to study the associations between adherence and injury rates.

3) To evaluate if players with optimal adherence to the Happy IPEP have a lower risk for any handball-related injuries compared to players with non-optimal adherence who comparably change their weekly training load.

In aim 2+3 we will evaluate associations as a prospective cohort based on the cluster-randomized trial.

**Harms**

- 30: Handling adverse events

  Adverse events are not reported in this study.

**Statistical software**

- 31: Details of the statistical package used for the analysis

  STATA 17.0 (or an updated version if applicable) (StataCorp, College Station, TX, USA) or other statistical analyses packages (such as R, SAS, SPSS) if needed.

**Operating procedures**

- 32: Data management

  The procedures for data collection and management were approved approved by the Research and Innovation Office at the University of Southern Denmark, ensuring that it is organised following current GDPR rules (number 10.925). Personal information about patients is kept
Statistical analyses plan – HAPPY. separate from the main data set and will not be shared with anyone outside the central study team. To protect confidentiality before, during and after the trial, all personal data is stored securely.

This SAP will form the basis for analyses of the described primary endpoints, which will be carried out by the same independent statistician, without any involvement from the investigators or study chairs. A study coordinator will code the two implementation arms into ‘Group A’ and Group B’ before handing the data over to the statistician. This will help ensure that the statistical analyses will be performed blinded from group (intervention/control) allocation.

To reduce risk of interpretation bias, blinded results from the ITT analysis (Group A vs. Group B) will be presented to all authors, who will agree on two alternative written interpretations, one where group A is the intervention group (teams receiving the Happy implementation strategy and Happy IPEP) and one where Group A is the control group (teams receiving the Happy IPEP only). After finalizing the blinded interpretation, the study coordinator will unblind who is Group A and Group B.
References


Statistical analyses plan – **HAPPY.**


