Getting Started in Video Ethnography –

A Catalyst for Guiding and Motivating Quality Improvement

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Kaiser Permanente
Care Management Institute

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About CMI

Since its inception in 1997, the Care Management Institute has provided the tools and techniques that help Kaiser Permanente improve care for its members. CMI is committed to the Kaiser Permanente promise of providing affordable, high-quality health care with a personal touch. To deliver on that promise, CMI partners with physicians, clinical experts, leaders, and members to serve as a gathering point for the study of new clinical approaches with a focus on the following principles:

- Keeping members at the center
- Harnessing technology
- Care coordination
- Applying evidence-based care
- Measuring results
- Spreading successful practices

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Section 1
Introduction

"To forge a partnership with patients and family, to share decision making, to put patients in control, to share openly with each other, and to anticipate patient needs requires commitment and rigor… new habits of mind and perspectives."[1]

1 Taylor J, Rutherford P. The pursuit of genuine partnerships with patients and family members: the challenge and opportunity for executive leaders. Frontiers of Health Services Management; 26:4, 3-14, 2010.

Video ethnography and patient-centered care

Patient-centeredness is a central element of high-quality health care. A simple and intuitively obvious concept, patient-centered care has proven difficult to achieve. Becoming truly patient-centered requires those of us who work in health care to move outside of our professional perspectives and learn deeply from the experiences of patients and their families.

Kaiser Permanente's Care Management Institute has developed a replicable method for using video ethnography to learn from patient and staff experiences by capturing interviews and observations on videotape, analyzing the footage to identify improvement opportunities, and highlighting them in short videos that reflect the heart of patient experiences. Sharing these videos in dynamic sessions throughout the organization motivates performance improvement activities and guides them toward areas of greatest opportunity.

Video ethnography complements other approaches to engaging patients in quality improvement and is aligned with other tools, such as the Model for Improvement developed by the Associates in Process Improvement and the Institute for Health Care Improvement (IHI). This toolkit is a step-by-step guide for individual quality improvement advisors or improvement teams, health care providers, nurses, physicians, applied researchers, and others interested in conducting field work interviews and observation to identify gaps and opportunities to improve health care quality from the perspectives of patients.

What is video ethnography?

Ethnography is a qualitative learning method developed by social scientists. Ethnography relies on in-depth interviews and observation to understand, interpret, and describe experiences, processes, systems, organizations, and cultures. Video ethnography, as described in this toolkit, combines ethnographic methods with video recording and editing, communicating key messages using video. Video ethnography is embedded within a quality improvement framework; data from interviews and observation are captured, rapidly analyzed, and communicated, informing and motivating quality improvement decision-making and activities across different audiences.

What skills are needed?

Ethnography requires an open, inquiring mind, along with core skills in identifying a patient sample, conducting effective interviews and observations, and analyzing data to identify key themes. Adding video to ethnography makes use of simple video technology for recording field work and editing raw images into a final video that effectively communicates quality improvement opportunities. Advanced video equipment and technical skills are not needed. Using video ethnography to motivate and guide quality improvement requires a solid knowledge of quality improvement approaches.

Why use video ethnography?

A central challenge of quality improvement in health care is how to more robustly incorporate patient perspectives. Video ethnography is an approach for doing just that. By observing patients as they receive care and interviewing them in their homes, in the clinic, or at the hospital bedside, we can begin to see and experience care through their eyes.

A growing number of organizations and businesses use ethnographic techniques to gain a deeper understanding of their customers. We focus here on ethnography for quality improvement purposes. Our approach recognizes the operational realities of rapid cycle change at the front lines of care.

Video ethnography, using patients' images and voices to communicate quality improvement opportunities, can provide greater depth of understanding than traditional interviews, focus groups, or surveys. The results are always revealing, leading to new ways of thinking about care delivery and generating ideas for improvement.

Video ethnography for quality improvement purposes differs from marketing or training videos. There is no script or staged environment. There is no predetermined message about improvement opportunities. The settings are real life, and ethnography teams spend time with patients and staff, seeing "through their eyes" as fully as possible. Messages incorporated in the resulting video are selected only after coming to understand patients' perspectives and choosing themes that are relevant for typical patients.

At Kaiser Permanente, quality improvement decisions informed by video ethnography have led to improved coordination of care, decreased readmissions, and better patient experiences. The voices of real patients in videos motivate change in ways that other data cannot. Through this approach, we have been able to uncover the hidden reasons behind events, explain discrepancies between what people say and what they do, and identify needs that our patients can't always articulate.

Video ethnography has power in the context of an integrated quality improvement approach. Its impact as an isolated technique or strategy is limited. Actionable insights arise from close interaction between the video ethnography team, others on the quality improvement team, and operational leaders, working together to make sense of the information provided by patients and families.

Video ethnography for quality improvement

- Short time frames
- Bounded to specific problems
- Motivates and guides action
- Collaborative
- Video reports are compelling, "voice of the patient"

Benefits of using video ethnography

- Identify gaps and opportunities in the system from the patient's perspective
- Uncover 'why' something is happening the way it is
- Explain discrepancies between what people say and what they do
- Illuminate needs that people can't always articulate explicitly

Limitations and alternatives

As part of an integrated approach to quality improvement, video ethnography provides a pivotal in-depth perspective from patients and families, helping us move closer to the ultimate quality goal of providing truly patient-centered care. However, video ethnography is just one method for learning from patients about their experiences. Other options to consider are including patients on improvement teams or using focus groups or surveys to understand patient experience. Each has its own advantages. For example, when just beginning improvement work in a new area, focus groups can provide a quick, broad overview of patient concerns.

Video ethnography is particularly effective at generating insights and hypotheses for quality improvement. Consider other methods instead of or in addition to video ethnography if your objective is to confirm hypotheses or to evaluate the impact of an intervention. Meeting these objectives generally requires larger sample sizes than is feasible with video ethnography and structured data that can be more readily quantified. For example, hypotheses generated from video ethnography could be confirmed with clinical data or a patient survey; the impact of an intervention could be quantified with a pre/post evaluation.

Some risks

As with every powerful tool, video ethnography has some risks. You will need to attend to several ethical and compliance issues, including informed consent, authorization for release of Protected Health Information, patient privacy, and data security. These are covered in the next section, Preparation Before Field Work.

The compelling nature of video ethnography can create a risk that your organization may want to "chase after anecdotes" and act immediately in response to individual patient stories. The remedy is to make sure you include patients in your sample that allow you to distinguish recurring themes from rare occurrences. The Preparation Before Field Work section provides guidance on adequate sample size. The Analyzing Your Data section will help you identify representative themes and opportunities for action.

