PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Implementation of patient-centered care: Which organizational determinants matter from decision-maker´s perspective? Results from a qualitative interview study across various health and social care organizations
AUTHORS	Hower, Kira; Vennedey, Vera; Hillen, Hendrik; Kuntz, Ludwig; Stock, Stephanie; Pfaff, Holger; Ansmann, Lena

VERSION 1 - REVIEW

REVIEWER	Maria J Santana Cumming School of Medicine, University of Calgary
REVIEW RETURNED	24-Nov-2018

GENERAL COMMENTS	Overall: • Great paper – well written and interesting! • Only major comment would be that it is a limitation to include not including the outer setting as part of the analysis (Patient Needs and Resources, Cosmopolitanism, Peer Pressure, External Policies and Incentives). In particular, external policies and incentives can influence PCC climate and culture. I would be interested in understanding whether there are regional policies and incentive structures that promote PCC in the HSCO's. Some of the findings indicate the staff are motivated to provide PCC and may not have contracts renewed if they do not provide PCC. Do policies influence this? Minor comments: • Abstract: Under the objectives, it is stated that there is a lack of concepts on possible determinants on PCC. While I agree that there are few comprehensive investigations, there are numerous conceptual frameworks (including those listed in the references) • Methods: Pg 7, lines 42-52 - participant information is typically reported in the results, so I might suggest moving this section • Results: o Pg. 11, line 43-44 – I'm unclear about what is meant by "oversupply of care." Is it suggested that this is seen as proving too much care that is beyond the scope of the healthcare provider's role? o Pg 15, line 14 – I'm wondering if "chef" is a typo? o Pg 22, line 14 – "feel well" could be further clarified as "experience well-being." Feeling well suggests lack of illness vs. overall well-being (physical and emotional) • Limitations: o Pg 27, line 40 – small typo for "suffers," which should be "suffer"

REVIEWER	Victoria Stanhhope Silver School of Social Work New York University USA
REVIEW RETURNED	09-Dec-2018

GENERAL COMMENTS	This qualitative study explored factors related to the implementation of PCC by interviewing decision-makers within health and social care organizations. Although an important topic, the study and its findings were too broad and under analyzed to make a valuable contribution to the literature. These are my recommendations for improvement: 1. There needs to be more depth on how PCC is conceptualized in the literature - to give some frame for how the decision-makers understand PCC within their organizations. There is also the issue of how different it looks across settings - particularly as this study is covering both health and social care delivery. 2. We need more detail on the specific study - rather than just the parent study - how is the design focusing on implementation and what type of qualitative study is it? 3. We need more detail on what exactly HSCOs are - what type of organizations and what types of services they deliver - this is particularly important for an international audience. 4. One of the challenges of this study, is taking an implementation approach without a specified practice. PCC is very broad and often understood very differently by providers and decision-makers. By at least elaborating more on core components in the literature review, would help interpret the results. It may even be that some pre-existing framework may help to organize the results which are hard to follow. 5. The section title "PCC Implementation Measures" is not clear. 6. Overall the qualitative analysis is weak. The findings read more like simply reporting out answers to questions - rather than an in-depth analysis to find commonalities and refine the data further to higher order meanings. The section headings are basic categories rather than conveying more refined understandings of the data. 7. The implementation framework could be presented in the results more clearly - describing the barriers and facilitators and then the strategies to address barriers in a more systematic way. 8. The findings cover too much area in not enough depth but also are repetitive at times. The utility of qualitative methods is to provide depth - but to do this the analysis needs to be more focused on fewer aspects of implementation and the analysis needs to be more refined. It may be that this paper should be parsed out into several papers. 9. Also, it is questionable whether decision-makers are the best informants on some of these front line implementation barriers, as is stated in the limitations - so these aspects could be omitted from the results.

VERSION 1 – AUTHOR RESPONSE

Reviewers' Comments to Author:

Reviewer: 1

Reviewer Name: Maria J Santana

Institution and Country: Cumming School of Medicine, University of Calgary

Please state any competing interests or state 'None declared': None declared

Overall:

#1. Great paper – well written and interesting!

