Reviewer’s report

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

Version: 0  Date: 28 Jan 2019

Reviewer: Julie Lowery

Reviewer's report:

This paper uses the Consolidated Framework for Implementation Research to help assess the barriers and facilitators to implementing a complex intervention for enhancing the delivery of primary care in Malaysia. The CFIR offers a potentially useful framework for understanding the challenges facing the implementation, while also identifying aspects of the existing infrastructure and available resources that could facilitate implementation. The findings from this analysis could help those responsible for the implementation develop strategies for designing intervention materials and managing issues related to implementation readiness. A total of 106 employees were interviewed (some individually, some in focus groups) across various types of professions, thus providing a nice cross-section of perspectives.

However, several aspects of the manuscript need improvement prior to publication.

Additional information on the proposed intervention would be helpful. The intervention is described as complex, and the goals of the intervention are mentioned, but little else. It would help the reader to appreciate the complexity of the intervention, and to better understand the implications of the findings for implementation, if additional information about the intervention were provided. Also, what information about the intervention was provided to the participants, to give them some context for the interview questions?

The interview responses, in addition to being assigned codes based on CFIR constructs, were coded as either "readiness for change" or "openness to change". The distinction between these two concepts needs to be clarified. "Readiness for change" is defined as "a state of being both psychologically and behaviorally prepared to take action to move into a new and different state of change." "Openness to change" is defined as "a willingness to accommodate and accept change." What is the difference between being psychologically prepared to change and being willing to change? What is the importance of distinguishing between these two concepts? What does it mean if one is present but not the other?

The findings are summarized in Table 2, with ticks indicating positive views by the participants. It is a little confusing—and not really accurate—to equate positive views with readiness for change. The assumption underlying the CFIR (based on the various models underlying the
framework) is that constructs viewed as positive by respondents are more likely to facilitate change—but this doesn't necessarily mean that the respondents are "ready" for change; this is a hypothesis to be tested. It would be more accurate to label the column with tick marks as "positive presence" or something similar.

The clarity of the manuscript could be greatly improved if the text under results directly corresponded to each of the constructs presented in Table 2. As the manuscript is written, not all of the constructs in the table are discussed (e.g., compatibility, relative priority, goals and feedback, access to knowledge and information). In addition, it would be helpful if the results within each domain (theme) were organized by "Barriers" and "Facilitators".

Several of the items included under Tension for Change would seem more appropriately coded under other constructs—e.g., minimal manpower (available resources); lack of proper tracking mechanism (compatibility, available resources, or structural characteristics), inadequate time (available resources), patients' beliefs (patient needs and resources). I do agree that the perception of "the patient influx as a golden chance for early detection and screenings, particularly NCDs" does suggest a positive tension for change.

In the Analysis section it is noted that the analysis was not limited only to CFIR constructs "as they were also allowed to create new subdomains and categories that may arise from the data inductively." What themes emerged that were not part of the CFIR?

Given that the purpose of this analysis was to "facilitate the development of intervention materials and manage issues related to implementation readiness", the discussion should focus on exactly how the identification of the specific barriers and facilitators achieved this goal. E.g., for each of the barriers identified, what are the recommendations for overcoming these? How can the people charged with implementation take advantage of all of those constructs viewed positively (i.e., facilitators) by respondents?

Under Strengths and Limitations is the statement, "Uncertainties and fear of the impending unknown among the participants became a disadvantage as some participants developed preconceived notions that may be unrealistic, which we have screened out during the analysis." What does "screened out during the analysis" mean? These uncertainties and fears and preconceived notions are critical findings that need to be highlighted, because they represent important potential barriers to implementation that will need to be addressed. Even if respondents' understanding of the intervention is inaccurate, the constructs are supposed to measure respondents' perceptions. These perceptions of the interventions should be coded under Access to Knowledge and Information, or more accurately under one or more of the constructs that are part of Intervention Characteristics (e.g., adaptability, complexity, cost). I realize that this domain wasn't included in the initial analysis; but I'd encourage the authors to consider its inclusion if they found that the respondents had strong perceptions regarding the intervention.
Minor comments

Lines 276-279: What is meant by clinic "type categorization" and "clinics set-up"?

In Table 1 it would be helpful to identify which participants were interviewed individually vs. which ones were interviewed as part of focus groups.

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