What you'll find in the tool kit

| Preparing for Field Work | In the Field | Analyzing Data and Identifying Actionable Opportunities | Creating Video and Other Deliverables |

Ongoing Engagement and Collaboration with Q1 leaders and inprovement teams

This toolkit contains key information on the four main stages of video ethnography for quality improvement

• Preparing for field work: planning and study design
• Field work: interviewing, observing, and videotaping
• Analyzing data and identifying actionable opportunities: debriefing, coding, analyzing, and prioritizing findings
• Creating video and other deliverables: choosing illustrative clips, editing videos, creating additional materials, and translating learning into action

The Kaiser Permanente Care Management Institute website also provides access to additional tools, and templates we've used for our video ethnography projects: http://www.kpcmi.org/news/ethnography/index.html

Health care organizations and other groups are using video in new and exciting ways to capture patients' voices; for instance, giving them Flip VideoTM cameras to create video journals of their experiences. Ethnographic methods are also being used to develop new products and services in health care. Our toolkit is not intended as an exhaustive manual on how to use video to capture patient voices or to develop new products or services. We focus here on a single approach with which we have had success in rapid quality improvement among a number of teams.

The methodology we describe can be tailored and adapted for specific quality improvement purposes. For example, a physician quality leader joined our trainings and developed a modified approach he calls "The Patient In The Room" series. He interviews one or two patients each month, pulls out key themes from the interviews, and shares this information at quality meetings and with hospital leaders. He finds that this approach sets a new tone in the room, often inspires greater empathy for patients, can identify a problem that may impact other patients, and energizes the quality group in important ways.

"I was so anxious to leave that I was like…'Yeah, yeah, yeah, let's do this. I'm all packed. I've got one foot out the door. I got ready to take my medication after I got home; I looked at the discharge instructions and then at what the doctor had written, and they didn't jibe. It was as much my fault as anyone's, because I was rushing to get home…"

- Example quotation from a patient from video ethnography work.

Section 2
Preparing for Field Work

"Before anything else, preparation is the key to success. "
-Alexander Graham Bell

| Preparing for Field Work | In the Field | Analyzing Data and Identifying Actionable Opportunities | Creating Video and Other Deliverables |

Ongoing Engagement and Collaboration with Q1 leaders and inprovement teams

Five steps of getting started

Good preparation before starting field work is essential to a successful video ethnography project. There are five steps:

1. Develop a project plan
2. Design a sampling process
3. Construct an interview and observation guide
4. Establish policies to protect patient privacy and maintain data security
5. Recruit participants

This section also includes important considerations related to ethical issues, security and compliance, and other issues associated with videotaping patients and observing care delivery.

Step 1: Develop a project plan

To develop a project plan, carefully consider several questions:

a. What do you want to improve? What is your improvement aim and what might you need to better understand to reach it?
b. What is your timeframe for the project?
c. Do you have agreement and full alignment with leadership, management, and front line teams at the facility and in your organization about the project plan?
d. Have you developed a budget for the project?
e. Do you have a team to support the work? Have you determined roles for different team members?

Each step is discussed in more detail.

a. What do you want to improve and learn?

Clearly identifying the problem you want to solve or the question you want to answer will provide structure for everything that follows. Your project will be more efficient and effective, and you'll make the best use of the time of the people you interview and/or observe.

Video ethnography can help achieve multiple quality improvement objectives.

Any given video ethnography project can have multiple objectives. The objectives for your project will be determined, in part, by the current stage of improvement. Are you just starting to explore possible strategies and interventions? Wondering how well existing ones are working? Trying to identify ways to make what you're already doing even better?

Once you know your objective, think through the key questions that will help you achieve it. What information do you need? Video ethnography can be used at any stage in the improvement process, but we have found benefit in several distinct applications, each of which use ethnography differently and influence the design of the project.

Identifying priority areas for improvement.
Perhaps you are just beginning a new initiative to improve cancer care and aren't sure where to focus. The ideal ethnographic assessment would emphasize breadth – learning from many patients at various stages of the cancer journey – over depth in any particular aspect.

Generating ideas for tests of change.
Once you have an established focus and are ready to plan tests of change, ethnography could dive deeper into the patient experience in that area, identifying gaps, rough spots, or unmet needs.

Assessing change in progress.

Quality improvement projects rarely proceed directly from the starting point to an ideal solution; false starts and detours are part of the process. Interviewing and observing patients as they move through a small-scale pilot can help point the way toward refinements. The priorities for ethnography would be timely learning from patients early in the pilot and identifying any unexpected consequences of the intervention.

Preparing for spread.

Once an improvement has been demonstrated in one site, others may want to adopt it. Video ethnography at this stage would focus on showing how an improvement affects patients, identifying key components for successful implementation, and perhaps suggesting areas that could be further refined as the intervention spreads.

b. What is your time frame?

Time frames for video ethnography projects can vary. We have had the greatest success with short time frames that are consistent with the pace of rapid-cycle learning. The time frame for executing a video ethnography project will partly depend on several factors: the scope of the project, the number of team members involved in the project, the amount of time they can dedicate to the project, and the amount of data collected. More data means more time spent in the field and analyzing footage.

A typical project timeline is as follows:

Month 1: Project planning

Identify the aim, objectives, and key questions, gain support and alignment with leadership and front line teams, develop a project team, determine who to interview and/or observe, develop interview questions, obtain or develop the right consent forms to use, identify field work site (s), and recruit participants. (Note that recruiting participants may occur once you are in the field—but you can still plan your recruitment strategy.)

Month 2: In the field

Recruit participants, conduct interviews and observation and begin analysis

Month 3: Analysis

Watch videos, review field notes, code and analyze the data, share emerging results with leadership and other key stakeholders to get agreement on the most actionable opportunities, and refine analysis in priority areas

Month 4: Produce deliverables

Identify video clips that best illustrate highest priority opportunities, edit video to reflect key themes, finalize actionable messages in video, develop report of findings to supplement the video (optional), share the video, and begin translating learnings into action (for example, by deciding on small tests of change and piloting these)

c. Do you have agreement and full alignment with leadership, management, and front line teams?

This is a critical step in the planning process. Leaders, managers, and front line teams should understand that your project is for quality improvement purposes and is not an audit or a performance appraisal; staff may feel uncomfortable having you interview patients receiving care from them or staff may be uneasy being videotaped doing their work unless they clearly understand the purpose.

Consider creating a friendly flyer with an overview of the project and pictures of the members of your team; post it on bulletin boards throughout a clinical unit where you will be conducting videotaped interviews. Meet with staff during morning or shift change huddles to let them know about your project and answer questions. At Kaiser Permanente, local leaders will often send an email in advance to enlist the support of staff and physicians. Most importantly, be as transparent as possible, collaborating with local staff and leadership in designing the study and reviewing the results. Include them at every step of the process.

d. What is your budget?

Required resources and budgets for video ethnography projects vary with the scope of the project. Minimum requirements are a video camera and staff time to conduct the project.

