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## Session: Conducting Formative Evaluation, Studying Implementation Facilitation, & Documenting Model Adaptation ‘Over the Shoulders’ of Facilitators

Presenter: Karen Drummond, PhD

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Heidi: And we are just at the top of the hour here so we’re going to go ahead and get things started. I want to introduce our presenter for today, Dr. Karen Drummond. Dr. Drummond is a research health scientist at the VA HSR&D Center for Mental Healthcare and Outcomes Research at the Central Arkansas Veterans Healthcare System and an assistant professor in the Division of Health Services Research in the Department of Psychiatry at the University of Arkansas for Medical Sciences. Karen, can I turn things over to you?

Dr. Karen Drummond: Yes, I’m ready. Hi everybody and welcome and thank you Heidi for introducing the presentation and helping to make this go smoothly today. So as Heidi mentioned, I’m an investigator at the Little Rock COIN and I’m an assistant professor as well….

Heidi: Karen, I’m sorry to interrupt.

Dr. Karen Drummond: In the division of health services…

Heidi: Karen, I’m sorry, we’re not seeing your screen. You need to click on that blue button to show your screen.

Dr. Karen Drummond: Okay, I did. I’m not sure why it’s not picking it up.

Heidi: Yep, we are not getting your screen yet. There we go. Okay and once you put it into slideshow mode then we should be good to go.

Dr. Karen Drummond: Are you seeing it?

Heidi: We are not seeing slideshow mode yet. We are just seeing the PowerPoint with the thumbnails.

Dr. Karen Drummond: Hmmm. I have put it into slideshow mode.

Heidi: Okay, you have multiple screens on your computer? [pause 02:04-02:10]. Do you have multiple screens on your computer?

Dr. Karen Drummond: Let’s see. No, I don’t have multiple screens so it should just be showing….

Heidi: Okay, are you seeing…

Dr. Karen Drummond: …what’s on my screen.

Heidi: Are you seeing the slideshow on your screen? My apologies to the audience for [unintelligible 02:31]. I’m trying to get this moving as quickly as possible. Are you seeing the slideshow on your screen Karen?

Dr. Karen Drummond: Yes, so I do. I see the slideshow on my screen.

[pause 02:44-02:57]

Heidi: Okay I’m going to. I’ve got Rob Auffrey. He’s got your slides up so I’m just going to transfer over to him. You’re just going to need to prompt him with next slide when you need to move from slide to slide.

Dr. Karen Drummond: Okay. We can do that. Okay, great.

Heidi: Rob, we’re not seeing your screen yet.

Dr. Karen Drummond: Just let me know. Are we ready?

Heidi: Okay, we’re good to go.

Dr. Karen Drummond: Okay, perfect. Yeah so as I was saying I’m also an assistant professor in the Division of Health Services Research at the University of Arkansas for Medical Sciences. And I’m a medical anthropologist and implementation scientist.

So today I’m going to be talking about some particular methods from a project that I’m currently working on and I’d like to start actually by acknowledging the facilitation team in the project. And that would be our two facilitators, Karen Anderson Oliver and Eva Woodward, our expert consultant on facilitation, Co-I JoAnn Kirchner. And then I also want to acknowledge the consultation that we’ve received from behavioral health QUERI implementation coordinators, Mona Ritchie and Jeff Smith who have been consulting throughout the project on some of our methods. Next slide.

So the overview for today is that I’ll give a background on the parent study of the methods that I’m going to be highlighting, a brief background on implementation facilitation for those of you who may not be as familiar. I will then go in-depth about how we are studying facilitation in our current project and then conclude with some lessons learned and some of the challenges that we’ve encountered so far. So next slide, we’re ready for the first poll.

Heidi: And here we’re wondering what is your primary role? And the options here are researcher, clinician or staff, administrator, manager or policy maker, student, trainee or fellow or other. And we know people may be in more than one category, but we’re looking for your primary role here. And if you’re in that other category, feel free to type that into the question screen and I can read through those while we’re going through the poll results.

Responses are coming in. I’ll give everyone a few more moments to respond before we close it out and go through the results.

Looks like we’re slowing down here so I’m going to close this and what we’re seeing is 66% of the audience saying that they are, their primary role is as a researcher. Six percent clinician or staff. Fifteen percent administrator, manager or policy maker. Five percent student, trainee or fellow and 8% other. Thank you everyone.