A. We thank the reviewer for the review of our manuscript and appreciate the helpful comments. Below we will elaborate on how we have responded to the comments and suggestions.

#2. Only major comment would be that it is a limitation to include not including the outer setting as part of the analysis (Patient Needs and Resources, Cosmopolitanism, Peer Pressure, External Policies and Incentives). In particular, external policies and incentives can influence PCC climate and culture. I would be interested in understanding whether there are regional policies and incentive structures that promote PCC in the HSCO's. Some of the findings indicate the staff are motivated to provide PCC and may not have contracts renewed if they do not provide PCC. Do policies influence this?

A. We would like to thank the reviewer for raising this important question. In Germany, there are no legally binding measures under which people are for example dismissed if they do not provide care according to the principles of PCC. Nonetheless, we fully agree with your assessment that determinants for PCC implementation in the outer setting (e.g., external policies and incentives) need further elaboration, particularly regarding their effects on organizations. We have collected certain information about determinants in the outer setting within the interviews and are currently conducting a survey addressing this topic. In response to the relevance of this topic, we will examine the determinants in the outer setting (the health and social care system) and their interactions with determinants in the inner setting (the organizations) in a separate article.

#3. Abstract: Under the objectives, it is stated that there is a lack of concepts on possible determinants on PCC. While I agree that there are few comprehensive investigations, there are numerous conceptual frameworks (including those listed in the references)

A. Thank you for raising this important point. To address your comment, the abstract of the revised manuscript now only highlights the "lack of comprehensive investigations on possible determinants of PCC implementation across various health and social care organizations (HSCOs)"

#4. Methods: Pg 7, lines 42-52 - participant information is typically reported in the results, so I might suggest moving this section

A. Thank you for proposing a restructuring of the content of our manuscript, which we follow gladly. The corresponding passage has been moved to the results section (page 12) in the revised manuscript.

#5. Results: Pg. 11, line 43-44 – I'm unclear about what is meant by "oversupply of care." Is it suggested that this is seen as proving too much care that is beyond the scope of the healthcare provider's role?

A. We apologize for the unclear wording. The assumption is exactly right, it is meant that some care providers also call for more personal responsibility and self-care of patients and do not regard everything as their task, they see this as too much care that is beyond the scope of their role. We clarified this on page 14: "However, taking over all tasks for patients was regarded as providing too much care that is beyond the scope of the provider's role."

#6. Pg 15, line 14 – I'm wondering if "chef" is a typo?

A. Yes, this was the wrong term. In the revised version of our manuscript, we have replaced the term "chef" by the term "supervisor" (page 17).

#7. Pg 22, line 14 – "feel well" could be further clarified as "experience well-being." Feeling well suggests lack of illness vs. overall well-being (physical and emotional)

A. Thank you for clarifying this point. Following your suggestion, the revised manuscript now uses the expression "experience well-being" (page 24).

#8. Limitations: Pg 27, line 40 – small typo for "suffers," which should be "suffer"

A. Thank you very much. We have corrected this typographical error.

Reviewer: 2

Reviewer Name: Victoria Stanhope

Institution and Country: Silver School of Social Work, New York University, USA

Please state any competing interests or state 'None declared': None

#1. This qualitative study explored factors related to the implementation of PCC by interviewing decision-makers within health and social care organizations. Although an important topic, the study and its findings were too broad and under analyzed to make a valuable contribution to the literature.

A. We thank the reviewer for the comprehensive review of our manuscript and appreciate the helpful comments. Below we will elaborate on how we have responded to the comments and suggestions.

#2. There needs to be more depth on how PCC is conceptualized in the literature - to give some frame for how the decision-makers understand PCC within their organizations. There is also the issue of how different it looks across settings - particularly as this study is covering both health and social care delivery.

A. In the revised version of our manuscript, we now refer to the Chronic Care Model of Wagner as probably the most prominent model of PCC and also to the Integrative model of PCC of Scholl et al. as the most recent synthesis model of PCC concepts (page 4). We agree that individual decision-makers' understanding of PCC might vary across HSCOs. We therefore addressed in line with your comment that a common understanding of PCC is lacking in research and practice, and discussed recent findings of core elements of PCC across health and social care professionals and contexts (page 4).