We recommend using a small, unobtrusive, digital camcorder device of the type sold for home video use, rather than a large professional-level video camera. An external microphone option allows for better sound recording. Appropriate camcorders are in the $300-700 range, and external microphones can range from $200 to $300.

Video editing can be accomplished by a team member familiar with editing software, which may come with a camera or computer or be purchased for $200 to $1000. Alternatively, professional video editing services can make the project much simpler and less daunting and help to create a more professional looking video. Many large organizations have video editing capabilities in their communications departments; check to see if they can provide editing services for your project. Video editing costs may run from a few hundred to a few thousand dollars, depending on the scope of the project and the amount of time you contribute to content editing. Section 5 contains more details and tips on editing video.

e. Do you have a team to support your
video ethnography project?

A project typically requires executive sponsorship and a team to carry it out.
Sponsors can provide support for resources and funding, help break down
any barriers that arise, and are pivotal to translating project learnings into ac-
tion and operational changes.

We recommend at least two people for each video ethnography project. For
some projects, multiple teams can use the same interview guide in different
patients' homes or different settings across the hospital or health care system.
Multiple teams can collect more data in a short period.

Team members can play more than one role over the course of a project. In
the field, the two primary roles are interviewer and camera operator. After re-
turning from the field, primary roles for team members are support for analy-
sis (viewing videos, noting recurring themes, and clustering these themes),
and video editing or collaborating with a professional video editor.

Assembling a multidisciplinary team can bring useful additional perspectives
to bear on the problem or process you are exploring. Involving representa-
tives from operations, clinical care, improvement, and/or analytics in every
step of the video ethnography project enhances your results.

Video ethnography team members and roles

Project Lead	• Plans the project and leads all stages of the work
Sponsor (s)	• Supports the project by helping make staff time and budget resources available • Helps make sense of data by reviewing initial analysis, identifying most actionable opportunities, and reviewing video drafts • Facilitates translation of learning into operational changes
Team member (s)	• Supports Project Lead in all stages of the work • A minimum of one team member per project is needed.

Step 2: Design a sampling process

Designing a sampling process refers to deciding who you will interview or observe and where you will conduct the interviews and observations for a video ethnography project. The patients, family members, and/or staff interviewed constitute the project sample that is drawn from a larger population. The purpose of designing a sampling process is to ensure that the project sample is representative of the larger population, so that your findings are more likely to be applicable to other members of the same population.

Samples for video ethnography are much smaller than those used in traditional research activities. The aim is to obtain a deep understanding of the experience of a small group, not the breadth of experience within a larger one. In addition, the analysis phase is time-consuming, and the more data obtained, the longer it will take. While sample sizes vary, one person is not enough to see patterns across a group of patients, and one hundred is too many for quality improvement purposes. Often, patterns begin to emerge around six to eight interviews and with approximately two days of observation and interviewing. Once you begin to see patterns or recurring themes in the interviews or observations, you can consider stopping. There is typically a point of diminishing return from collecting data.

Two main approaches for choosing people to interview are convenience sampling and purposive sampling. In convenience sampling, you simply choose participants and processes to observe based on who and what is readily available. The benefit of convenience sampling is that it is easy; the drawback is that the sample is less certain to be representative of the larger population. Purposive sampling, on the other hand, actively selects participants because they reflect a variety of characteristics that make them more representative of the larger population of interest or because they represent extremes (such as frequent hospital readmissions).The drawback to purposive sampling is that it can be more time-consuming to find participants to interview and/or observe.

Many video ethnography projects use a combination of both strategies. See the box below for an example of identifying an appropriate sample.

Regardless of whether your sampling process is simple or complex, it's important to write it down clearly for staff helping recruit participants. A good description will also be important later, in explaining to others the degree to which participants were representative.

Example of Sampling Plan

Objective of the project: Understand patient experiences and needs as they transition from the hospital to the home, particularly high risk patients

Considerations: Understanding how patients in the hospital experience the transition to home might include patients with differing characteristics, such as age, differing levels of need for help at home (functional status), reason for admission, presence of chronic illness, and the like. This purposive approach would make sure that the sample was as representative as possible of the larger population of inpatients.

	Hospital #1	Hospital #2	Hospital #3
High risk Patients	6	6	6
Non-high risk	2	2	2

1. High risk recruits are 65+ years of age, with multiple chronic conditions and at least one prior hospitalization.
2. One high risk recruit is hospitalized for a common medically necessary
3. One or two high risk recruits are over age 80.
4. One non-high risk recruit is an otherwise healthy patient who was hospitalized for a common elective surgery (e.g., knee replacement).
5. At least half the participants are to be recruited while still in the hospital, to capture the transition process in action from the beginning. Others will be recruited post-discharge and will be able to share their experiences with post-discharge care and to provide reflection on their discharge experiences after some time has elapsed.

Key questions for designing a sampling process:

- What do you want to learn about?
- Where can you learn more about that issue? (e.g., in the hospital, the home, the clinic?)
- Who can you learn from?
- What are characteristics and behaviors you want to better understand? How might they help determine who you will interview (e.g., patients with diabetes only or patients over 65 with heart failure and enrolled in a heart failure case management program)?
- What processes can you observe that would provide important information?
- How many people should you talk with?
- How long might you spend in the field to begin to see patterns?
- Who will you include and who will you exclude from interviews?
- How will you recruit potential participants? (In advance, on-the-fly, or a combination of both.)

A sampling plan must also address where and when your interviews and observation will take place. Choose the location that is most relevant to the process you are studying. For example, learning about medication adherence would best be done in patients' homes, because that is where most patients store their medications, take them (or not), and order refills. In contrast, observing patients in their homes might not be the best location if you are studying care coordination for surgery patients. It might make more sense to shadow patients as they move from reception to preparation, recovery, and then a hospital floor or discharge.

The timing of your interaction with patients can be critical for some projects. In studying cancer care, for example, the experiences and needs of newly diagnosed patients will be much different than those of patients who have completed initial treatment. Aspects of treatment that loom large in anticipation may seem minor in retrospect and vice versa. You would want to include both perspectives in your project to maintain balance in assessing opportunities for improvement.

Step 3: Develop an interview and observation guide

You will need an interview and observation guide to focus your field work. To develop it, keep in mind the most critical information you want to obtain from patients and what key processes, events, or circumstances you want to observe. It may make sense to tailor your interview and observation guide to your sampling process, perhaps shortening your interaction for frail patients or going into greater detail with high-risk patients.

With the improvement team, brainstorm a list of topics that might be most important to learn about from patients. This will usually include provider communication, relationships, patient preferences, efficiency of care, comfort, and similar factors.

To develop your interview guide, start with general areas of inquiry and then develop more detailed questions under each. For example, a quality improvement project to improve programs for patients with heart failure might include the general inquiry area of "medications." Construct several questions and points of observation in that domain area.