Dr. Karen Drummond: Okay, thank you. So yeah, that’s interesting. We have a lot of researchers in the house and then some of the other roles so that’s great. A great mix. I think there will be something for everyone here today. So we’re ready for poll question number two.

Heidi: And our question here, which of the following best describes your familiarity with implementation facilitation? Very familiar, moderately familiar, slightly familiar or not at all familiar. And again, we’ll give everyone a few moments to respond before we close the poll and go through the results. And it looks like we’re slowing down here so I’m going to close this out and what we’re seeing is 17% saying very familiar, 35% moderately familiar, 41% slightly familiar and 8% not at all familiar. Thank you everyone.

Dr. Karen Drummond: Okay, thanks for the responses. Okay, good. So then I think again a good mix for everybody here and hopefully those of you who are only moderately or slightly familiar are going to be a lot more familiar after today.

Okay so, first to give you a sense of the parent study in which the methods that we’re presenting is embedded. What we refer to informally as the tele-PCMHI project. So this is one of the HSR&D CREATE projects in our COIN. And it is led by Rick Owen, so I’d also like to acknowledge him here today. And it’s a hybrid type two project in which we are able to simultaneously study implementation and effectiveness. And what we’re doing, in short, is that we have adapted Primary Care Mental Health Integration or PCMHI, and that’s for those of you not as familiar, that’s integrating mental health services into primary care contexts. And the VA has been doing a lot of work for many years on PCMHI and it is mandated in the VA for large facilities, but it is not currently mandated for smaller facilities like small CBOCs. So what we are doing is to adapt this for tele delivery to rural community-based clinics in the VA. And the study is focused in the rural south, so clinics in Arkansas and Louisiana. And so we have done preliminary adaptation. There is ongoing tailoring as we’ll talk about. And then we are studying the implementation process and the effectiveness of tele-PCMHI. And we have a protocol paper that we hope to soon be able to cite so I put the citation of the paper under review here, and hopefully we’ll have something to circulate soon. Next slide.

So in first step of our project was to develop a service delivery model for PCMHI via telehealth. To do this we conducted an expert panel process. I don’t know if you guys are seeing the right slide. It should be up, the step one slide, just before. But we conducted an expert panel process to identify and reach consensus on core components and components that are more adaptable of doing PCMHI via telehealth. Karen Oliver and I conducted this process together. We first conducted interviews with early adopters. So we identified facilities where the PCMHI program was already doing some element of their PCMHI service via telehealth. And we conducted interviews with those early adopters. Out of those interviews we were able to draft a service-delivery model of what seemed to be the essential domains and components. We then conducted an expert panel process to get feedback on our draft and to come to consensus on the domains and the essential components as well as the more adaptable components. And then revise that into the teleservice delivery model that we would test in the study. And Karen and I are now writing up these results of this first early work. Okay, next slide.

In the next step, we are now in the process of implementing and testing the tele-PCMHI service delivery model. So we have an implementation facilitation strategy that is used to support implementation. The project also has funded a psychologist position within the VAMC PCMHI program to provide PCMHI services via telehealth to six CBOCs. And facilitation efforts at the parent VAMC and all six CBOCs are ongoing, although we do have a stepped-wedge design starting with two clinics at a time. So facilitation has been active in four of our six and our facilitators are just starting to engage our wave three CBOCs. Okay, next slide.

So we are now going to turn to a bit of background on implementation facilitation for those of you that are already thinking, okay what is that? What is that strategy? Next slide.

So we know that innovations are challenging to implement for a variety of reasons. We know that top-down initiatives or mandates are not sufficient. We also know that when you add education efforts to top-down initiatives that also is rarely sufficient. Then we also know that readiness to implement, there’s great variation across facilities and clinics in their readiness to implement an innovation. And there’s participation of many different players involved, multiple stakeholder groups and the providers and staff who are charged with ultimately using these innovations, their availability is extremely limited. So there are a number of challenges that mean that you need something to help pave the way. Next slide.

So implementation facilitation is a process where facilitators can problem solve with the clinics and facilities trying to implement an innovation and provide support. And this has to occur in the context of recognizing that there is a need for improvement. So that willingness to implement an innovation, and then a supportive interpersonal relationship between facilitators and all of the various stakeholders. Next slide.

