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Session: An Introduction to the ‘integrated-Promoting Action on Research Implementation in Health Services’ (i-PARIHS) Framework

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Molly: And with that we are at the top of the hour, so at this time I would like to introduce our speaker. Joining us today we have Jeffrey Smith. He is the implementation coordinator at VA Quality Enhancement, for VA Quality Enhancement Research Initiative for Team-Based Behavioral Health. That’s part of QUERI. And that’s in central Arkansas at the Veterans Healthcare System there in North Little Rock, Arkansas. He’s also an instructor of psychiatric, at the psychiatric, I'm sorry, Psychiatric Research Institute in the University of Arkansas for Medical Sciences, also at Little Rock, Arkansas. I apologize for tripping over my words there. And with that, Jeff, are you ready to share your screen?

Jeffrey Smith: I am. Is everyone seeing my screen?

Molly: We are good to go. Thank you.

Jeffrey Smith: Fantastic. Well, thanks Molly, for the introduction. And yes, you are correct in the pronunciation of i-PARIHS. This is an introduction to the integrated-Promoting Action on Research Implementation in Health Services framework, otherwise known as i-PARIHS. And really just intended today to give an introduction to the framework and some brief descriptions about how it differs from the original PARIHS framework, the ways that it’s been updated.

And I should give you all a heads up as well, a little bit, I think I have a cold. I hope it’s just a cold. But I’m only mildly medicated, so I’m hoping this goes off without a hitch, but I just wanted to provide that disclaimer. I guess another disclaimer is that a lot of times when I’m talking about a framework, some people get the impression that I’m trying to sell it to them. I’m not doing that. This is intended to be a description of i-PARIHS to the group, and people have their own perspectives on which framework or implementation model or theory works best for them in their circumstances. We found in our work in the Behavioral Health QUERI that i‑PARIHS, and before that the PARIHS framework, has been very useful to us in thinking about implementation and the facilitation strategies that we’ve applied in a number of our projects. But again, this is intended to provide information not selling a framework to you, so I just wanted to make that clear.

The objective for today’s presentation is to give you just a brief history and background on the original PARIHS framework, very brief actually, because the intent is to really focus on i‑PARIHS. And then I’ll summarize some of the critiques that have emerged from the literature from people who have conducted literature reviews. I’ll try the original PARIHS framework on some of its limitations and areas for improvement. And then I’ll describe the updated integrated i‑PARIHS framework and also provide some information briefly on how it might be used to guide or inform your implementation research.

So before we get started with that, I wanted to first pose a poll question to the group just to get a sense for who is online, so if you all wouldn’t mind responding to the poll question on the screen, that would be helpful.

Molly: Excellent. Thank you. So as Jeff said, we’d like to get an idea for what your primary role in VA is. I understand that many of you probably wear many different hats in the organization, but we’d like to know your primary role. So go ahead and just click the circle right there next to your response. The answer options are student, trainee, or fellow; clinician; researcher; administrator, manager, or policy maker; or other. And if you are selecting other, please note that at the end of the session I will put up a feedback survey with more extensive lists of job titles, so you might find yours there to select. Looks like we’ve got about 80% response rate. That’s great, so I’m going to close that out and share those results: 13% of our respondents selected student, trainee or fellow; 4% clinician; 65% researcher; 8% admin, manager or policy marker; and 10% other. So thank you to those respondents. Jeff, do you have any commentary before I move on to the next poll?

Jeffrey Smith: No, I just want to thank those that responded. It looks like we’re weighted towards the researchers on this, though we do have a good distribution of other people represented. So I just wanted to thank everyone who’s joined us today for coming on and listening in.

Molly: Excellent. So for the next question we would like you, which best describes your familiarity with the original PARIHS framework? Are you familiar with the original PARIHS and have used it in your work? Are you familiar with the original PARIHS but never used it? What is PARIHS? I’m, i.e., very limited or no familiarity. And the answers are streaming in. We’ve got about 70% response rate so far, so we’ll give people a few more seconds. All right, the answers are slowing down a bit, so I’m going to go ahead and close this out and share those results. We’ve got 8% who feel they are very familiar, are familiar with the original PARIHS and have used it in their work; 39% are familiar with original PARIHS but never used it; and 53% say what is PARIHS? So we’re have to have those 53% here. And I will turn this back over to you now.

Jeffrey Smith: Okay, let’s see, okay. Well, thanks, Molly, and thank you to everyone who responded. It looks like about 40% of you were familiar with it or actually a little over 40% were familiar with PARIHS and having to use it in your work or [unintelligible 6:07] just familiar with it. And so for others of you this will be a good opportunity to learn a little bit about PARIHS and the new i-PARIHS framework as well.