Example interview questions and points of observation related to medications for heart failure patients

Interview questions	• Do you have a complete, easy-to-understand list of all the medications you should be taking? • What questions do you have about your medications, like which medications to take or when to take them? • Are you able to take your medications as your doctor or providers have recommended? • What is the hardest thing for you related to your medications?
Observation points of interest	• Can you show me where you keep your medications? • Can you explain and show me how you decide what to take and when? • Do you have a list of your medications and what they are and when to take them? Yes/No. If yes, can you show me that list? Can you walk me through how you use this list?

Open-ended questions are likely to elicit longer answers. They tend to start with words like Who, What, Where, When, How, and Why and phrases like "Tell me about." Close-ended questions result in short answers, often yes or no, and tend to start with words like Do and Can. Include both types in your interview guide. Insert follow-up questions (called probes) or reminders to yourself to help the conversation go deeper by asking questions about topics you haven't anticipated.

Considerations for developing your interview and observation guide:

• Start with a little small talk and easier questions that allow participants to warm up to the interview and the interviewer

• Use common, easy to understand language without jargon and acronyms

• Include prompts for you to elicit patients' stories while you are in the field

• Ask people to show you tools they use and point out important parts of their environment, whether the setting is patients' homes, the hospital, or an outpatient clinic

• Pre-test questions before you go out into the field, by asking a colleague or friend to role-play the part of a patient participant

• Do some training or coaching with your team to make sure everyone has had practice following the interview and observation guide

The Kaiser Permanente Care Management Institute website contains an example interview and observation guide and a template to help you get started:
http://www.kpcmi.org/news/ethnography/index.html

Step 4: Establish policies to protect patient privacy and maintain data security

Video ethnography raises many of the same ethical issues that arise with other types of data collection and observation in quality improvement work. Field work, particularly when it involves video, may bring up additional ethical questions because it relies on interacting with and recording patients and staff in the context of their daily lives. You record personal issues and problems and are exposed to protected health information. Make sure you have adequate procedures and practices in place to safeguard it.

Check with your organization's guidelines for the types of projects that require institutional review board oversight or approval; quality improvement projects may be exempt.

In addition, you may observe errors in care delivery. Before going into the field, we recommend that you develop a team strategy regarding how to handle any problems that come to your attention. If care delivery or safety issues arise in interviews or observation, notify local staff and leadership immediately. Safety comes first.

Informed consent

Work with your organization's legal advisors to develop suitable consent and authorization forms and processes. The consent forms must cover two related but distinct issues. First, the form must indicate that participants consent to be interviewed, observed, and recorded and that they consent to have their recorded images and voice used for quality improvement and education. Secondly, participants must authorize release of their Protected Health Information (PHI) for this purpose. Video recordings generally constitute PHI as defined by the Health Insurance Portability and Accountability Act, since the video associates an identifiable individual with their health information. Consent may not be sufficient to allow use of video if participants do not also sign a specific authorization for release of the PHI.

Data security

Follow all guidelines for protecting PHI and all HIPAA regulations. If you have any concerns, consult with your organization's legal, privacy, and/or ethics representative.

Tips for recruiting patients, handling equipment and storing data to maintain PHI security:
• When recruiting, keep patient information secure.
• Designate a team member responsible for ensuring that all video cameras and memory devices are accounted for and devoid of any patient information at the end of the day or as soon as possible after videotaping.
• In the field, keep your cameras with you and secure at all times. Never leave a camera, videotape, or any device containing PHI in a car for any period of time.

- Ideally, save all video on secure and protected storage devices and avoid or limit the use of open, external storage (e.g, usb memory sticks, un-encrypted or otherwise protected external drives.)
- If you must use an external drive, encrypt it before storing data.
- Use memory devices with limited capacity to minimize the number of patient images on any single memory device. In the event of the memory device being misplaced or stolen, the number of affected patients will be minimized.

Step 5: Recruit participants to interview and/or observe

Your project depends on successfully recruiting patients or staff to interview. In our experience, most patients and staff are eager and excited to share their stories to improve health care and to be videotaped doing so.

Some considerations for recruitment:
- Early in the interview or observation, confirm that the patient's characteristics match the sampling plan and that the recruiting process is yielding the participants you intended.
- Enlist local staff such as a nurse care manager who is close to the point of care to help you recruit patients. Recruitment is easier when a trusting relationship already exists.
- For home visits or longer interviews held in medical offices, we sometimes bring participants small thank you gifts. Be sure to check ethics guidelines in your organization regarding gifting policies.

Note on hiring external consultants to help you:
A host of consulting firms can help support your quality improvement video ethnography work. Our experience with several firms is that it can be helpful to have additional experts supporting the work. Consulting firms are particularly helpful when you lack sufficient staff to conduct a project, are first learning to do this type of work and would benefit from coaching and mentoring, and/or when a project is of a larger scale. The cost of hiring consulting support for video ethnography work can be substantial, but the value of expert assistance might be well worth the cost. Section 7 lists contact information for several firms.

Section 3
In the Field

"What people say, what people do, and what they say they
  do are entirely different things."
  -Margaret Mead

Preparing for Field Work	In the Field	Analyzing Data and Identifying Actionable Opportunities	Creating Video and Other Deliverables

Ongoing Engagement and Collaboration with Q1 leaders and inprovement teams

In the field work stage of video ethnography, three fundamental elements are important:

1. Play-by-play pragmatics
2. Asking good questions and being a keen observer
3. The ethnographic mindset

1. Play-by-Play Pragmatics

Like much quality improvement, video ethnography involves many details that must be addressed. These include how to prepare for the interview and observations before you leave the office, what to do when you first arrive at the site where you will conduct these, how to greet participants and begin the interview and observation process, and what to do when the interview and observation process is over.

Preparing for interviews begins with making sure you take with you everything you will need and that everyone involved knows what they are responsible for. Who will be the lead interviewer and/or observer and who will operate the camera? Make sure all equipment is charged and ready to go; bring extra batteries, all cords, and the camera manual. Bring consent forms and the schedule for the day. Review the interview and observation guide and bring it with you. Make sure you have contact information and directions to the interview location.

When you arrive at an interview or observation site, meet your local hosts and confirm where you will be conducting interviews and observations. Ask if there is space available for a "base camp" where the project team can huddle away from the participants to be interviewed and/or observed. Set up and test all equipment. Introduce yourselves to the staff in the area where you are interviewing or observing or ask your host to introduce you.

When you meet an interview participant, thank them for meeting with you and introduce the team members. Review the purpose of the interview and observations—to improve the quality of care—and ask to conduct an informed consent process. Remind the participant that they can ask us to stop filming at any time. Begin videotaping only after consent forms are signed. Confirm the amount of time the participant has free for the interview and/or observations. Turn the camcorder on, and ease into the interview with small talk and simple questions. At the end of the interview or observations, thank the participant. Keep the camera rolling—some of the best stories come as the team is walking out the door.