#3. We need more detail on the specific study - rather than just the parent study - how is the design focusing on implementation and what type of qualitative study is it?

A. We agree with the reviewer that the specific study (OrgValue) could be described in more detail. In the revised version of the manuscript, we added more information on the aims, the design, and methods of the study as well as its embedment in the parent study (CoRe-Net) in the methods

section. CoRe-Net is a network of researchers working in the field of health services research. Currently, three sub-projects are embedded within the network. While the other two projects focus on the care of specific patient groups in specific situations, the subproject OrgValue takes a broader perspective on the determinants and current level of implementation of patient centered care throughout different health care organizations. To do so, we conducted semi-structured face-to-face narrative interviews with key informants (managerial or clinical decision makers). Our interviewees constituted a purposeful sample so that each type of health and social care organization considered in CoRe-Net was represented by at least three interviewees. Qualitative content analysis was chosen to explore the participants' unique perspectives in order to extract on the descriptive level of content and not to provide a deep level of interpretation and underlying meanings. In the analysis, we used a combined process of inductive and deductive code development. The final set of codes was derived from an iterative process of analyzing interviews, refining the coding scheme, and re-analyzing the interviews. Each step of the analysis was performed independently by at least two researchers in order to minimize subjectivity. In the revised version of our manuscript, we have added additional information on the type and approach of the qualitative study (pages 9-12).

#4. We need more detail on what exactly HSCOs are - what type of organizations and what types of services they deliver - this is particularly important for an international audience.

A. Thank you for alerting us to this. We agree that the manuscript should provide more information about HSCOs in Germany.

We therefore added to the background section on pages 5-6:

"Within the German health care system, health and social care services are delivered at home (e.g., from long-term outpatient nursing or palliative care facilities), in outpatient HSCOs (e.g., practices for general and specialist medical care or psychotherapeutic care,) in inpatient HSCOs (e.g., hospitals for acute medical care, rehabilitation clinics for restorative rehabilitating care or hospice care) or semi-inpatient HSCOs (day-care facility) [23]."

Additionally, in the methods section (sampling), we added on page 7:

"These included general practitioners (GPs) and private practice specialists (delivering symptom oriented diagnostics and acute treatment), psychotherapists (delivering psychotherapeutic care), long-term outpatient care (delivering nursing and or palliative care), outpatient rehabilitation services and rehabilitation clinics (delivering restorative rehabilitating care), long-term inpatient care (including hospices) (delivering nursing or palliative care for critically ill patients), and hospitals (delivering acute medical care)."

#5. One of the challenges of this study, is taking an implementation approach without a specified practice. PCC is very broad and often understood very differently by providers and decision-makers. By at least elaborating more on core components in the literature review, would help interpret the results. It may even be that some pre-existing framework may help to organize the results which are hard to follow.

A. The study focuses rather on the implementation status than on the process of implementation related to specific practices. We have therefore chosen an explorative approach to explore and compare the concept of PCC of different professionals in different health and social care contexts. In accordance with your remark, we have added to the introduction that "The understanding of PCC elements regarding principles and activities often depends on definitions of professionals and the context of health and social care." although "there is a consensus about core elements of PCC across professional groups" but that "These differences can affect the implementation of PCC" (page 4). After explaining different contexts of care in Germany in more detail now on pages 5-6, we conclude that "different contexts might be associated with different determinants for PCC implementation and

strategies to deal with resource scarcities". In accordance to that, we found that PCC is a concept that is - to certain extend - understood differently by professionals in different contexts. Therefore, the dimensions mentioned by the interviewees were compared with the Integrative model of PCC of Scholl et al., which are now explained in more detail in the introduction section (page 4) and considered in the data analysis section (page 11). Based on the Integrative model of PCC of Scholl et al., we were able to identify a consensus of core dimensions of PCC across individuals and contexts, but the focus and emphasis differ by professionals in accordance to Kitson et al. (2013). This allowed us to derive determinants of PCC implementation linked to the core dimensions that also differed to some extent by contexts and professionals.