So this slide talks about, provides a little information on the original PARIHS framework. Many of you will know that it was introduced in 1998 by Alison Kitson and her colleagues in the U.K. Some of you are likely aware that Alison has since moved to the University of Adelaide in Australia, but I just wanted to let you all know where this came from originally. Originally PARIHS asserted that successful implementation of evidence into practice was a function of the quality and type of evidence, the characteristics of the setting or context in which the evidence was introduced, and the way in which the evidence was facilitated into practice. Each of these dimensions of evidence, context, and facilitation was further subdivided into sub-elements that needed to be considered in order for implementation to be successful.

I’m not going to go into the detail on the sub-elements of the original PARIHS framework, again since our emphasis here is on i-PARIHS, but I will say that in the new i-PARIHS this is just a heads-up for what you’ll see in a few slides from now. In the new i-PARIHS framework, the evidence domain was dropped and actually integrated into new domains, which has been [unintelligible 7:44].

Molly: Jeff? I apologize for interrupting. Are you on speaker phone by chance?

Jeffery Smith: I am.

Molly: If you could pull it a little bit closer and try and remain facing it that would be helpful. The volume is kind of fading in and out. Thank you so much.

Jeffery Smith: Okay. Is this better?

Molly: We’ll soon find out. I’m sure audience will let me know. But for me, it sounds great.

Jeffery Smith: If it’s not getting any better then I’ll pick up the receiver.

Molly: Okay, wonderful, thank you.

Jeffery Smith: According to the developers, the original PARIHS framework was one of the first to make explicit the multi-dimensional and complex nature of implementation as well as highlighting what they called the central importance of context. And since ’98 when it was originally proposed, many researchers have applied PARIHS in their implementation studies and found it useful, some saying that the framework has intuitive appeal and relevance from their perspectives to real-world settings. These people that have tried it have including some of our VA QUERI investigators, including our own group here in Little Rock with the original mental health QUERI.

So that also, based on that experience and use of PARIHS, they pointed out some limitations and some suggested areas for improvement as well. So this next slide actually summarizes some of those critiques from the critical appraisal of the original PARIHS framework. Christian Helfrich in 2010 published an article where some of the implementation research coordinators within the older QUERI program, the previous QUERI program, did this critical appraisal of PARIHS from a lit review and noted the following: That it had a lack, there was a lack of evidence from prospective studies on the effectiveness and utility of PARIHS. And as you skip to the bottom of this slide you’ll see on Alison Kitson and Gill Harvey’s 2015 resource, they’ve also noted that the lack of information from prospective studies is still, that’s still very limited, and so we just need more prospective studies on the use of i-PARHIS now. But there was, the Helfrich paper shows that there was also a lack of clarity between the elements and sub-elements of PARIHS, and it seemed to be a predominant focus on the facilitation role rather than the process once the facilitators actually did [inaudible 10:43] an implementation effort. and so they tried to address that in the new i-PARIHS framework as well. And also that there was lack of a clear definition for successful implementation, which also they’ve tried to address in i-PARIHS.

A systematic review by Tabak in 2012 of framework showed that there was, within PARIHS there was a lack of focus on the system and policy level of implementation. In 2013 another review of frameworks showed that, or suggested that PARIHS failed to pay attention to the individual health professional and also to the wider social, political, and legal context of implementation.

And then as I mentioned a moment ago, Alison Kitson and Gill Harvey in 2015. And I’ll give you the, at the end of this presentation I actually give you the full citation for this. It’s actually a book. But they found, I mentioned the, about the issue about the prospective studies remain limited but also a failure to acknowledge the central role of individuals in determining the process.

[Music 11:58]

As I mentioned, people that, we’ve been using it, other people have used it obviously within this field and have found it to be useful. But it’s actually been helpful that there have been these critiques of PARIHS because people, even though they see value in it, they are actually just doing this critical appraisal and trying to making suggestions for how it can be enhanced and improved, and that’s what they’re hoping that they’ve achieved with the new i-PARIHS framework.

So this is the next poll question. I’ll turn it over to Molly for just a moment. We wanted to get your ideas about, or get your responses about your familiarity with the new i-PARIHS framework.

Molly: Thank you. So I’ll go ahead and launch that poll now. Jeff, we are still getting a number of responses about your audio, so I hate to do this, but I’m going to ask you to go ahead and speak through the receiver from here.

Jeffery Smith: I picked up.

Molly: Oh! Wonderful. Thank you so much. Okay, so again, we’d like to find out which best describes your familiarity with the updated i-PARIHS framework. I'm familiar with i-PARIHS and I've used it in my work; am familiar with i-PARIHS but never used it; what is i-PARIHS, very limited or no familiarity with it. And it looks like about 60% of our attendees have responded so we’ll give people a little more time. All right, responses seem to have slowed down. I’m going to go ahead and close this out and share those results: 10% are familiar and have used it; 16% of our respondents are familiar with it but not used it; and 73% say what is i-PARIHS, very limited or no familiarity with it. So thank you, once again, and I will turn it back over to you.