When the interview or observation is over, make sure that the camera is securely in your possession at all times until you return to the office. When you do return, protect personal health information by downloading data to a secure device as soon as possible. Once the data is safely stored, completely delete it from the tape or camera memory card. Store your consent forms appropriately for your organization and for ease of access for future retrieval. As a final gesture, send personalized thank you notes to all participants you interviewed and observed. Your data analysis will begin with a team debrief and brainstorming session shortly after the first interview; see Section 4 for details.

2. Asking good questions and being a keen observer

Ethnography—collecting original data through observation and interviews—is both an art and a science. This is an active process. Even though you developed an interview and observation guide, the most important tool is the ethnographer—you.

Start interviews by breaking the ice and asking easy questions. Asking participants to talk about easy topics, builds the trust and confidence that allows them to talk about more challenging ones. Establish rapport, build trust, be humble, and stay relaxed so participants can also relax. Maintain neutrality. Avoid comments that could be perceived as judgments (ask, "What was that like?", rather than guessing, "That must have been painful") and don't correct participants. Listen actively, let them talk, and allow for pauses and silence. Listen as though you have no experience with what your participant is describing.

Interview success is less about the structure of a guide and more about the behavior and attitude of the interviewer. The keys to a successful interview are humility, respect, empathy, gratitude that people are taking the time to talk to you—and genuine curiosity. Offer personal information about yourself very selectively to avoid letting your perspective, biases, or experiences interfere with how comfortable participants feel to tell their stories.

You will use the interview guide as a tool, but the key to video ethnography is following patients' cues and going where they want to go in terms of sharing information and experience. The guide will help you maintain balance between being open to letting participants direct the interview and making sure you get important feedback for the specific problem you are trying to solve.

Videotaping tips

Lights
- Tape in locations with good light or spend a little time prior to videotaping on improving the lighting wherever you are (close blinds, turn on lamps, etc)
- Make sure the participant is not backlit

Camera
- Do not film non-consented individuals
- Use simple, unobtrusive monopods or tripods to improve quality of the video
- For every minute you spend on an interview, you'll want a minute of watching something non-verbal
- Capture movement and interview while the participant is doing something, in addition to traditional interviewing where the participant is mostly sitting
- Be ready to pan the camera to things or people the participant refers to (e.g., papers from the hospital on the kitchen table)
- Capture body language and body position relative to equipment and/or environment
- Keep the camera rolling after the interview has ended. Participants often reveal something new just as you are about to leave

Audio
- Make sure you're getting steady sound
- Check your audio before starting an interview or observations
- Minimize noise. Close the door if you are in a hospital room and ask if the television can be turned off
- Don't be afraid to ask someone to repeat something if you lost the sound for a second

Special methods and techniques

While observation and interviews are the fundamental tools of ethnography, ethnographers have developed several specialized methods. Some of these are described below. There is no preset formula for deciding which method to use and when to deploy it. It depends on the context, the topic, and the participants you are learning from, so it is important to be flexible and nimble at moving between methods.

To begin, you may want to use the classical methods of asking, watching, and listening. You may also want to use different techniques to dig deeper.

Probes

Follow up questions, also called probes, are important to helping interviews deepen into more than an exchange of questions and answers. It is difficult to anticipate exactly what areas you will want more information about, so come prepared with some general probes that encourage participants to expand the conversation.

Show and tell

To avoid relying on participants' memories and to make information more concrete, participants can demonstrate or show you certain things, such as where their medications are stored and how they manage them or where they keep the hospital discharge instructions and the phone number to reach their provider. Asking patients for a tour of their care setting is a method for asking them to show and tell you more about their lives.

Similarly, asking a staff person for a guided tour through an area or process—such as a medication room in a clinic—increases understanding of process and routines and where opportunities for improvement may lie. You can ask participants to walk you through a familiar place, a daily activity, a process, or a routine. To go deeper into an area of interest, you can also ask them to sketch something. For example, we have asked patients to draw their support network, reminding them that stick figures, circles, and basic shapes are fine, and no artistic skills are needed. Sketches help probe deeper into patient experiences, revealing more about what matters to them.

For example, When asked to draw the people who help care for her, one patient listed her relatives, personally paid for home care worker, and friends. When we inquired why she didn't include any doctors or nurses she explained that she hadn't bonded with any. This was very important information that we hadn't understood yet.

Shadowing

This term and process is familiar to many healthcare workers. Shadowing blends observation and targeted questions as you follow someone wherever they go. It is particularly useful for better understanding the experiences of patients and clinicians, the challenges they face, and what opportunities exist to improve their experience. For instance, at Kaiser Permanente, we may shadow a physician interacting with patients, charting in the electronic health record, and catching up on email over the course of two or three hours or a

full day. Or we may shadow a patient and their family attending to their daily routines at home after coming from a hospital stay. The video camera may or may not be used, depending on the situation and whether or not informed consent is possible for everyone who would appear on camera. Insight from shadowing patients, providers, and staff is very powerful and helps strengthen data from interviews. Even if it is not possible to videotape the shadowing experience, the insights it produces help make the recorded interview you might do later that much richer.

3. The ethnographic mindset

A good interview combines the discipline of covering the quality improvement agenda and the openness of "going with the flow." It requires the interviewer to be fully present in the experience, self-aware and able to manage the impressions that others have of him or her. Fieldwork is absorbing, strenuous, and exciting—and it's highly personal. You are your main data collection tool.

Specific attributes of successful observational interviewers include:
• Openness and curiosity
• Ability to enter the participant's world
• Deep listening
• Asking Why? How?
• Picking up on the participant's use of language
• Looking for inconsistencies
• Working on multiple levels simultaneously: the content of the conversation, the cues of the participant, the interview guide, the quality improvement aim

Common mistakes to avoid:
• Interrupting participants
• Relying on questions that can be answered in just a few words
• Sequencing questions poorly
• Suggesting answers
• Positioning yourself as an expert

In video ethnography, the individual being interviewed or observed is the expert. The ethnographer's role is to build an understanding of the whole person, to learn how the world works from the participant's perspective by navigating through the flow of the interview and observation guide and forming questions that allow for more details to emerge. The participant can jump to any topic; the ethnographer reflects back what he or she hears, using the same language the participant uses in ordinary conversations. The ethnographer asks the participant to avoid holding back any information, even if it seems unimportant. The primary role of the ethnographer is to encourage detail by asking questions like, 'Can you think of more?' or "What happened next?" or "Can you show me where you keep your medications?"