So in the current study we’re employing the i-PARIHS framework. And the i-PARIHS framework suggests that while there are multiple factors that always need to be taken into account for preparing for and guiding implementation, including the innovation itself. What innovation or intervention are you trying to implement? The context in which you’re trying to implement it. Many, many factors about that context. And then the recipients. Who is charged with implementing or receiving this innovation? And knowing as much as you can about those recipients. i-PARIHS suggests that you need to know everything you can about all of those things and then facilitation is then the active ingredient that will improve the chances of successful implementation. So you may have individuals external to the organization or unit, or internal to that organization or unit that is implementing, or a combination or external and internal facilitators. Those facilitators are going to apply various implementation strategies in their work to help with implementation. So while facilitation itself is a strategy, it is not the only one used in facilitation. Facilitators need to be flexible and they really need in order to work with so many stakeholders, they need a good deal of strong interpersonal skills. So these are just some of the elements of facilitation. Next slide please.

So we have very good evidence for implementation facilitation. And I just have on this slide two of those pieces of evidence in the literature cited, but there are many, many more. But just to give a couple of examples of some of the evidence for facilitation. Next slide.

So now to give you details about how facilitation is being done as our strategy in the tele-PCMHI study. So we have two external facilitators. They are technically external in that neither are individuals charged with actual implementation. They are both facilitating external. However, we do need to note that one of our facilitators is a part-time PCMHI provider in the program supporting the study’s tele-PCMHI service. So some aspects of facilitation in her case are more like internal facilitation. Internal facilitators, because they are embedded in the program that is implementing, they have access to key stakeholders. They have insider understandings of their PCMHI program in this case. So there are aspects that make her a bit of a hybrid internal-external. But she is not providing tele-PCMHI service to our study sites. Another feature is that we have one facilitator who is very experienced in implementation facilitation and one who is more of a novice facilitator. She has received extensive training. She’s gone through the behavioral health QUERI facilitation training program and is mentored by JoAnn Kirchner and so she has a great deal of training. But this was the first experience doing facilitation so we do consider that to be more novice. But she’s, I will say, seems to, my opinion, has quite a natural talent for this. So her knowledge and skill is gaining rapidly. And then another feature is that our facilitators are working collaboratively together with all of our sites. So in some studies you may have multiple facilitators but they’re taking charge of certain clinics or study sites. In this case though, both facilitators work collaboratively with the parent VAMC, delivering the service and with all six of our CBOCs. Okay, next slide.

So we have multiple study goals in examining implementation facilitation. We are of course documenting and analyzing facilitation activities. We are interested in knowing, what is it that our facilitators are doing in order to facilitate the implementation of tele-PCMHI in our study sites? We are examining also the way in which they are collaboratively working together and the pros and cons of doing facilitation in that way as opposed to dividing and conquering so to speak. We are able to document facilitation mentoring and how the more novice facilitator has been learning facilitation and gaining skills in real time, as that is occurring throughout the project. We are conducting formative evaluation through studying facilitation and this is going to be really the core of what I will focus on today. But I do want to mention that because we are having further adaptation and tailoring of tele-PCMHI for site-specific needs and resources, we are also tracking and examining that adaptation and tailoring through studying facilitation as well. So next slide.

And I’ll be focusing now on further details about how we are doing formative evaluation by studying facilitation. And I want to start with a little background on formative evaluation first for those that are not as familiar in our audience today. So formative evaluation is an assessment process that’s quite rigorous so that we can identify both potential and actual influences on implementation. This may involve quantitative or qualitative methods or both. Often it is a combination of quantitative and qualitative measures. And it may be conducted at one or more stages of implementation. So depending upon your study needs and design and your budget quite frankly, you may be doing this only at one phase. Or you may do it throughout the study. So here I’ve got the phases of implementation for you to see, from developmental which you would do before implementation as more of a diagnostic tool of the barriers and enablers to the implementation you want to do. There is formative evaluation that you can do throughout implementation to understand the actual barriers and enablers that are going on and hopefully adjust and address them during your implementation. And then after implementation you can use all of the earlier data if you have it, but you want to collect some new data to understand the retrospective view of what happened and let’s talk about what were the challenges? How did you address them? What things helped you? How did you harness those things? What were the solutions you came up with? How could we improve this? All those sorts of questions that we want to ask after an implementation process to do further evaluation. And that can be combined with other forms of looking at your outcomes. Okay, so next slide.