Jeffrey Smith: Okay. Thank you, Molly. So yeah, that’s very helpful to see. So now we’ll go to, for the 73% of you who have no familiarity with i-PARIHS, we’re going to talk a great deal about it now. Whereas, as I mentioned this a moment ago, whereas the core domains within the original PARIHS framework were evidence, context, and facilitation, in the now updated i‑PARIHS framework, the core domains are facilitation, innovation, and innovation there refers to the clinical innovation or the new practice or program that you’re targeting for implementation. The other domain, the other core domains are recipients and context. And in this case with facilitation represented in the i-PARIHS framework as the active element for assessing, aligning, and integrating the other three constructs into an implementation process. The next few slides will provide information on the sub-elements within those domains, those additional domains.

So within, in the revised i-PARIHS framework, successful implementation is specified in terms of the achievement of implementation or project goals and results from the facilitation of an innovation with the recipients in their local organizational and/or health system context. And so the first thing that we will talk about in terms of domains of i-PARIHS that influence of successful implementation is context, and so i-PARIHS proposes that factors within the inner and outer context of the targeted recipient affect implementation of the clinical innovation or of evidence-based practices. The inner context includes both the immediate setting for implementation such as a VA Medical Center, department of service, a primary care clinic, a CBOC, and the organization in which that department or clinic is located. For example, the larger VA Medical Center. Outer context refers to the wider health system in which the organization is based and the policies or regulatory frameworks and political environment that govern the way that health system functions. So for example, in our case that would be the VHA, the larger VHA.

Examples of i-PARIHS inner context constructs that can influence implementation include leadership support, culture, organizational priorities, evaluation and feedback processes, learning networks, and the structure or the resources available within that setting. Examples of outer context constructs include policy drivers and priorities, incentive and mandates from the larger health system and/or inner organizational networks and relationships. So that’s, those are kind of the core elements and sub-elements of context.

With regard to innovation, according to i-PARIHS, the clinical innovation is the focus of implementation and is broadly defined as anything that the intended users or recipients perceive as new. So that's the innovation is something new to the setting and whether that be an evidence-based practice in some cases, settings that are rolled out may not have a solid evidence base behind it. So that’s why they refer to just a supporting a roll-out of an innovation as something new within the setting. Although the construct of innovation does include characteristics of innovation supported by theory and empirical evidence such as relative advantage, usability, trial ability, those of you familiar with Rogers Diffusion of Innovation Theory will be familiar with those terms, those constructs. The innovation domain explicitly focuses on finding and applying evidence. And evidence is not just information obtained from research but also information obtained from other sources such as clinical experience and also patient preferences or experience as well.

I should say here the i-PARIHS developers noted that the power of various types of evidence to prompt providers to change their existing practices varies widely across providers and systems. In fact, the i-PARIHS developers assert that reliance on research-based evidence alone does little to change clinical practice by itself and that substantial theory and empirical evidence suggests that providers' own experiences and perspectives will also influence adoption of these innovations or evidence-based practices.

Next I’m going to talk a little bit about the i-PARIHS domain of recipients. The construct of recipients focuses on the intended targets for implementation, which may be individual providers or healthcare teams, for example. Key characteristics of recipients within the framework include their own personal motivation to change, their values and beliefs, their specific goals that they would want to achieve within an implementation effort, the skills and knowledge about the innovation that they come in with through the process, available time and resources to support local implementation, and whether there are local opinion leaders available to support adoption of evidence-based practices as well.

This recipient also includes a characteristic of collaboration and teamwork if the innovation is to be delivered by clinical teams as well. So this slide just shows that all of these main, the domains of context, innovation, and recipients together. You can see, and this next slide shows kind of the interactions. The characteristics or sub-elements within those broader domains actually interact and all together can influence successful implementation. So before I go there, so how, so the issue then is like how do we find some way to exercise influence, exert influence on these factors within the domains of context, innovation, and recipients to try to engender successful implementation?

So within i-PARIHS facilitation is that active ingredient that tries to integrate action around the innovation and the recipients within their local organizational or wider health system context to enable successful implementation. And then, so that’s put forth within i-PARIHS. The framework also, essentially it locates the success or otherwise of implementation on the ability of the facilitator and the facilitation process to enable recipients within their particular context to adopt and apply the clinical innovation by tailoring their intervention appropriately. And appropriately there, it refers to tailoring the intervention in a way that maintains fidelity to the evidence base, if there is an evidence base, behind the practice of programs being implemented.

And so on the slide it also includes a definition from a compilation that Byron Powell led a group of us, within our group a couple years ago, to look at the different implementation strategies that have been used within mental health settings. And within that compilation of strategies, Powell defines facilitation as a process of interactive problem solving and support that occurs in the context of a recognized need for improvement and a supportive interpersonal relationship. So within our own work, if we've applied facilitation it actually bundles an integrated set of strategies including identifying and engaging chief stakeholders, including leadership, clinical champions or opinion leaders, problem solving, assistance with technical issues, developing networks for information exchange either within groups or across groups if you’re working with multiple settings in a given project. Doing, facilitators also assist with marketing, training, and also audit and feedback and role modeling as well. So it’s a very, as you can see, it’s a very comprehensive role that facilitators can play in time to support recipients in picking up a new evidence-based program or practice or clinical innovation as the case may be.

