Author’s response to reviews

Title: Assessing Receptiveness to Change among Primary Healthcare Providers by Adopting the Consolidated Framework for Implementation Research (CFIR)

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Authors’ response to reviews (resubmission)

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Version 2: Date: 27th May 2019
Author’s response to reviewers:

Editor Comments:

1. Please include a title page at the front of your manuscript file

RESPONSE – Thank you, we have included the title page with names, institutions, countries and email address of all authors.

Reviewer 1 (Julie Lowery)

REVIEWER REPORT

The authors did an excellent job of addressing most of my initial concerns, including revisions to Table 2, organization of the findings to correspond to the constructs presented in Table 2, recoding several constructs, and focusing the discussion on translating the barriers and facilitators into recommendations for actionable items during implementation. A few concerns remain, but these should be relatively easy to address.

RESPONSE

Thank you and we aim to best adhere to the recommendations given.

REVIEWER REPORT

I have a lingering concern regarding the consistent use of, and appropriate distinction between, the terms "readiness", "openness", and "receptiveness." In line 61, the term "healthcare providers' receptiveness" is used; but this is define two sentences later as "openness". I would suggest keeping the terminology consistent and using one or the other—either "openness" or "receptiveness"--to not confuse the reader. The term "receptiveness" is used repeatedly in the remainder of the manuscript; so, this term needs to be clarified. In addition, while I understand that the authors added the statement in lines 68-70 in response to my request to clarify the distinction between readiness and openness, it seems that a better distinction, based on the preceding sentences in this paragraph, as well as the definitions in the cited papers (Weiner, Wanberg and Banas), is that "readiness" is used at the organizational level, while "openness" characterizes the individual employees' perceptions. Perhaps the following statement could be substituted for lines 68-70: "Thus, both organizational readiness and individual employees' openness are important determinants of implementation success", or something similar.

RESPONSE
We have taken into consideration of the issue and we have defined receptiveness as an interchangeable terminology to openness that is predefined in the Merriam-Webster dictionary as openness and responsiveness to ideas and change. We have also added the suggested statement in our paper to reinforce the original idea stated.

REVIEWER REPORT

The statement (lines 76-78) is made, "The four major domains of CFIR—intervention characteristic, outer setting, inner setting and characteristics of individuals were used to practically guide systematic assessment on intervention implementation and effectiveness…" I don't believe that for purposes of this study intervention implementation and effectiveness were assessed, since the intervention was not actually implemented. Instead I believe the purpose of the study was to use the CFIR to guide assessment of organizational readiness and employee openness, as stated earlier.

RESPONSE

Thank you and we truly agree to suggestion. We have removed the “effectiveness of the intervention assessment” as it was not part of the paper.

REVIEWER REPORT

Under Study Settings and Participants is the statement, "The clinics were categorized according to the population size served and service availability." It would be helpful to see the exact definition of these categories and the number of providers sampled from each category—perhaps as an addition to Table 1.

RESPONSE

Thank you for the suggestion and we have added the information to Table 1.

REVIEWER REPORT

Lines 116-117 include the statement, "Information saturation is achieved when no new information can be added to HCPs' perception of change." Did the authors use this approach in their sampling strategy, which suggests that after they interviewed a certain number of providers, they stopped, because no new information was being obtained? Or was the sample size of 106 based on the number of people who responded to invitations to participate? How many people were invited to participate in interviews?
RESPONSE

Thank you for the suggestion. We have added the following statement to answer the issue of saturation and number of participation:

“For this study, saturation was achieved during the 18 FGD whereby all of the domains does not have any new information. The additional two FGD were conducted as confirmatory session to ensure no new information were found. All 106 participants were invited through their head of clinic. Interviews were conducted at their workplace (clinic) and during their preferred accommodated time. This approach was adopted to maximise participation and was found to be fruitful as there were no dropouts.”

REVIEWER REPORT

I appreciate the authors' response to my question about what new constructs were identified that were not in the CFIR—namely, that after deliberation it was determined that all themes could be categorized within existing CFIR constructs. However, I would suggest that the statement describing the results of this deliberation (statements 155-158) be moved to the Results section, rather than include this as part of the Analysis section.

RESPONSE

Thank you for the suggestion and we have moved the statement to the result section and re-written as follows:

“During preliminary analysis, ‘non-compliance to appointment’ and ‘non-compliance to treatment management’ seemed to fit a new construct that was initially called ‘Patient’s Behaviour’, which was not in the CFIR. After long deliberation, codes in this new construct were refitted into CFIR’s ‘Patients and Resources’ construct”.

REVIEWER REPORT

I would recommend a few small changes in organization of the introduction to the Results, to improve ready:

*  Move lines 169-173 (starting with "Table 2 summarizes...") to immediately follow the heading, "Identified Barriers and Facilitators Based on CFIR Constructs and Sub-constructs."

RESPONSE

Thank you for suggestion, we have moved the paragraph.
REVIEWER REPORT

I would recommend a few small changes in organization of the introduction to the Results, to improve readability:

* Move the statement, "Table 3 provides illustrative selected quotes…" to the very end of the paragraph, immediately before presenting the findings for each of the CFIR domains.

RESPONSE

Thank you for suggestion, we have moved the paragraph.

EWER REPORT

I would recommend a few small changes in organization of the introduction to the Results, to improve readability:

* Some kind of transition is needed for the statement that begins, "HCPs had expressed openness to any new interventions…" I'm not sure what this means relative to the immediately preceding statement, which mentions challenges and barriers? Is the intention, "Despite these challenges, HCPs had expressed openness…” Or if something else, please clarify.