Observe
• Activities
• Environment
• Interactions
• Objects
• Users

Pay particular attention to
• Workarounds
• Confusion or discomfort
• Discrepancies between what participants say and do

Section 4
Analyzing Data and Identifying Actionable Opportunities

"Not everything that counts can be counted."
-Albert Einstein

| Preparing for Field Work | In the Field | Analyzing Data and Identifying Actionable Opportunities | Creating Video and Other Deliverables |

Ongoing Engagement and Collaboration with Q1 leaders and inprovement teams

Turning 10-20 hours of raw field work footage into a compelling 5-10 minute video that motivates and guides performance improvement efforts can seem like a daunting task. The goal of this stage is to take seemingly unconnected stories and insights and group them into themes and patterns, identify improvement opportunities, and present the results in a compelling way. This takes place in four steps:

1. Debrief and identify a set of codes
2. Code video recordings
3. Analyze: tabulate, sort, and filter the data
4. Identify and prioritize improvement opportunities

Teamwork and multiple iterations are the key strategies for identifying actionable opportunities. Extracting meaning from interviews and observation isn't a job for one person to do alone. Teamwork transforms the analysis from an extended reflective activity to a rapid, dynamic process in which the team advances its thinking together. Set aside ample blocks of time for your team to work together.

Some rigor is required to identify recurring and compelling themes and confidently determine opportunities for improvement and action. We earlier noted the risk of 'chasing after anecdotes.' This can be prevented by determining that themes occur more than once. Even though the sample sizes for ethnography may be small, themes that recur a few times constitute data reflecting a pattern. Although this evidence has limitations, it supports improvement work by generating ideas for small tests of change.

When analyzing data, think in terms of developing a frequency bar graph, as depicted below. Focus on identifying discrete themes and the frequency with which they occur.
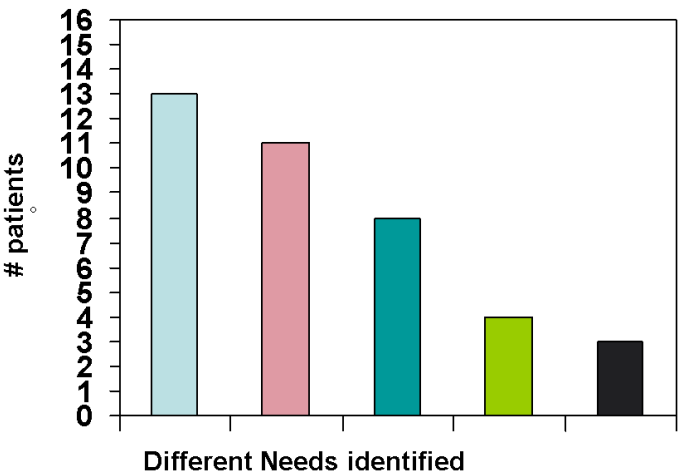
Step 1. Debrief and identify a set of codes

Daily team debriefs while you are in the field are a very helpful strategy for beginning to make sense of the large amount of data from interviews and observations. Debriefing serves several purposes. It surfaces what individual team members heard and observed and allows them to share learnings with each other. It creates an initial structure for further analysis of interview and observation data. Debriefing allows the project team to intuitively and collectively start to connect the dots in the data being gathered. This step is also a good time to integrate any other sources of data being used, such as other quality improvement or administrative metrics.

Debriefs begin with team members working alone with a large piece of form core or easel paper and a stack of sticky notes, like Post-its®. Write the first name of the person interviewed on the large surface. On each sticky note, capture a single detail, quote, or interesting anecdote from the observational interview. Write large enough so that it's legible to someone sitting across the room. Be descriptive—the purpose of debriefing shortly after interviews and observation is to capture the details. Arrange the sticky notes on the larger sheet in a way that makes sense to you.

The next step in debriefing is to share your notes with the rest of the project team. Tell detailed stories about what you heard and observed. As a team, discuss and debate the observations and the meaning behind them. Argue and reach agreements, go off topic and circle back to the observation being discussed. Debriefing surfaces the thoughts and interpretations of all team members; the goal is a robust discussion, not a tidy sorting of observations into categories. Embrace a diversity of opinions, rather than seeking group agreement.

Each team member alternates between working alone to capture what he or she saw or heard and working as a team to find the meaning behind observations and quotes. Team members help each other keep the original project goals in mind, even if a new direction is uncovered.

They refrain from narrowing observations into categories too quickly, and keep the patient in mind throughout the process.

On the last day of field work or within a week at the latest, hold a final debrief and brainstorming session with the project team. Identify a list of common recurring findings that emerged from interviews and observations. Once the team reaches agreement on the list of recurring findings, try to cluster it into between three and seven larger themes of issues or needs.

To identify themes, look for patterns in your findings. As you reflect on all the daily debriefing sessions and any notes you took during observations, think about processes, emotions, relationships, roles, time frames, types of people, beliefs, and the like. Start by grouping similar findings into themes. Then look at all the findings again, looking for differences this time. Do you need to group things differently or can your themes reflect tensions, as well as similarities? Look, too, for what's missing; what did you expect to find that isn't reflected in your findings?

In quality improvement, one important area of focus is needs or care gaps that patients, families, and providers identify. Explicit needs are stated ("It's cold in here," "He was late for my appointment"). Implicit needs are inferred by identifying gaps between what participants say or do and their ideal. For instance, a patient might say, "I was so healthy. It was disgusting. How can I have cancer, I feel so healthy to have cancer. Nobody smoked, you know. And then you go through the feeling that what did I do wrong?" The implicit need is for an explanation of why cancer developed.

At the end of the final debrief step, you should have a list of six to ten themes that emerged from your interviews and observations. Assign each theme a representative word or phrase, also known as a 'code.' Codes are labels that identify related information from interviews and observation. They refer to groups of thoughts that are neither too large nor too small. In quality improvement work, codes can be considered potential opportunity areas for improved care.

As you develop the themes and assign them representative codes, also flesh out definitions for the codes that capture the type of information in the theme. Developing the list of codes and their definitions may take some time. Allow ample opportunity for debate and discussion.

Example List of Codes and Definitions
(from a Kaiser Permanente project on improving transitions from the hospital to the home)

	CODE	Definition
1	Caregiver	How do caregivers and other family members help patients get needed care? The different roles family or friends take on as caregivers. The emotional impact (both good and bad) on various relationships. Also, the ways the family copes with stress, anxiety, and boredom.
2	Communication	The media, accessibility, and functions of contact from patient to providers, between providers, and from provider to patient or caregiver.
3	Discharge	The administrative and logistical mechanics of the day leaving the hospital. The physical and emotional experience of leaving the hospital.
4	Food	Issues around food choice, access, and consumption. How people see food as a component of health and healing.
5	Information	What patients/caregivers absorb, how they process, translate, store, and access information and learn. May include brochures, phone calls, instructions, and education given to patient or caregivers. How they learn about health, healing, care, or details of their particular illness
6	Living Situation	The social, emotional and lifestyle configuration of where and how patients live. Symbolic meaning of home, including associations with comfort, relaxation, safety, and home as a healing environment.
7	Medication	Issues around accessing, taking, and effects of medications. Patient and caregiver medication understanding, acquisition, management and use.
8	PCP	The value patients see in their PCP; how they describe the PCP's role.
9	Relationship to Provider	Patient feeling a personal connection with nurses, doctors and other staff. "Working" the system to make it deliver on the patient's needs.
10	Social Network	The role and impact of the people who are not primary caregivers but are concerned and. help or could help with life-management or social tasks. Includes people who the patient or caregiver bonds with because of similar background, understanding, or experience.