And the particular roles that the facilitators assume and when they assume them in these settings often depends on the facility’s needs over the course of the implementation process. And so we talked a little bit about a moment or two ago about whether it’s tailoring of the clinical innovation to the site but in a way that maintains fidelity, and then when practicing facilitation there’s typically tailoring of the approaches instead of using tools that a facilitator applies to a given setting based on the context and the needs of that setting.

So this slide, again, shows where facilitation kind of fits into the mix. And the facilitators can be external or internal to the organization. I talked about how they can apply multiple discrete implementation strategies to tailor to the needs and the priorities of the site and the context that’s been assessed. It’s also typically is a very, has to practice a great deal of flexibility in working with sites and really taking strong interpersonal skills to effectively carry out this role of facilitation.

And so, yeah, so this slide really just shows, we talked about how these factors related to context, innovation, and the recipient all interact with one another to affect successful implementation. Well, similarly, the facilitator is deciding which strategies and tools to employ based on what they’ve encountered at a given site with regard to these different domains of context, innovation, and recipients as well. And so in that way they’re kind of interdependent about what a facilitator does and how they influence a site and then also how the site influences what the facilitator does. All together the idea is to have facilitation to exercise influence over these domains and then to support successful implementation of the new clinical innovation program or practice.

So this next slide just talks a little bit about how the i-PARIHS framework may be used to guide implementation and implementation strategy. So you’ve heard me talking a good bit about facilitation and what you do as a facilitator in those previous slides. So the framework itself and the domains and elements within it can inform how we operationalize or what we focus on within the facilitation strategy. In the 2015 book that I’ll give you the citation for that at the end of the presentation, but it actually provides some guidance on characteristics of positive facilitation and good facilitators. And so that’s kind of, that’s where they tried to address that earlier critique from the original PARIHS framework about how there was not, the original PARIHS framework really focused more on the role of facilitators and less on the process, and so they tried to address that in this facilitator’s guide that they developed with the new i‑PARIHS. They refer to it as a facilitation toolkit, but it’s a very helpful resource for those of you who want to apply PARIHS, use PARIHS, and try, and to apply a facilitation strategy as well.

The i-PARIHS can also help identify factors within those domains and constructs that we just talked about a few moments ago to assess and address as a focus of the facilitation strategy. For those of you who are familiar with Cheryl Stetler’s paper in 2006 on formative evaluation, some of the, some formative evaluation techniques are often done by a facilitator, and in those cases it actually makes those formative evaluation approaches part of the implementation intervention. But I’m not going to get too bogged down into the weeds on that, but when these formative evaluation techniques are applied by the facilitator, i-PARIHS can help inform the questions that we ask of our stakeholders, our clinical partners in semi-structured qualitative interviews or focus groups with them to try and get a sense for the local context and accounts of challenges or barriers that we would need to address in an implementation plan. And also about the, information about the resources or facilitators, enablers that they can, their sites can contribute toward the implementation process as well. And this last bullet here talks about how the i-PARIHS framework can provide guidance on facilitator roles in different phases.

So this is actually just a graphic from the facilitator’s guide, the i-PARIHS facilitator’s guide, and it describes the facilitation process in terms of phases. And starting with the upper right quadrant of clarify and engage and ending over here in the upper and then proceeding clockwise and ending in the review and share quadrant in the upper left part of this pie chart. But the developer simplified that these stages, although they’re presented in a sequential way, in practice there’s likely to be and typically would be more of an iterative process with overlap between some of these phases and even movement backwards and forwards between some of the phases as well. But again, for simplicity’s sake we try to present it in this manner.

In the clarify and engage phase, that really emphasizes or focuses more where a facilitator works to identify the problem at a site and do some, get the right people together and involved and do some implementation planning and coming up with an initial plan. In the assess and measure a lot of you would recognize that in terms of audit and feedback, so assessing current performance and context and how that may influence successful implementation. And this is a perfect example of how that can be, you can do, you can actually back up between, in doing implementation planning you should actually be able to consider the context that you’re in and the current performance and what are the determinants of that current performance as well. So again, these are, you can move back and forth between these phases.

And then in the third phase here, action and implementation, that’s where the i-PARIHS developers talk about using PDSA cycles, so plan, do, study, act. Trying to influence change, to implement change on a relatively small scale initially, do the review, how successful it was, and share the feedback with others, maybe refine the process based on what you learn, trying to assist and perfect a strategy within the site that will actual support adoption, uptake, and use of the clinical innovation.