#6. The section title "PCC Implementation Measures" is not clear.

A. Thank you for pointing that out. This section describes concrete activities that care providers should implement from the perspective of the interviewees and derived from Integrative model of PCC of Scholl et al. to address the needs of patients. We hope that the use of the term "actions" will make this point clearer. We have renamed the term at the respective points in the manuscript.

#7. Overall the qualitative analysis is weak. The findings read more like simply reporting out answers to questions - rather than an in-depth analysis to find commonalities and refine the data further to higher order meanings. The section headings are basic categories rather than conveying more refined understandings of the data.

A. Thank you very much for this comment and we agree that our analysis is not in-depth on each individual topic. However, the aim of this paper was to provide an overview of the understanding of PCC and determinants for implementation across various health and social care organizations. We regard it as a strength of our study to shed light on core dimensions of PCC and determinants of PCC implementation considering various contexts. In our study, we discussed aspects and determinants of PCC, which were considered across organizations, while also identifying differences between organizations. Since we gathered rich interview material and already left out the outer setting (policy level) completely, additional analyses focusing on specific principles and activities or determinants of PCC will be published separately. However, we agree that an in depth-analysis is required to find commonalities and refined understandings of higher order meanings. We therefore addressed this issue in the limitation section in the revised version of our manuscript.

Our qualitative data collection and analysis were conducted carefully, by including a diverse sample, by developing a coding scheme by individual researchers based on inductive and deductive approaches and then developing a common understanding of codings. Finally, data coding and interpretation were conducted by three researchers to minimize risks of subjectivity of our findings. In the revised version of our manuscript, we explained these important steps in the methods section (pages 8-12).

#8. The implementation framework could be presented in the results more clearly - describing the barriers and facilitators and then the strategies to address barriers in a more systematic way.

A. We appreciate and understand this suggestion for systematization and consider this type of presentation to be a good approach. We have critically discussed the question of whether the determinants and strategies to address these should be presented in separate sections. After attempting to present separable strategies we decided to leave them linked to the determinants due to two reasons.

The first reason for this type of presentation was that the focus of the analysis was on the determinants according to the CFIR scheme. In order to clarify this, we have added in the results section that the CFIR scheme was our orientation. We have also referred to the appendix, which explains the specific categories and determinants of the analysis scheme in detail.

The second reason for this type of presentation was that individual determinants or a whole category of determinants themselves represent strategies to implement PCC (e.g., "Determinants of PCC implementation related to the organizational level: Strategies, structures, processes, and culture (inner setting)"). In the discussion, separate strategies for fostering promotion factors and addressing barriers are listed separately.

#9. The findings cover too much area in not enough depth but also are repetitive at times. The utility of qualitative methods is to provide depth - but to do this the analysis needs to be more focused on fewer aspects of implementation and the analysis needs to be more refined. It may be that this paper should be parsed out into several papers.

A. Please refer to our reply on comment #7.

#10. Also, it is questionable whether decision-makers are the best informants on some of these front line implementation barriers, as is stated in the limitations - so these aspects could be omitted from the results.

A. We agree that more information about the selection of representatives of the HSCOs and their typology should be provided to understand why these were the persons who gave us the best and most detailed information on the issues relevant to us. Because the decision makers themselves are or were involved in care practice and are in constant contact with patients and providers, we gain insights from the perspective of both leading positions (for management-related, personnel-related or resource-related information and strategies) and front-line staff (for concrete information on patient care), which was the aim of this study. For example, GPs or psychotherapists are front-line staff and CEO in one person.

However, we agree that we are not able to gain information about perspectives of staff members in lower positions through this study. We now refer to this in the limitations section in more detail and wrote on page 30:

“The perspective of staff members in lower positions is not considered. Therefore, any differences in perspective cannot be identified through this study. However, people in lower positions would not have provided us with information about management-related, personnel-related or resource-related information and strategies in the organization, which was also an aim of this study.”