RESPONSE

Thank you for suggestion, we have included transition statement “Despite these challenges”.

REVIEWER REPORT

I would recommend a few small changes in organization of the introduction to the Results, to improve readability:

* Similarly, I'm not sure what the following statement means: "Their readiness was based on experience and assessment of current primary healthcare clinics' settings that may facilitate the implementation of new interventions." This is a bit vague. What does "experience and assessment…” mean exactly?.

RESPONSE

The sentence has been revised to further clarify the ambiguous intention. “experience” mentioned are the personal experience of the HCP and “assessment” refers to the personal insights of the HCP making their own assessments based on their experience. The new sentence are as follow: “Their readiness to change was based on experience handling their clinic and
It would be informative to provide some explanation of the "several activities related to NCD management" (lines 188-189) that "can facilitate the proposed plan for enhancing the NCD services." This would clarify how these activities could facilitate the design and packaging of the intervention.

Thank you for the suggestion, we have added several examples in regards to the related activities. The new sentence is as follows:

The availability of several activities (such as family doctor concept, community health empowerment program and clinic appointment system) related to NCD management can facilitate the proposed plan for enhancing the NCD services and strengthen the suggestion for dedicated NCD care management teams in primary healthcare settings.

I would suggest removing the phrase, "which can be contemplated as their readiness for change" in line 207. I'm not sure this follows from the observations about providers' recommendations regarding patient needs and resources.

After considering the suggestion, we have decided to remove the statement.

It's not clear why the issue of clinic resources and lack of manpower mentioned under Tension for Change (lines 252-256) is included here. As stated, this "echoes the earlier issue of clinic resources", and seems that this is where it belongs—under Structural Characteristics.

After considering the suggestion, we have decided to remove the statement because it does not really fit well with ‘Tension for Change’.
REVIEWER REPORT

The other examples included under Tension for Change are good ones; but Table 2 notes both positive and negative influences. The authors should clarify which ones are positive and which are negative. From the examples provided, it seems that the examples would be considered mostly positive, given the definition of Tension for Change. Alternatively, if the providers are satisfied with the status quo, then a tension for change doesn't exist, which would be a potential barrier (negative influence) to implementation of the proposed intervention.

RESPONSE

Thank you for the suggestion. After reflecting on the suggestion, we have amended the table 2 to change according to your suggestion and changes the negative views into the positive notes.

REVIEWER REPORT

I would suggest reconsideration of some of the items coded as Relative Priority. I agree that respondents' positive perception of the family doctor is a good example of Relative Priority. However, I'm not sure about the other examples provided:

* The need for time and work routine adjustments for adaptations to the practice ◊ compatibility?
* Proper training before the proposed intervention is implemented ◊ available resources?
* Provision of monetary and non-monetary reimbursements for successful tasks and achievements -> incentives and rewards?

RESPONSE

Thank you for the suggestion. After considering the examples given, we have also decided to drop other examples that does not fit well with the Relative Priority.

REVIEWER REPORT

Under Individual Characteristics, Knowledge and Belief about the Implementation, it seems that the uncertainties and fear of the impending unknown would be considered a negative influence. If so, this should be checked in Table 2, in addition to the positive influence of expectation of improved overall health outcomes.
RESPONSE

Thank you for the suggestion. The statement on the uncertainties and fear of impending unknown is actually from another study that we have chosen to cross-compare with our results.

REVIEWER REPORT

Under Strengths and Limitations, please clarify the statement, "Therefore, the actual richness of information gathered from the focus group discussions and in-depth interviews extended beyond the CFIR constructs and domains."

Also, additional explanation of the following statement would be helpful: "Considering using a mixed method approach which could counter balance the potential issues of a qualitative approach." Specifically what are the "issues" that could be addressed with a mixed method approach?

Also, the authors state that they used triangulation of data sources to reduce bias. What other data sources were used besides interview responses?

RESPONSE

Thank you for the suggestion. We have modified the whole section to better explain the idea as follows "Nevertheless, comprehensiveness of analysis guided by CFIR facilitates exploration of data from different dimension. Although qualitative data can provide rich information, quantitative measurement for the seriousness and severity of issues raised was not performed in the study. Future study, possibly using mixed method approach of a larger scale for an additional structured questionnaire on an item-scale (Likert for example) assessing the key readiness question in an indirect manner would have explored perception as a cross-check measure."

In term of triangulation of data sources to reduce bias, data was obtained through FGD/IDI from different categories of HCPs. We agreed to drop this statement from the limitation.

REVIEWER REPORT

Under Conclusion is the statement, "In addition, cultural and local adaptations of the implementation are very likely to happen in view of the variances of clinic setting and the perceived community mind-set." How did this conclusion emerge from the findings? I didn't see where this was discussed previously. Consider adding one of the other significant barriers that emerged—e.g., compatibility.

RESPONSE
This conclusion came from the reflections of the researcher and taking into consideration of the local implementations at the clinic. By using this notion, upon future implementation, possible interactions with culture and norms may affect the implementation of future interventions.

REVIEWER REPORT

In the Abstract is the statement, "Communication, goal setting and monitoring were imperative in sensitizing change." How did this conclusion emerge from the findings? I didn't see these constructs emphasized in the discussion in the actual text of the manuscript.

RESPONSE

Thank you for kindly pointing out the error. The sentence was from an earlier iteration of the paper which we have overlooked to remove.