We can now look at, in our present project, how we are doing formative evaluation. So we’re calling it over the shoulders of facilitators. What we recognize was that formative evaluation, the kinds of questions that I might ask if I were to be conducting the FE through interviewing study site personnel before implementation, the same things I would ask them, the facilitators are going to be asking about and uncovering as part of their work as facilitators. So the developmental, as well as the implementation-focused FE, that information is already being gathered. And we thought hey, we could reduce the burden on our study sites if we instead harnessed this activity that’s already going on and studied what the facilitators were uncovering and documented that by an evaluation team member. So that’s our approach, is to do FE by studying what facilitators learn and uncover at the study sites and gather that information from them. And then after implementation, that is when I will engage with the study site personnel and with the actual clinic folks and leadership there, ask them all of those post-implementation questions and combine that with what we learned from facilitators throughout their efforts in order to do a full interpretive, formative evaluation and create these ultimate case studies of implementation at each study site. So now I want to drill down further into our methods for doing this. And I’ll start, you can go to the next slide please and I’ll begin with some comments about the overall approach and then get into details.

So our approach, we adapted methods that had been used successfully in previous work on PCMHI implementation by Mona Ritchie and JoAnn Kirchner and colleagues. So we have an evaluation team member, this is my role in this study. I’m not a facilitator, I’m an evaluation team member and I am a medical anthropologist and implementation scientist who is embedded in the implementation team. So it’s much like, for any anthropologists in our audience, it’s much like doing field work but in a very virtual sense. So I am not observing them in action. It is removed. And we decided to do it that way to reduce overwhelming the sites. We didn’t want to have a big study team coming in. CBOCs are often very small and JoAnn Kirchner has learned from her work that you don’t want to overwhelm them with a big team of facilitators or researchers. So we keep it simple. We’ve got the two facilitators working with them and our tele-PCMHI psychologist delivering the service and I’m in the background. So they don’t have to see me doing observations. So I take a fly on the wall role as the implementation team discusses what’s going on in their weekly team meetings. And then I conduct debriefing interviews weekly with the facilitators to drill down further. Okay, next slide.

So more on the data collection methods, little bit more detail. So I am doing detailed documentation of the implementation team meetings. The facilitators are reporting to the implementation team on their progress at the CBOCs and I am, as I said I’m a fly on the wall, so I’m not interacting in those meetings. I am there simply to document the conversation. So it’s much like taking field notes of the entire interaction and capturing verbatim quotes in the moment. It requires that you can type very quickly, fortunately I can. And so we can have a detailed documentation. Over time I’ve developed a bit of a loose template to fill in details on things that effect all the sites and then a section for each of the clinics their working in, to fill in that update on that clinic and capture as much as possible both the content and the spirit of the conversation in the room. Then, during debriefing interviews which happen usually the very same day as the implementation team meeting, I’m doing on the fly transcription of the debriefing interviews, which are really conversations with the facilitators, where I do ask some questions but allow it to be a very free conversation of them telling me more about what’s going on in the sites and also talking with each other about what’s going on. And so I’m capturing everything that goes on during that conversation. The facilitators also will occasionally forward key email exchanges to me with stakeholders. I don’t get all of the emails but often they’ve referenced an interesting interaction over email and they’ll forward that to me so that I have more of the context of that email exchange. And finally, the facilitators are completing time and activity tracking logs so that we’re able to look at how much time it’s taking for each type of facilitation activity over the course of the project. Okay, next slide.

The next slide is just a moment of comic relief though it is out of the study. So data can come to you in interesting ways sometimes. And so here we have with one of the facilitators, who is pictured in the photograph with her permission, full permission, how a dispatch from the field came to me very early one morning via text when she texted me the photo that you see and wanted to tell me about the first barrier they were encountering when they were trying to leave on their first site visit to our first CBOC. So she texted me and wrote, “Karen D – our first barrier…getting gas at the VA gas station for the VA van that takes a special type of fuel!” So it was very early in the morning. No one was there and they were trying to figure out how do we gas up this car so we can go make it on time to our site visit. So I just thought that was funny to share with you all. And they occasionally will send me texts from their site visits. We’re not using it as formal study data but it gives me a sense of what’s happening out there in the field since I am not embedded with them in the field as they go on site visits. Okay, next slide.