We also added in the methods section (sampling) on page 8:

“Participants of the interview study were clinical and managerial decision-makers as key informants of these HSCOs caring for the selected vulnerable patient groups. Selecting key informants is a valuable approach, which is frequently used in order to assess the knowledge of employees who generally have decision-making authority [27–29]. A preliminary panel discussion with practice partners of these HSCOs revealed that key informants have the most extensive knowledge about their organization in terms of processes, structures, culture, resource allocation and deficiencies, strategies and organizational behavior, for which we wanted to collect information in our study. It was important that the participants are or were involved in patient care or are in constant exchange with patients or care providers in the organization. Depending on the type of HSCO, clinical and managerial decision-makers can be different persons within an organization (e.g., hospital CEO and chief physician) or one person fulfilling two functions (e.g., GP in private practice). By interviewing multiple representatives per HSCO type, information from multiple perspectives and different degrees of involvement in patient care or managerial processes could be obtained.”

VERSION 2 – REVIEW

REVIEWER	Victoria Stanhhope New York University, USA
REVIEW RETURNED	15-Jan-2019

GENERAL COMMENTS	The revisions have improved the manuscript in terms of the setting and the findings but I still have concerns about how this study is approaching implementation and how it relates to the parent study. 1. Overall, it seems too much to both define/conceptualize person-centered care and discuss its implementation in one paper. And also, as I stated in the previous review, strictly speaking one cannot speak to implementation until one has a precise understanding of the intervention. Admittedly, PCC is a broad overarching approach to care and I do think this paper does make a contribution in furthering our understanding of PCC. However, it does not fit the traditional notion of an intervention so the use of the CFIR which presumes a specified intervention that has been demonstrated to be effective becomes problematic. 2. Related to this point, the paper is using the CFIR framework incorrectly by applying it to the intervention itself - what it is - rather than how aspects of the intervention relate to implementation. This study is speaking to what is PCC -- not how do aspects of the intervention align with the organizational setting which is the intent of the CFIR domain. 3. This study cannot be characterized as mixed-methods. It is a qualitative study even if part of the larger study is mixed-methods. Also it seems if the overall design is mixed-methods - as the paper said the strength of mixed methods is to triangulate findings- it would make the paper stronger if the quantitative and the qualitative findings were presented together to allow for an integration. 4. With such a broad understanding of PCC, then the implementation findings get very broad too - to the extent that some of the inner setting findings just seem to be about general organizational readiness rather than the specific intervention - what an organization needs to just function well and deliver quality care. 5. In conclusion, for the paper to provide more depth and be more coherent I would recommend that the authors separate out conceptualizing PCC and the implementation of PCC in two papers. The conceptualization of PCC in this paper is a good contribution to our understanding. I would also encourage presentation of the findings as mixed methods if that is part of the parent study design.

VERSION 2 – AUTHOR RESPONSE

Reviewer(s)' Comments to Author:

Reviewer: 2

We thank the reviewer for the review of our manuscript and appreciate the helpful comments. The suggestions helped to make major improvements in the manuscript and clarified important methodological as well as conceptual points of our study. Below we will elaborate on how we have responded to the comments and suggestions.

1. Overall, it seems too much to both define/conceptualize person-centered care and discuss its implementation in one paper. And also, as I stated in the previous review, strictly speaking one cannot speak to implementation until one has a precise understanding of the intervention. Admittedly, PCC is a broad overarching approach to care and I do think this paper does make a contribution in furthering our understanding of PCC. However, it does not fit the traditional notion of an intervention so the use of the CFIR which presumes a specified intervention that has been demonstrated to be effective becomes problematic.

A. This is an important concern and we agree that a conceptualization/definition of PCC as well as a discussion of implementation determinants is way too extensive for one paper. We therefore followed your suggestion in comment #5 and excluded the part of the manuscript that aims to conceptualize PCC. In line with this, we believe that there are very strong arguments for focusing this manuscript on the identification of determinants of PCC implementation in a various set of HSCOs contexts.

