Author’s response to reviews

Title: Using developmental evaluation to support knowledge translation: Reflections from a large-scale quality improvement project in Indigenous primary health care

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Reviewer reports:

Reviewer #1: Thank you for the opportunity to review this manuscript. It is well-written and interesting. I particularly liked the authors’ honesty about their own skill-base (innovation and evaluation (lines 267-277)) and their courage in identifying and implementing a developmental evaluation (DE) approach in the ESP project. While DE was new to them (298), they link it with their existing knowledge base and practice experience, particularly action research and participatory methodologies. They are clear that while the project they are evaluating is a national initiative, they recognise and value the local context in which primary health care is delivered and where change needs to happen if health disparities for Aboriginal and Torres Strait Islander peoples are to be eliminated. In talking about the change needed to achieve this they describe an ecological model of health care delivery at three levels: health practitioners, health organisations/centres, and health system.

Their goal in using DE was to, in their words, strengthen knowledge translation and dissemination and - presumably consequent - improvement interventions (lines 67-68) across these levels. They describe their DE methodology and the benefits and challenges of implementing this approach, along with some reflection on whether or not what they did was DE. For the latter they reflect on how their methodology reflected Patton's eight DE principles (Box 2). There are many good parts to this paper that will encourage others to consider the utility of DE within their health context, particularly in terms of evidence-informed change to strengthen equity.
In the remainder of this review I raise some issues that I believe the authors are fully able to respond to but that they may consider to be outside their 'brief' in terms of their focus on a smaller space / gap between the provision of evidence and the impetus for change (see, for example, Table 1). I suspect I may be asking too much in terms of a broader inquisition of health care disparities and how change can happen to better support Aboriginal and Torres Strait Islander health and wellbeing. However I also offer this critique within the context above, namely that this is an informative paper.

1. In what ways are the Australian Indigenous primary care (PHC) services Indigenous? While it is stated that the context for the project is 'indigenous settings' (26) it is never clear what this means in terms of, for example, the ethnicity of health practitioners, the values base of health care practice, the organisation of health centres, the system of health care funding, etc. What I was left with was the impression that potentially the only aspect that makes PHC services indigenous is that they are serving an indigenous patient / client / community base. The absence of any broader context for understanding these PHC services means that issues related to the drivers of health disparity go unnamed and therefore unquestioned in examining / evaluating health practitioner, health centre, or health system evidence-informed changes to reduce disparities. I am referring in particular to the broader social and economic determinants of health alongside more systemic issues of colonisation, racism, and a lack of culturally responsive health care. I would be very surprised if some of the Indigenous stakeholders interviewed did not raise these issues - but again, I am unclear about who these stakeholders were and whether or not any community people or patients of these services were involved in this project. My overall impression, if I'm honest, is that mostly white people deliver in these services and it is they who were engaged with during this project, and that these broader and potentially more 'sensitive' issues were not touched upon because of the smaller space / gap I mention above.

You are correct in understanding that the ESP project targeted people working in Indigenous PHC rather than consumers of PHC services. We have made several additions to clarify the ESP project settings and participants, as follows:

Lines 70-79: Added background information about Indigenous people’s health and PHC services in Australia.

Lines 131-132: Detailed the number of Indigenous community-controlled and government-managed health services contributing the CQI data used in the project.

Line 166: Expanded on the role types of targeted stakeholders.

Line 167: Expanded on the diversity of project contexts.

Line 171: Referred to different types of knowledge the project was aiming to capture in data interpretation.

Lines 237-239: Indicated Indigenous participation in the project.
2. There is some mention of tailoring evidence and reports for Aboriginal and Torres Strait Islander stakeholders (lines 263-4), but this is not expanded upon. In light of #1 above however I was curious about how responsive the DE made the authors to issues of culture and how they then reflected this in their practice. The value of cultural responsiveness is described in terms of other continuous quality improvement (CQI) projects (lines 83-90), but this is not followed up on in relation to the project described in the paper.

We have added an example (Line 290-291) of how we, as an ‘external’ research team conducting a system-wide project, were able to support people on-the-ground to facilitate input that reflected community and cultural contexts. Note also that we specify Indigenous membership of the ESP research team in Line 195.

3. The term 'complex' is used liberally throughout the paper to describe PHC contexts (e.g., lines 68, 158, 165). I was unclear from the paper what in particular about these contexts is complex. I raise this because the term is sometimes used as code within health care and other contexts to assuage the system of responsibility for disparities; namely, that they (the system, organisation, health practitioner) have tried (top-down) solutions but these haven't worked because patients and their families haven't changed, so things must be more complex. So often we expect / demand patient change rather than looking at ourselves and our organisation - which in a way is simpler because it's about being patient-centred but harder because the system is not used to it and will do its best to avoid it even in the face of evidence and demands from indigenous peoples. I'm not saying the authors are using complex it this way; I wanting to indicate that it may be worthwhile exploring / explaining the use of the term more in the paper.