So preparing our data for analysis. So as is good after any data that you have collected that involve notes or observations, you want to clean them up immediately following each meeting or interview so that you can fill in the blanks on your own shorthand and you have better recall. So I do have time blocked out to do this immediately after each meeting and then immediately after each debriefing with the facilitators. The notes are then divided into separate documents for analysis. So we have a set of documents for those elements of facilitation that are affecting all of our project sites. And then we have site-specific sets for each of our clinics, our CBOCs, so that we’re able to better develop our case studies of each implementation effort within each clinic. The final clean notes are immediately available for rapid analysis and we have done some of that. But the finalized versions of these divided sets of notes are now uploaded into Atlas.ti for coding as well. Okay, next slide.

So our analysis is an inductive, deductive approach that is very common in this kind of work. So we have themes that are informed by the i-PARIHS framework since that is guiding our study. We have, we’re going to be using research on the assessment of adaptations in order to analyze our continuing adaptation and tailoring of tele-PCMHI. And then we always want to leave room for those inductive and emerging themes that come up. So we’ve already done some data extraction and rapid analysis of certain themes that were of interest, of our inductive themes in particular. And then we are beginning now with coding. I am initially the sole coder while the facilitators are in active facilitation, but later on when they are stepping back from the last wave of sites they may be able to participate in some coding as well. We’re still deciding how that will go, but for the moment I will be the sole coder on the data. Okay, next slide.

I want to give examples here. So for an example of deductive themes using the i-PARIHS constructs as codes. So we talked previously about the i-PARIHS domains of the innovation itself that you’re trying to implement. So we have themes that are centered on the subconstructs within the innovation domain of, you know what’s the evidence for the innovation? How do people on the ground view that innovation and its usefulness and advantage over other things. Then of course we are gathering a great deal of information about the context of each clinic as well as the parent facility that is delivering the tele-PCMHI services. And so things like leadership support, the culture of the individual clinics, policies, structures and systems. These are all some of the several subdomains, subconstructs I should say. Then the recipients, the individuals who are implementing tele-PCMHI both at the parent facility and then at the individual clinics and the things that facilitators are uncovering about those individuals that may affect implementation. And we’re of course greatly interested in facilitation, our active ingredient of implementation and we have codes for all of the variety of facilitation activities that facilitators do in working with sites. Engaging stakeholders, educating them about PCMHI in general as well as this tele-PCMHI model and many, many other things that facilitators do. And we’ll be coding those types of activities that they do. The goal here is to identify the i-PARIHS domains that have the greatest influence on implementation success or lack thereof at the project sites. We want to diagnose the barriers and facilitators by categorizing them into these domains and then describe what facilitators did to help sites implement the innovation, overcome barriers and harness enablers to implementing.

Next slide is an example of one of our inductive emerging themes. Lagniappes. What is that you say? So, this is a southern cultural term, lagniappe, translating to a little something extra. So it’s something like a baker’s dozen. How this came about was in conversation in the implementation team meetings, the facilitators and their expert consultant, JoAnn Kirchner were identifying that there were some unanticipated positive consequences of the facilitation work they were doing. And the term lagniappe was suggested. Hey, this is something that’s a little extra that’s going above and beyond what we intended to do in the study. So something that has actual or potential benefit to a clinic or to the system and it was unforeseen. Something is uncovered during facilitation that is not within the scope of the original facilitation goals to implement tele-PCMHI, but that is important and needed to be addressed. And so this became a theme for our focused rapid analysis. It’s been, the results of that initial analysis were presented at DNI and at the practice facilitation conferences in December. And we’re continuing to gather data on these unanticipated positive consequences and they’re now becoming part of coding and are an inductive code.

So to give a brief example here, this helped in one clinic the facilitators helped a clinic to identify that they didn’t have sufficient mental health emergency plans, particularly for suicidal ideation. This was uncovered, facilitators worked with the sites to clarify these plans and also let leadership know at the parent facility, the CBOC leadership, regional leadership, hey this is an issue and that leader then visited the clinic, made sure everything was clarified and that they were more comfortable. And then it has now spread to other CBOCs and so we’re seeing a broader impact of this effort across the system. Okay, we’re coming up to time for Q&A, but I do want to highlight a couple of things. Some lessons learned and then some challenges we’ve encountered. So first, the lessons learned. Next slide.