So that was, there I was talking more about how i-PARIHS may be used to guide the implementation strategy of facilitation. And in terms of guiding evaluation, i-PARIHS can, you can use the domains and constructs to inform the data collection and analysis. So instrumentation, you can use instruments that relate to the i-PARIHS domains and constructs. There actually is, that’s really an area for additional growth in terms of developing and validating instruments that can be used for i-PARIHS. Again, it’s just been proposed in 2015 and so in some of the work our group has been doing with Alison and Gill Harvey, here recently we've talked a good bit about maybe even developing, working to develop a repository of instruments where people could share the different tools, the data collection instruments that they’ve used to apply i-PARIHS where they could share those and let other people take a look at them for whether they may be useful for adaptation for their own work as well.

So similarly, so for qualitative work if you’re doing interviews, semi-structured interviews or focus groups for a project, you can use the i-PARIHS domains and constructs to inform the questions that you ask of the recipients in those cases. Here we talk a little bit about deductive coding and qualitative data. We’re actually working within our own group here at Behavioral Health QUERI to try to develop a common qualitative code book that can be used, again, based on the i-PARIHS domains and constructs, that can be used across all of the projects that we have going on within our program. And so that’s kind of a work in process. But we are working towards that end. So the idea that you can identify potentially, by collecting that type of data you can identify the PARIHS domains or constructs in a given project, or as I just noted, across multiple projects within a QUERI program where a suite of research, related research, that may have the greatest influence on implementation success or failure or may have an influence on the intensity of facilitation leader, that one site versus another, that there are contextual factors that tend to have a greater influence on the intensity of facilitation that will be useful to know, and so that’s one area that we’re trying to explore within our own QUERI program, whether and how the i-PARIHS constructs may be used to help inform on the front end whether, how intense, the dose of facilitation, essentially how intensely a facilitation needs to be operationalized for the site that we’re working in and whether we may need an external and an internal facilitator or external only. Questions like that, those would be useful to have that data. So we’re trying to work towards that process.

As I mentioned when I first started talking about the evaluation here, we think that i-PARIHS can be used, it’s an area that needs attention to inform the on-going development and refinement of instruments that can be used with i-PARIHS and to assess its core constructs. As an example, for the original PARIHS framework, I don’t know if Christian Helfrich is on the call, but Christian actually had, and Anne Sales actually originally worked to develop an Organizational Readiness to Change Assessment, referred to as ORCA, that was based on the original PARIHS domains and constructs. And so work like that is really an area of need for the new i-PARIHS framework, the updated i-PARIHS framework as well.

So this is a slide that, I kept promising you that the facilitation guide, the citation for it would be provided at the end. And so the first bullet there provides the citations for the facilitation guide that Alison and Gill Harvey produced for i-PARIHS in 2015. It’s a really great book to check out if you’re interested in checking out i-PARIHS or in applying facilitation strategies to support implementation. And then another resource to check out, which is based actually somewhat on the guide is this second bullet, a paper that Alison and Gill published in *Implementation Science* last year to provide an update about i-PARIHS and what the new directions are.

So that’s, I don’t know where we are on time. That concludes the presentation, the slides that I have, and I’ll be happy to answer any questions or your comments are welcome as well if you’ve applied i-PARIHS or have your own perspectives on it, any of the information that was provided during the talk.

Molly: Thank you very much. So for our attendees, for those of you that joined after the top of the hour, to submit a question or comment just use the GoToWebinar control panel on the right-hand side of your screen. There’s a section labeled questions toward the bottom. Just click the arrow next to that. That will expand the dialog box and you can submit your question or comment there. And we do have several pending questions, so I’ll jump right into them. First off: Great presentation and wonderful speaker. Does the inclusion of VISN, for instance, regional priorities tend to fall within inner content or outer context? Sorry, there as a couple letters missing there. So does the inclusion\_

Jeffrey Smith: Yeah, that, oh, go ahead. I’m sorry.

Molly: No, no, no, tend to fall within inner context or outer context?

Jeffrey Smith: Yeah, so the short answer is it depends. If the innovation is targeted for implementation at the network level, then I would say that the VISN then, if it’s a network level implementation effort, I would say then that the VISN would be inner context. However, if the actual innovation is being implemented within individual clinics or services within a VAMC within a VISN, I would tend to think that the VISN then would be considered as part of the outer context because in some cases, especially in mental health services, VISNs are organized differently in terms of the influence, the supervising authority that the network level mental health liaisons have over individual services, individuals, mental health services within the different VAMCs within that network. And so depending on those issues that can actually play a factor into who actually is being mostly targeted to help support implementation of a given effort. So I don’t know if I confused you with that latter part. But for those of you who are not familiar with that kind of unique aspect of mental health services and how to organize at the network and facility level, but that’s a factor that we have to consider in our work in the Behavioral Health QUERI.

Molly: Thank you. The next question: If there is, who can serve as a facilitator? What are the qualifications to be in this role?