We have taken your advice. The new text providing background information about Indigenous people’s health and PHC services in Australia outlines key aspects of the PHC context that make it complex and states the need for PHC systems to change rather than requiring clients to change. (Lines 70-79). This sets the scene for the focus and aim of the ESP knowledge translation project.

Note also the change to Lines 183-185, to emphasise the focus on system improvement to better meet the needs of Indigenous people.

4. I was surprised that the authors did not think it valuable / informative to look at how DE had been implemented in Indigenous contexts (lines 94-104), but then again - in light of #1 - perhaps this wasn't an indigenous context.

We had referred only to limited literature describing use of DE in Australian Indigenous health programs (lines 60-61). We have added specific reference to the use of DE in Indigenous contexts, and cited examples (Lines 115-117).

5. The brief description offered of 'typical' process evaluation (lines 233-4) is naive and akin to a straw man against which to argue for DE. The explanation provided on page 15 (lines 314-319) is more nuanced and informative.
The problematic phrase (now Line 258) has been deleted.

6. I do not see the need for a ‘new’ DE principle as suggested (lines 304-8). Rather, the description offered in the text reflects the principle of co-creation (#7). It’s just that the interpretation of this principle in Box 2 is too narrow.

The reviewer’s perspective has prompted reconsideration of the way we interpreted the “Co-creation” principle in the context of our DE. We have incorporated our reflections on knowledge exchange and our “All teach, all learn” approach under the “Co-creation” heading in Box 2 and deleted the paragraph about a ‘new’ principle.

7. The examination by the authors of the role extension of evaluators (and innovators) when using DE has been canvassed within evaluation by feminist evaluators and others using participatory methodologies, and at least one volume of New Directions for Evaluation (American Evaluation Association) has been devoted to evaluation and facilitation. So no-one should be surprised that a closer, more participatory methodology leads to this role extension.

The authors agree with this comment and thank you for your review of our manuscript.

Reviewer #2: The authors present a descriptive paper describing their experience with using developmental evaluation (DE) to support the implementation of an interactive dissemination strategy focused on engaging stakeholders with aggregated CQI data from Aboriginal and Torres Strait Islander primary health care (PHC) services with the ultimate aim of identifying evidence practice gaps and further strategies for improvement.

Overall the paper is well written and describes a complex scenario well. I have a few minor comments.

It appears the only stakeholders involved were health care providers. This may have been a necessitated by the online components of both the ESP (program) and evaluation. Some comment would be ideal re if there was opportunity to involve clients/patients and the likely benefits or drawbacks of doing so in this DE process.

Thank you for you review and suggestions for strengthening the manuscript.

You correctly observed that the target audience for the ESP project was not clients/consumers of PHC services, although some community members of governing health boards contributed (See Line 238). To clarify the target audience, we have added more information about the roles of stakeholders targeted, i.e. people in policy, management, CQI facilitator, health practitioner and academic roles. (Lines 166-167). See also Box 2.
Indigenous participants (mostly) provided input as health professionals, bringing the benefit of Indigenous cultural, community perspectives to the process. Information about Indigenous participation has been added (Lines 237-239).

We have commented on the potential benefits of engaging clients/consumers in similar processes in the Discussion section (Lines 420-422).

It is unclear whether the Aboriginal and Torres Strait Islander PHC services were community controlled (ACCHOS) or not (AMS), or in fact if both types of organisations were included? The difference has some influence on principles, systems, and the scope of care provided in Aboriginal and Torres Strait Islander PHC. Some comment re whether the experience here is applicable (particularly with regards to the future) to all Aboriginal and Torres Strait Islander PHC settings would be ideal.

To clarify that both types of organisations were included, we have specified the number of Indigenous community-controlled and government-managed PHC services that contributed the CQI data used in the ESP project. (Lines 131-132)

There are remarkable differences in the size, resources (infrastructure and workforce), demographics, geography and range of service delivery across Aboriginal and Torres Strait Islander primary health care. Barriers to the ESP in one setting may not be issues in another. Were these differences encountered across sites/settings involved and how did the DE process accommodate these potentially vast differences in context. Some elaboration would be ideal.

Thank you for this suggestion. In the Background, we have added a heading and text that provides information about Indigenous people’s health and PHC services, and the variation between services and settings (Lines 70-76). In the Discussion section, we have clarified it was not within the scope of the project for the DE to adapt reports and processes for individual settings (Lines 413-414).