Compared to the amount of research on PCC conceptualization, relatively few studies have examined determinants of PCC implementation across multiple types of HSCO. Our study addresses this research gap which was also identified in the review about PCC conceptualization by Scholl et al., who stated that “a comprehensive investigation of barriers and facilitators of the identified dimensions of patient-centeredness is necessary in future studies. Patient-centered care can only become reality if barriers on all levels of care have been addressed and ways to overcome them have been found” (page 8).

The discussion about determinants for implementation required an understanding about implementation objects – here: decision-maker`s understanding about PCC activities related to patient’s needs. We let interviewees define PCC and compared their understanding with concepts of PCC to validate their understanding of PCC for further analyses of determinants of PCC implementation.

Implementation of PCC is defined as PCC activities related to patient’s needs that are implemented in their organizational context and routine care. This has been assessed from the decision-makers’ perspectives. The term implementation used here thus addresses the integration of PCC practices in routine care.

In line with yours’s and the suggestions of the Editor we decided to strengthen the focus of our manuscript by excluding the results on PCC implementation (needs and activities) from the manuscript, which can now be found in the supplementary appendix as described in the method section:

“Each topic was operationalized by core questions facilitating story-telling and narrative-generating sub-questions. The interview guide was flexibly adapted to the decision-maker´s type of care organization, the position or background, or the course of the conversation. The first step was to assess decision-maker`s understanding about PCC according to Scholl et al. in order to ensure that there was a consensus on core elements of PCC (Key questions were: "What characterizes PCC in your organization?”; “Do you remember a case where PCC was delivered at its best/not at all?”

(needs and activities)) (see online supplementary appendix 1). The discussion about the understanding was the basis to derive determinants of PCC implementation and strategies to address determinants across HSCOs in a second step (Key questions were: “What were possible reasons that care was (not at all) delivered in a patient-centered fashion?”; “What are strategies in your organization to create the conditions necessary for PCC?“).”

2. Related to this point, the paper is using the CFIR framework incorrectly by applying it to the intervention itself - what it is - rather than how aspects of the intervention relate to implementation. This study is speaking to what is PCC -- not how do aspects of the intervention align with the organizational setting which is the intent of the CFIR domain.

A. The CFIR was applied in previous studies to capture and categorize determinants for implementation with an intervention process (e.g., Bokhour et al. 2018) and without an intervention process (e.g., Zebrowski et al. 2018). We agree that we do not study the implementation of a specific intervention, but rather the implementation of a broader concept of PCC (without an intervention process), which of course has to be brought into practice by various interventions. We used the CFIR framework to capture and categorize the determinants of PCC implementation (as Bokhour et al. 2018) but without an intervention process according to the approach of Zebrowski et al. 2018.

As mentioned in your comment, we have assigned the implementation object itself (PCC understandings and activities) to the framework (as intervention characteristics) – although the CFIR was developed to capture determinants for the implementation of a defined intervention. We apologize for the potential confusion that might have resulted from this approach. Since the focus of the revised manuscript is on organizational determinants for the implementation of PCC, the revised version does only contain those characteristics of the CFIR for which we can identify determinants of PCC implementation (Inner Setting and Characteristics of Individuals) and dropped the application of the CFIR framework with regard to the understanding of PCC and activities for PCC within HSCOs as intervention characteristics. We hope that this will make the manuscript more consistent in presenting results on the organizational determinants of PCC implementation.

Literature:

Bokhour, B, Fix, GM, Mueller, N, Barker, AM, Lavela, S, Hill, JN, Solomon, J, VanDeusen Lukas, C. How can healthcare organizations implement patient-centered care? Examining a large-scale cultural transformation. BMC Health Services Research 2018; 18(1): 168.

Zebrowsky, AM et al. Qualitative study of system-level factors related to genomic implementation. Genetics in Medicine 2018. DOI: 10.1038/s41436-018-0378-9

3. This study cannot be characterized as mixed-methods. It is a qualitative study even if part of the larger study is mixed-methods. Also it seems if the overall design is mixed-methods - as the paper said the strength of mixed methods is to triangulate findings- it would make the paper stronger if the quantitative and the qualitative findings were presented together to allow for an integration.