So, so far we’re finding great benefit to documenting the implementation team meetings. To doing this in addition to the debriefings with facilitators. We’re able to capture this expert mentoring in action and we think that could be an important thing to be examining. We’re also able to capture the consultations that are occurring in those meetings with an operations partner. So we have a Co-I who’s a member of the facility mental health leadership and he attends the implementation team meetings every week and is able to give us that operations point of view. And this has been extremely valuable to facilitation efforts and so we are able to document that. And if we were not documenting the team meetings in detail we would not be able to capture that very important contribution. And then because they occur on the same day, this documentation readily feeds into the debriefing interviews that drill down into greater detail. We’re also learning that the debriefings of facilitators and doing FE through their efforts seems to be working. We know it reduces the burden on the sites. We’re not asking the clinic personnel to talk to me as an evaluator until after implementation. It’s also efficient. Those of us who do this kind of work are very familiar with how difficult it is to recruit clinic personnel for evaluation interviews. Especially if you want to do them multiple times in a study. And even if you can recruit them, scheduling is extremely challenging. They’re very, very busy. So we feel it’s an efficient way to conduct FE and there’s also no waiting time. So facilitators don’t have to wait for me to analyze developmental or even progress-focused formative evaluation data and then deliver that to them so that they can make adjustments to implementation plans. They are aware that they are charged with obtaining this information and they are not having to wait. Finally, what we didn’t expect at all was that debriefings, rather than being a burden, have had an added value for the facilitators themselves. So both of them have independently and together reported to me that they find the debriefings very useful to their individual and collaborative process. And our facilitator who is newer to facilitation has told me multiple times that this debriefing process has been helpful to her in her learning process and in improving her facilitation skills. And then lastly, next slide.

I do want to highlight a couple of challenges that we’re still working through. We have to acknowledge that we are relying upon facilitator perceptions for formative evaluation work versus independent interviews with the sites until post-implementation. But we do believe that this is still a robust way to gather the same information. And the debriefings are providing us the opportunity for analytical conversations early on and throughout the study about the barriers and facilitators as they are occurring. And finally, lots of data is being produced here by two hours of weekly documentation and all the work that’s involved there. So keeping up with data analysis poses a significant challenge. But doing some of our rapid analysis data extraction has helped us to keep up with what we think we have. And we’re planning that the coding will happen with a rapid analysis approach and mindset and that that will also help us to get through a lot of data.

And then I just have some slides with some resources, some other, there’s so many good Cyberseminars, but a few I wanted to point to on facilitation for more information about that and on i-PARIHS if you need more information on that. And some resources available through QUERI as well. And then our references.

And so now I’d love to turn it over and hear what folks are wanting to ask about.

Heidi: Fantastic. For the audience, we do have some good time for Q&A here. If you do have any questions, please use that questions pane to send them in and we will just start working through the questions as we have received them. The first question that I have here. Can you provide some concrete examples of tasks carried out by facilitators? What do they do in the clinic?

Dr. Karen Drummond: Okay. Yeah I can, I can. There’s so many coming to mind so forgive me here while I think of a couple to highlight. So since you say in the clinic, I’m going to start with, there’s a great deal they do before they ever do that first site visit to prepare. But since you said in the clinic, I’m going to focus there. So facilitators, in doing a site visit, they are wanting to…One of the chief things is to explain to clinic personnel what they need to know about the innovation that’s going to be implemented for one thing. So in this study, to be more concrete, I talked about that tele-PCMHI model development phase through the expert panel process. So our facilitators were able to take that information in and explain first of all, here’s what PCMHI is and what you need to know about it, for sites especially that did not yet have any on-site primary care mental health integration staff. So PCMHI itself can be very new to them, much less doing it by telehealth. So they spent a good deal of time educating the clinic personnel on what this is and what can it do for you. So they can translate what we’ve done in research and then translate it to the field to say, here’s what we’re doing, why we’re doing it and what it does to help you. So there’s a translation that happens there that’s very important.