Step 2. Code video recordings

Your initial impressions about the main themes patients expressed are a great starting point, but now it's time to review the video recordings in detail and code the information they contain.

Coding observational interviews divides what participants have said into units of thought and applies labels to selected units. The purpose of coding is three-fold:
• To clearly link evidence from observational interviews with emerging findings
• To understand the strength and frequency of themes and opportunity areas
• To make it easy to later relocate key quotes or recorded segments

To code the data from observational interviews, use an Excel workbook (note that while there are several very good qualitative software packages available for coding purposes – for simplicity and ease of use, we recommend using Excel). The first tab contains codes and a brief definition of each, as well as space for noting additional comments. This will serve as a drop-down list on the next tab, which is the sheet actually used for coding.

Example of first tab in coding workbook

	A	B	C	D
1	Codes	Definition / Opportunity		
2	Satisfaction	Relationship is important		Additional points to consider:
3	Communication	Access to KP Cares, 1 number to call		**What's the need?**
4	They spend time	Good relationship betw member & provider		**What's the need not being met?**
5	Frail/elderly	Member cannot answer questions, other instances of physical or mental challenges		**What helps?**
6	Caregiver is important	Family cg, non family paid cg, facility as caregiver		**What doesn't work?**
7	Medications	Anything related to medications		**What's working & not in coding use +/-**
8	Pharmacy	Anything related to long term care pharmacy		
9	Continuum of care	Complexity of post hospitalization settings what experiences and needs are		
10				

| A. CodeDEFINITIONS | B. CODE sheet - Observations | C. First CUT Sheet for Video | D. Additional Video Revisions |

The second tab contains additional information, as in the headings on the example below. This is the code sheet, the primary tool for completing the coding of all interviews and observations. Additional examples and a template coding workbook are available on our website.

Example of code sheet

	A	B	C	D	E	F	G	H	I	J
1	Who	File Name	Code/Theme	Start (H:MM:SS)	End (H:MM:SS)	Quote / Observation Description	+/-	Great Footage! (x)	Notes	0:04:59
2	John	John01.mov	Communication	0:02:56	0:03:02	Waves to doctor.	+		Friendly relationship	0:00:06
3	Mary	Mary 02.mov	Frail/elderly, Satisfaction	0:02:35	0:04:01	"I used to walk to the market every day for fish. I can hardly get the mail today."	-		Recognition of change	0:01:26
4	Mary	Mary01.mov	Medications	0:00:03	0:01:08	Cabinet of meds. Very organized and plentiful.	+			0:01:05
5	John	John02.mov	Pharmacy, Communication	0:01:02	0:02:44	"My dad took care of me. Now I need to take care of him."	+	X		0:01:42
6	John	John01.mov	Satisfaction	0:01:00	0:01:40	"He just left me there."	-		Reason to switch	0:00:40

| A. CodeDEFINITIONS | B. CODE sheet - Observations | C. First CUT Sheet for Video | D. Additional Video Revisions |

To code observational interviews:

1. Open video in one window on a computer monitor and open the code sheet in a second window.
2. On the code sheet tab, note the first name of the subject and the specific name of the file you're working from.
3. Start the video. When you hear a great quote or observe something illustrative, note the video start and stop time, assign a code (or more than one) from the drop-down menu you create, capture the quote or observation in brief form, and make any needed notes (e.g., insights, thoughts, potential findings) for each data point.

4. Iteratively refine the codes and definitions. As you watch the videos, new codes may arise that did not emerge in the team debrief and initial code definition session.

5. Use the "notes" field (see last column in "Example of code sheet") to capture thoughts and ideas that come to mind as you are watching the video and coding so you can come back to them when you begin distilling the key insights and opportunities.

A segment from the video tape may have more than one code associated with it. For example, if a patient interviewed stated that "My doctor is great. She talks to you and she listens. She doesn't have her hand on the door knob. I wish all my other providers were like her." This segment may have two defined and focused codes associated with it such as "relationship with PCP" and "provider communication skills" and possibly a third more general and overarching code such as "facilitator" or "positive experience." Later on when you begin synthesizing and identifying patterns, you can sort the data by focused codes or you can filter for all the facilitators or positive experiences. Sorting and filtering your codes enables you to cluster the data so that you can determine frequency and intensity of themes and key aspects of patient experience or patient needs that emerged from your interviews and observations.

A note about transcripts
We use the method described here for coding for quality improvement purposes; it does not require written transcripts. Every hour of video costs $150-200 to transcribe. This can add $1500-2500 or more in transcription fees to the budget. Some people find that transcripts speed up coding and creation of the final video product; we have not found that to be the case. In contrast, it is our experience that coding while watching video allows deeper reflection on observations and interviews and recognition of visual cues that may have been missed in the field.

Step 3. Analyze: tabulate, sort, and filter the data

When you have finished coding all video recordings, sort the data in different ways. Count the frequency with which each theme emerged from interviews and observations. This step provides some quantitative data about the relative importance or weight of each theme; however, it is important to note that the frequency with which patients mention themes is at least partially dependent on your interview guide. The goal of this step is pattern recognition, making sense of the data, and synthesis.

You can create a frequency table like the one below to further identify the most common issues and themes that emerged.

Communication PCP Relationship to Provider	**Provider**	451
Just In Case Progress Recovery Activities	**Progress**	329
Caregiver Social Network	**Caregiving**	324
Discharge Information	**Informing**	270
Participation What Matters Most	**What Matters**	254
Food Physical Home Living Situation	**Home**	183
Expectations Prior Experience	**Expectations**	175
Medication	**Medication**	138
		1344

You can also sort the data by looking at the interaction of codes – for example, if you have a code on communication and a code for gaps in care, you could identify the communication factors that were identified as gaps in care. Sorting and filtering the data in different ways, along with conducting frequency counts enables you to see patterns in the data that facilitate identification of the most common and compelling improvement needs and gaps that can be translated into opportunities for improvement.

Step 4. Identify and prioritize improvement opportunities

When you finish tabulating, sorting, and filtering the data to identify the most common and most compelling codes, review the video segments associated with each code. Summarize the most common messages within each theme. Identify what's working for patients within each theme—and what isn't working.

The goal of this step is to distill the findings for each theme into a clear statement about what is most important to patients, what they talk about or do most frequently, and what they mention with the most intensity.