A. We agree that the results in the manuscript do not result from a mixed-method approach – again, we apologize for potential confusion that may result from our description of the larger OrgValue-study that our qualitative research is part of. To avoid confusion regarding the mixed methods approach, we have revised the methods section and now only refer to the qualitative study in the project.

As you correctly noted, it is the larger study that follows a mixed-methods approach. The results of the qualitative study under consideration provided the basis for a quantitative survey (e.g., to capture issues of determinants, to extract appropriate instruments) among decision-makers from HSCOs in Cologne. While we fully agree that a combination of qualitative and quantitative results does make a paper stronger, we also share your concern in comment #5 that our paper should have a clearly defined focus, which now is on exploring organizational determinants for PCC across HSCOs based

on a qualitative approach. Adding our quantitative results would probably come to the cost of understandability and simplicity in the structure of the paper. Finally, the questionnaire survey is carried out now (since: 01/2019) and that is why we are not able to integrate any results from the survey into this paper.

4. With such a broad understanding of PCC, then the implementation findings get very broad too - to the extent that some of the inner setting findings just seem to be about general organizational readiness rather than the specific intervention - what an organization needs to just function well and deliver quality care.

A. We agree that some of our results are rather broad. However, as previously mentioned, the aim of this study was to capture exploratory determinants of PCC implementation across various HSCO contexts. We therefore rather provide a general overview across HSCO contexts. The organizations covered by our study sample deliver care to patients at different stages of the care process. We are hence able to identify a landscape made up by barriers and facilitators for PCC. Despite this rather broad view of our research, we can “zoom-in” into this landscape and identify determinants that exist in special types of organizations. For example, with regard to the category “structure” (staffing & workload) we found that “in long-term inpatient care, temporary employment was described as inevitable, yet undesirable”.

Therefore, we identified possible starting points as a basis for initiating the tailoring of specific interventions and implementation strategies, and the redesign of HSCOs towards more patient-centeredness.

By discussing the determinants of PCC in the inner setting of HSCOs and at the individual level with respect to influences of factors at the system level, within the revisions, the manuscript has received more depth of detail.

5. In conclusion, for the paper to provide more depth and be more coherent I would recommend that the authors separate out conceptualizing PCC and the implementation of PCC in two papers. The conceptualization of PCC in this paper is a good contribution to our understanding. I would also encourage presentation of the findings as mixed methods if that is part of the parent study design.

A. We hope that we could clarify that the aim of this study was not primarily to conceptualize PCC from the perspective of German HSCOs, but – as a basis for deriving determinants of PCC implementation - to assess the understanding of PCC in order to ensure that there was a consensus on core elements of PCC. The two topics are now separated in the manuscript as such that the understandings of PCC is only included in the appendix not the manuscript itself. We believe that both aspects should be made available for readers, but we hope our way of separation of the topics is an appropriate compromise.

As explained in the response to comment #3, we think that our manuscripts needs a clear focus and that a consideration of the quantitative findings would come to the cost of understandability and simplicity of the structure of the manuscript.

Correction: *Implementation of patient-centred care: which organisational determinants matter from decision maker's perspective? Results from a qualitative interview study across various health and social care organisations*

Hower KI, Vennedey V, Hillen HA, *et al*. Implementation of patient-centred care: which organisational determinants matter from decision maker's perspective? Results from a qualitative interview study across various health and social care organisations. *BMJ Open* 2019;9:e027591. doi: 10.1136/bmjopen-2018-027591

Some information regarding last authorship, collaborators and the trial registration number were left out in the previous version of this manuscript. The missing details are as follows:
The last authorship is on behalf of CoRe-Net.

The collaborators are Christian Albus, Lena Ansmann, Frank Jessen, Ute Karbach, Ludwig Kuntz, Holger Pfaff, Christian Rietz, Ingrid Schubert, Frank Schulz-Nieswandt, Stephanie Stock, Julia Strupp, Raymond Voltz, Nadine Scholten.

Also, the trial registration number is DRKS00011925.

BMJ Open 2019;**9**:e02759corr1. doi:10.1136/bmjopen-2018-027591corr1