They’re also using interpersonal skills to get to know people on the ground. Very important for the CBOC context where these are small teams that are very tight-knit. They are like family to one another and so they are coming in from the outside and they want to get to know them. So some of it is just some getting to know you stuff that they do of just hey, here’s who I am as a person and not just someone coming to you from the parent facility and asking you to do all these things. So interpersonal getting to know each other.

And there’s so many things that they do from there. They then are forming a QI team. So they want people in the clinic to be able to work side by side with them and learn from each other and say, okay here’s what this looks like. How could this work in your site? Tell us about how you see this being potentially a challenge? What are the challenges? Let’s talk about that and how we might address them. And they want a little team in that clinic to be able to work with them on an ongoing basis and have telephone calls. So during the site visit they’re getting a sense of who that team might be, who needs to be represented? Who’s listened to in that clinic? So they’re doing as much, no they’re doing more listening than talking, right? And so that’s important that they’re doing a lot of listening. What are the site’s concerns and the concerns of the stakeholders on the ground? There’s so much more so I don’t want to ramble too much, but please feel free to reach out offline so that we can give more information if needed.

Heidi: Great, thank you. The next question that I have here, apologize if you said this and I did not catch it. For the analysis are you doing inductive analysis or are you using the i-PARIHS constructs deductively?

Dr. Karen Drummond: Okay, thank you. Yeah, I will clarify that. So it is both. So inductive and deductive. So i-PARIHS, we do have deductive codes derived from i-PARIHS, but we are doing inductive analysis. So we are definitely always looking for what is unanticipated, what is not in the i-PARIHS constructs or what we find to be particularly interesting like this concept of lagniappes. You know, what are these things that we didn’t expect that are benefiting sites? And so we create themes that come from the data itself. So yes, it is both.

Heidi: Great, thank you. The next question here. How is this facilitation similar to or different from coaching?

Dr. Karen Drummond: That’s a great question. I think that coaching is an integral part of facilitation. I don’t know that I’m the right person to answer that so again feel free to reach out offline so I could connect you to those who might have a more refined sense, but my sense is that it is part of it, but again, implementation facilitation as an implementation strategy is involving these ideas of the knowledge we know about implementing innovations and so it is a strategy that is targeting this implementation of innovations in healthcare settings in this case. And so, I think there are probably some interesting differences and I’m sorry that I can’t really speak to that, but I have ideas about who could. So do feel free to reach out after.

Heidi: Great, thank you. The next question that I have here. How does the fly on the wall and the over the shoulder approach differ from ethnography?

Dr. Karen Drummond: Oh, that’s a great one. Yes and I think about that continually through the study of course as an anthropologist. So, there are limitations to the way that we are doing this that make it very different from ethnography where one would be a participant observer in the setting physically. So as a fly on the wall I am not in the study sites. I also, something I didn’t highlight before is that for two and half years now I have been teleworking so I’m not even physically embedded during the meetings. This is both an advantage and a disadvantage. So I’m even more of a fly on the wall, I feel, because I’m not physically in the room. I am listening. They know I’m on the phone. Everyone’s very well aware of my involvement and presence, but I’m not there physically. I of course miss the nonverbal interaction that goes on but the team is small and very great about describing anything that they think I need to know, like if they burst into laughter they’re going to explain why are we doing that. And so they’re quite good about filling me in.

I think for out purposes I do get what we need, but it is very different from ethnography both in documenting the team meetings, in the facilitation interviews which are conducted via phone. One of the facilitators is also remote so the three of us are in different locations in the debriefing interviews and she is also on the phone during the implementation meetings. So she’s also not in the room. And of course things that I miss by not being there during site visits. But again, the facilitators seem to be to me very thorough in describing both the content of what happens but also the feelings and the essence and the spirit. So yeah, there are very, very clear differences so I would hesitate to call this even virtual ethnography really. But that’s debatable I suppose. I’d love to debate that with other anthropologists.

Heidi: Great, thank you. That is actually all of the questions that we have received in. Karen I don’t know if you have any last minute remarks you’d like to make before we close things out today?

Dr. Karen Drummond: Just thank you everyone for your time and listening today. And because this is something that is in progress and under development in some ways, or under refinement in terms of methods, I really welcome offline feedback as well so please feel free to reach out with any questions or feedback. And thank you.

[ END OF AUDIO ]