Jeffrey Smith: Yeah, that is a fantastic question. And actually the i-PARIHS developers have a full table of the characteristics of good facilitators. And so that is, the one slide that I had in here talks about that they have to have good interpersonal skills, that kind of goes without saying. They need to be flexible. In a perfect world they would be someone who has actually been involved in implementation efforts previously with some success. It really is a role about helping and enabling a site to implement a new program or a practice rather than doing it for them. And so I would actually just, rather than go kind of go through the full lineage here of what, of the different roles or the different characteristics, I would refer the questioner there to the 2015 Facilitation Guide and chapter five to check out those characteristics about who makes a good facilitator because it is a very important question. Not just anyone can serve effectively in this role, and so that’s one of the, obviously one of the key decision points. If you’re going to apply this facilitation strategy, you have to make sure that you have a good [inaudible 42:00] for the person in that role. I’ve seen it happen in different ways where we’ve had good people who are great to serve in the role and then just in terms of their characteristics and expectations for what they wanted to, how they wanted to actually operationalize [unintelligible 42:17] it really worked out in a bad way, too. So it’s an important question that I would refer you to the primary resource of the facilitation guide, and chapter five of that would have a great deal more information.

Molly: Thank you. So I’m just going to back up one step, and it looks like somebody was looking for clarification on what you meant by quote, network level.

Jeffrey Smith: Well, for me within the VA, I’m thinking of the VISN level, so when I’m saying network level that's typically, I don’t know where I said that, but that’s typically shorthand for me about a characteristic or factor or process that’s happening at the VISN level.

Molly: Thank you. All right. So the next question. I’m not very familiar with the various implementation frameworks, but I am curious to know what is unique to i-PARIHS and what is common amongst i-PARIHS and other frameworks.

Jeffrey Smith: Well, one thing that I would say that is especially unique to i-PARIHS is how they define the facilitation role and now how they’ve done a better job of really providing additional information, explicit information about the process of facilitation and what you do. There are a number of frameworks out there that talk a good bit about what the determinants of current practice are and what types of factors or barriers or facilitators may influence implementation, but they talk relatively less about a process or strategy for actually addressing it. And so i-PARIHS is relatively unique in that way, in talking about and providing explicit information about a strategy that can be used to exert influence on those other domains of context, recipients, and innovation to support successful implementation. The areas were similar, where i-PARIHS is similar to other frameworks is, within those domains of recipients, context and innovation. It does include a number of the factors that can help, that can determine implementation success or failure that you may want to consider in your data collection to try to ensure that you capture that, in an evaluation that you understand what the determinants of implementation success or failure were. So those, that's just, then like I said, the main unique, the main thing that’s unique about i-PARIHS is the facilitation strategy that it proposes to exercise influence over those other domains and factors. The things that are common, the thing that is common with other frameworks is that it does assess those large number of other domains and factors.

Molly: Thank you. With so many factors affecting implementation, is there a guide for qualitative work to examine them? From a methods standpoint, are there key references for interview or focus group work?

Jeffrey Smith: So with regard to i-PARIHS specifically, I wouldn’t say that there are, there’s like specific guidance. But in terms of using the i-PARIHS domains and concepts to inform your original development of questions that you want to ask of stakeholders or recipients that you're targeting to implement the new innovation, I would say that, again, the domains and the concepts provide a good starting point for developing an interview guide, for example. But generally just a good, exercising good qualitative data collection and analysis skills helps you to essentially engage with the recipients, get their perspectives on the current context and what the determinants are of their current practice, things that will be critical to address in an implementation plan with a site, and issues that you may, and factors that you may be able to actually leverage to support implementation. So it’s not all about identifying barriers. It’s about identifying facilitators or enablers within the different sites that you can use. But I wouldn’t point anyone to a specific resource other than to say using i-PARIHS domains and constructs to inform development of interview guides and a selection of any quantitative instruments as well using the domains and constructs in that way. But essentially just practicing on the qualitative side, practicing really rigorous qualitative data collection and analytic approaches is the way you go about doing that.

Molly: Thank you. The next question we have: I just want to mention, oh, I'm sorry, we have a comment here. I just want to mention for those who are interested in facilitation there are HARQ training curriculum that may be of interest, titled the Primary Care Practice Facilitation Curriculum, and if you need that repeated to you just write into the question section. I can get that to you.

Jeffrey Smith: Yeah, that’s a\_

Molly: Oh, sorry.

Jeffrey Smith: I was just going say that, yeah, that’s good information for folks. Practice Facilitation is a form of facilitation, a lot of that works, it’s not like explicitly referenced that it’s based on the original PARIHS framework or the new i-PARIHS framework, but a lot of the activities and strategies and roles that the facilitator plays to practice facilitation. There’s a good bit of overlap there. And so, yeah, that’s a good resource to check out. We’ve actually within Behavioral Health QUERI, we’ve been doing some trainings as well, not only of our own investigators but we’ve kind of been, we’ve done, oh, three facilitation trainings this year for people involved in other projects and initiatives within the system. And we typically just rely on folks to reach out and let us know that there’s interest, and then we organize a training once we kind of have a critical mass that would be needed to make it, to carry it out effectively. So we do that every now and then as well as part of our Behavioral Health QUERI and Implementation Core. So I just wanted to note that as well.

