Characterizing Implementation in High Versus Low Fidelity Nursing Homes within a Large Pragmatic Trial

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Podium

Session Type:

Call for Abstracts Sessions

Abstract

Research Objective: The PRagmatic trial Of Video Education in Nursing homes (PROVEN) is one of the first large pragmatic randomized clinical trials (RCTs) to be conducted in nursing homes. PROVEN is being conducted in partnership with two health care corporations in 360 nursing facilities across the U.S. (N=119 intervention; N=241 control). The trial's primary aim is to evaluate the effectiveness of a suite of videos to improve advance care planning (ACP) for nursing home patients. This report leveraged mixed methods data to characterize pragmatic RCT implementation in high versus low fidelity nursing homes.

Study Design: The PROVEN protocol required a designated facility champion to offer an ACP video to long-stay patients every 6 months during the 18-month implementation period. Champions completed a

"Video Status Report" (VSR), embedded within electronic medical records, each time a video was offered. VSR data was used to derive facility's fidelity rates (i.e., cumulative video offer). Qualitative semi-structured telephone interviews were conducted with champion(s) at 4, 9, and 15 months into the implementation period. Fifteen-month interviews were purposively sampled from facilities within the highest and lowest (i.e., top and bottom quintiles) fidelity rates. Thematic analysis of interview data consisted of a deductive approach based upon Hasson et al.'s (2010) revised Conceptual Framework for Implementation Fidelity (CFIF) domains. Two researchers coded independently the verbatim transcripts using NVivo 11 software and convened regularly to reach consensus on their findings. Matrices were developed to compare coded narrative by domain across facility fidelity status ("high" versus "low").

Population Studied: 33 champions (typically social workers) from 28 purposively sampled intervention facilities.

Principal Findings: We compared high and low fidelity facilities across the six CFIF domains; different patterns were observed in four: Context, Participant Responsiveness, Recruitment, and Strategies to Facilitate Implementation. Context was characterized by resource challenges (e.g., staff time) in low fidelity facilities. Participant Responsiveness to the program contrasted in that high fidelity facility champions most frequently mentioned an openness amongst patients and families to view an offered video; champions in low fidelity facilities often described patients and families as reluctant to watch a video which appeared to lead to negative champion responsiveness in turn. For Recruitment, high fidelity facility champions approached offering the video enthusiastically and strategically, while low fidelity facility champions approached it more with reticence. Related to Strategies to Facilitate Implementation, high fidelity facility champions commented on the positive impact of regular feedback from the leadership team (e.g., 1:1 coaching calls).

Conclusions: In this pragmatic RCT, low fidelity nursing homes were characterized by limited champion resources, perceived negative patient/family responsiveness to the program, and tentative champion recruitment efforts. High fidelity nursing homes were characterized by more patient/family willingness to engage in the program, enthusiastic and strategic approaches to recruitment, and champions' appreciation of facilitation by the leadership team.

Implications for Policy or Practice: Organizational readiness should be formally assessed for nursing home facilities participating in pragmatic trials early and throughout implementation. Facilities deemed "at-risk" for implementing the trial with low fidelity may need "remedial" support in selecting skilled and invested champions and in countering challenges with recruitment mid-stream through continuous champion coaching.

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