Molly: Thank you. So that prompted a whole slew of people writing in resources.

Jeffrey Smith: Uh-oh. I might be in trouble now. Okay.

Molly: So what I’m going to do is I’m going to get through the content questions first and then I will\_

Jeffrey Smith: Yeah, so for those folks, though, before you get to that there. We do have a facilitation guide that’s available online that we kind of use as the foundation for our training program, so after the fact I can send, I can give that link to Molly after the session here. And Molly, if you like you can send it out to everybody if they want to check out the facilitation guide as well.

Molly: Yeah, that sounds great. I can definitely tack it onto the reminder email that everyone will receive. Okay, so we’ll get to the content questions and then I will list off the plethora of resources we’ve got here. So how do you suggest using i-PARIHS as we develop/adapt interventions?

Jeffrey Smith: So developing and adapting interventions, within i-PARIHS that would fall under the domain of innovation. So there, within the innovation domain of i-PARIHS it talks about the evidence for the clinical innovation in that case. And so if you start talking about adapting intervention in some way, the innovation or intervention in some way to better fit the local context at a site or a facility that they’re working in, it’s important to, those will be the factors to consider. So the relative advantage of one approach to implementing the intervention versus another, all of those sub-elements within the innovation construct will be important to consider. But more important to consider than all of those is if there’s an evidence base with a clinical program or practice already that any of those adaptations or derivations to try to make it a better fit for local context, that you have a content expert or the original program developer available to provide some guidance or feedback about, to be sure that any of the proposed adaptations won’t result into a deviation from the evidence base that may make the intervention itself less potent or effective than it was shown to be in the original trial. So that’s just one thing that I would fill in there.

Molly: Thank you. Is it, oh, sorry, it is probably better to use one framework to implement an intervention if you were to combine or integrate i-PARIHS with another framework. What are some of the examples of frameworks you would use?

Jeffrey Smith: So we’ve actually done this with PARIHS and i-PARIHS. But we’ve essentially in a complementary way used PARIHS or i-PARIHS along with the RE-AIM framework. RE-AIM is a framework to guide selection of evaluation measures for a project, and so it provides, RE-AIM provides a little more explicit information about the different questions or measures that you may want to use for an evaluation within a project than the original framework PARIHS framework did or even i-PARIHS now. It’s a little more rubber meets the road in terms of defining evaluation questions. So RE-AIM we found is a really nice framework to use in a complementary way with the original PARIHS framework and now i-PARIHS as well.

And for those of you who are not familiar with RE-AIM, it was originally developed by Russ Glasgow and colleagues many years ago now, but it’s been adapted over the years as well. It stands for, RE-AIM stands for assess measures of reach, are you reaching the actual targeted providers or patients that the intervention should be focused on? Effectiveness, so whenever you actually implement the intervention in the new setting, is the outcome that you would hope for or expect based on previous trials? The A in RE-AIM stands for adoption. Are providers actually, or patients, actually showing some level of adopting of the clinical practice? The I stands for implementation, and that means that is the, that’s where you get into issues of fidelity, fidelity to the clinical innovation and even fidelity to the implementation strategy within our own QUERI work. We want to be sure that we’re paying attention to both, fidelity to the clinical intervention but also fidelity to the, either to the implementation strategy or to the implementation plan in some cases that we often develop with sites whenever we’re applying a facilitation strategy. Implementation also includes issues related to cost. So if there are any economists online, we want to make sure that you know that you’re represented within RE-AIM under the implementation domain. The M in RE-AIM stands for maintenance, and that really is looking at issues of sustainability and whether the clinical intervention is sustained once the active implementation strategy is taken away.

Molly: Thank you. I’m interested in using i-PARIHS for evaluation using mostly qualitative methods. What resources would you recommend to be looked at in addition to the book and Stetler’s article?

Jeffrey Smith: Well, that’s a great question. So for, I’m trying to think of work that’s been done that’s really, that’s where the qualitative component was a focus, so resources there. Well, like I said, typically we have used PARIHS and i-PARIHS to kind of guide our questions for process evaluation or formative evaluation, but I’m trying, I think I would actually, so now I have it. So the Helfrich article in 2010 that was on one of the slides in the presentation, one of the resources there for the original PARIHS framework. One of the additional files, that implementation science paper actually had a whole host of questions that people could use who were doing qualitative work for their implementation guides and was based on the original, again, it was based on the original PARIHS domains of evidence, context, and facilitation. But context and facilitation remain as domains in the new i-PARIHS. And then some of the questions that were there for innovation could have officially, the evidence context, the evidence construct within the origin PARIHS was officially integrated in ways into the recipient and innovation, those new constructs within i-PARIHS. So I would just encourage you to take a look at that additional file for the domains of evidence, context, and implementation. And even successful implementation provides a lot of great questions that one could consider for a qualitative, to inform qualitative interview guides and focus group guides, that type of thing.

Molly: Thank you. So\_

Jeffrey Smith: Sorry that was a long-winded answer, but I finally got around to it. It’s always back in the mind.

Molly: No problem at all. We like to keep you on your toes. So I’m going to go through two more questions if you’ve got time.

Jeffrey Smith: Sure.

Molly: And then for audience, I have some many wonderful resources that have been sent in. What I’m going to do is I’m going to compile a list of them and I will add them to the archive materials. So when you receive your follow-up email in a few days, go to the end of the handouts and you will see an additional page that has some more resources and all that done through our presenter before I just start throwing everything at the wall. And okay, so a few more questions and then we’ll wrap this up. What are the advantages of i-PARIHS compared to CFIR, Consolidated Framework for Implementation Research?

Jeffrey Smith: Advantages, well, like I said, within our own work in Behavioral Health QUERI and then previously in Mental Health QUERI, we applied facilitation strategies. We applied a great deal of time and effort into developing, refining, and refining our use of facilitation strategies to support implementation. And so given that we found the benefits, we found that facilitation was an effective strategy for us in trying to support implementation. That has really why we kind of stayed this, originally with PARIHS and now with i-PARIHS [audio hiccup 59:15] facilitation is an explicit component within the framework. And in fact we specify that the active ingredient by the i-PARIHS developers of how you support the recipients in an implementation process. Now CFIR does have a process domain, and within the process domain of CFIR it does include facilitative strategies. And so people can apply a facilitation strategy using CFIR as the foundational framework for their work. We’ve just found in our case to be more helpful to ground our application of the facilitation strategies within, now i-PARIHS, just given that facilitation was an explicit focus and domain unto itself within the framework. But lots of people use CFIR. It is a fantastic framework. Laura did a great job putting that together with her colleagues in the old Diabetes QUERI in the former QUERI program, and so people have found it very beneficial and helpful to use as well in this work. And Laura has done a great job of actually developing kind of what she called a Wiki page. I don’t know if Laura is online, but she has a Wiki page where people, where she actually offers some tools and resources that people can use in applying CFIR. So that’s a really good resource that she’s made available to folks in that regard, too.

Molly: Thank you. So we just have one more content question. Are you able to stay on? I know we’ve passed, just passed the top of the hour.

Jeffrey Smith: Yeah, yeah, I’m fine. Yeah. Absolutely.

Molly: If any of our attendees need to drop off, when you exit the session, please wait just a moment while the feedback survey populates on your screen. It’s just a few questions but we look closely at your responses and it helps us to improve our presentations as well as the program as a whole. So this one should be a pretty easy one. How can you get on the list for training for BH QUERI?

Jeffrey Smith: So the facilitation training, the easiest way is to email me or, well, my email is on the screen. So email me and then I can forward it on. Krissi Morris within our, she’s kind of our administrative core leader within our group is, helps us coordinate and manage the facilitation training program. And so email either me, my email is on screen, or Krissi Morris within our group as well, and we can get your name down as an interested party. And like I said, once we kind of get a critical mass of people for the trainings in the work to set one up at a time that works for the majority of the group and then we go from there. So the trainings are typically held, we hold them here in Little Rock. We don’t have any additional funds to support doing this elsewhere. People have to cover with their own travel to come here to receive the training. We’re going to be in a training that we have coming up in January, which is full I should say, it’s full at this point. We have one group that’s going to be participating virtually, and so we’re going to be testing that out as an initial test of having one team available to receive training virtually while we have other people with us here in Little Rock to see how that works and how that process might need to be refined for future trainings if we want to be able to involve more people virtually. So long-winded answer again, I’m sorry, but yeah, for information you can contact me, Jeffrey.Smith6@va.gov, or Krissi Morris within Behavioral Health QUERI.

Molly: Wonderful. Well, I do want to wrap up now. Do you have any concluding comments you’d like to make, Jeff?

Jeffrey Smith: I’d just like to thank everyone for their participation, for the great questions there as well. I mean that’s a really fantastic topic to touch on and really to expand the discussion about i-PARIHS. I hope everyone found something useful in the presentation and just appreciate everyone’s participation and feedback, so thank you.

Molly: Excellent. Well, I can’t thank you enough for coming on and lending your expertise to the field. And of course, a big thanks to Christine Kowalski and Anne Sales who help organize this monthly QUERI Cyberseminar, which takes place the first Thursday of every month at noon Eastern. So keep an eye on your emails while we advertise the December ones. And so Jeff, once again, and for our attendees I will be compiling these resources and adding them to the archive materials so keep your eyes out for the follow-up email. And with that I’m going to go ahead and close out today’s session. So again, for our attendees, please wait just a moment while the feedback survey populates on your screen so we can get your feedback. Thank you, Jeff. Have a great rest of the day.

Jeffrey Smith: Thank you. Thanks, everyone. Bye-bye.

[ END OF AUDIO ]