On the strength of the data, you may find that you can begin to formulate strategies to address the opportunities you identify. The key throughout this step is to remain firmly grounded in the experiences patients describe and demonstrate. Avoid jumping too quickly to problem solving or solutions – these are best achieved with the larger improvement team once you have distilled the most common, compelling, and actionable findings from the video ethnography.

Below is an example of output from the coding and analysis process that represents how to best distill learnings and facilitate creation of a video and other deliverables that is representative of the most frequent and compelling themes. The First two columns are developed from the debrief sessions and at the start of the coding process. The Third column results from coding and analyzing video recordings and tabulating, filtering and sorting the data (making sense of the data by extracting key takeaways and learnings). The Fourth column in the example below represents output from the process of identifying potential improvement opportunities.

Example: Defining the code, distilling key learning related to the code, and identifying potential improvement opportunitities (from a Kaiser Permanente project on improving transitions from the hospital to the home).

Code	Code definition	Key takeaway or learning (related to this code in particular)	Potential Improvement opportunity
Communicating and connecting	Transferring information from provider to patient, from patient to provider, and between providers; experiencing satisfying relationships with providers	Feeling connection and trust with providers is the foundation for communication. Although investing in building connections with patients may be time-consuming for providers, patients often do not hear the communication unless it occurs.	Because connection is a precondition to good clinician-patient communication, maximizing continuity of connections with a trusted provider might enhance communication during the transition from hospital to home.

With the potential opportunities to improve care identified, meet with operational leaders and the quality improvement team to determine which opportunities seem most actionable in the context of current quality improvement efforts. Use this prioritized list of improvement opportunities as the basis for the outline of your video. The next section walks you through translating learnings into deliverables that can motivate and guide action.

Section 5
Creating Video and Other Deliverables

"The real voyage of discovery consists not in seeking new landscapes but in having new eyes."
- *Marcel Proust*

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Ongoing Engagement and Collaboration with Q1 leaders and inprovement teams

Creating video and other deliverables based on your ethnographic project takes place in four steps:

1. Identify video segments that illustrate actionable opportunities
2. Create a video cut sheet
3. Edit video
4. Produce additional deliverables

Creating a video from the themes and recurring patterns that emerged from the coding and analysis process can be challenging. It's also where video ethnography departs most from other forms of video production. The video you will produce will be based on the key themes from patients' perspective and the most actionable opportunities that operations leaders and the quality improvement team have identified by working with the project team. Unlike other forms of video, your end product won't necessarily feature the most compelling stories or characters since they might not be most representative.

What's most important at this stage is the discipline to stay on message, know your audience, and focus on what is most actionable. Keep the takeaways and overarching message of the video simple. Your goal is to create a video that is no more than 5-10 minutes in length; shorter is better.

Step 1. Identify video segments that illustrate actionable opportunities

Review the video segments that best illustrate the most actionable opportunities identified in the previous step. To avoid chasing after anecdotes, look for segments that are representative of the entire theme; be aware that these may not correspond to the most emotionally compelling moments. The representative segments will become the basis for the deliverable you produce. In the next section, we dive deeper into how to create a compelling video and other action-oriented deliverables to inspire, motivate, and guide your improvement work.

Step 2. Create a video cut sheet

Begin by developing a video edit cut sheet to provide instructions for a professional video editor. It tells the video editor what segments of video go where, any voiceovers to include, needed subtitles or text, and the like. A re-organized and highly distilled version of the code sheet, the cut sheet can be created by cutting and pasting from the code sheet. Choose video clips that best represent the key opportunity areas or findings you want to highlight; one column on the template code sheet allows you to identify particularly good video so you can easily find it again.

Example cutsheet

Who	File Name	Segments	Start (H:MM:SS)	End (H:MM:SS)	Quote / Observation Description	0:04:59	Text in Video	Voice Over	Notes to Video Team
		"FBI" Warning				0:00:00	© 2010 by [DEPT], [ORGANIZATION] WARNING: It is prohibited to down load or re-record this video. This material is copyrighted to Kaiser Permanente's Care Management Institute all rights reserved [or other copyright depending on who makes the video].		
		Intro				0:00:00	Pharamacy Satisfaction		
		Background				0:00:00	In 2010, The Pharamacy Team wanted to explore opportunities for providing a better patient experience.		
		Communication					Speak to me plainly		
John	John01.mov	Communication	0:02:56	0:03:02	Waves to doctor.	0:00:06	John, Retired Teacher		
John	John02.mov	Pharmacy, Comm	0:01:02	0:02:44	"My dad took care of me. Now I need to take care of him."	0:01:42			
		Satisfaction					It's the basic things that keep me satisfied		
Mary	Mary 02.mov	Frail/elderly, Satis	0:02:35	0:04:01	"I used to walk to the market every day for fish. I can hardly get the mail today."	0:01:26	Mary, Mother of 5		
John	John01.mov	Satisfaction	0:01:00	0:01:40	"He just left me there."	0:00:40			
		Medications					Think like me: Understand my medication mental model		
Mary	Mary01.mov	Medications	0:00:03	0:01:08	Cabinet of meds. Very organized and plentiful.	0:01:05			
		Closing Thought					0:00:00	How might we cover the basics and offer more personalized service?		
		Credits					0:00:00	We thank the individuals appearing in this video for consenting to share their stories with us.		
							0:00:00	We thank the staff, physicians, and leadership at Oakland Medical Center for helping make this video possible.		
							0:00:00	This work is sponsored by Northern California, Kaiser Permanente Coalition of Pharamacists		
							0:00:00	This video work was led by: Elvie Sendosa Harold Maude, MD		
							0:00:00	Additional thanks to: Gloria Fontana		

A. CodeDEFINITIONS | B. CODE sheet - Observations | C. First CUT Sheet for Video | D. Additional Video Revisions

We recommend that you include a written message in your video stating that it was developed to support quality improvement and that all patients provided informed consent. It's important that your viewers understand that the objectives and methods of video ethnography are very different than a promotional or training video; especially important is the understanding that video ethnography highlights opportunities for improvement.

Step 3. Video editing

When possible, we recommend that video ethnography teams work with a multi-media specialist who can focus on the video editing while the teams can focus and direct the content editing. Work side by side with a professional video editor unless you're already adept at video editing. At Kaiser Permanente, professional video editors have helped us create videos that are more compelling than we could do on our own.

Do as much of the content editing and selection of clips as you can on your own to minimize the amount of professional editing time you'll need. Use common sense communication tactics when telling a story with video. Videos with no more than three or four segments are ideal. Begin with some voiceover and/or music and describe the context of the quality improvement problem or questions. Consider providing examples of what's working well, in addition to identifying challenges. Illustrate the gaps or most actionable opportunities. Start with a very powerful video clip to engage viewers and end with an inspirational one if possible. The following diagram outlines an effective rhythm for a five to ten minute video.

Example Rhythm for 5-10 minute video
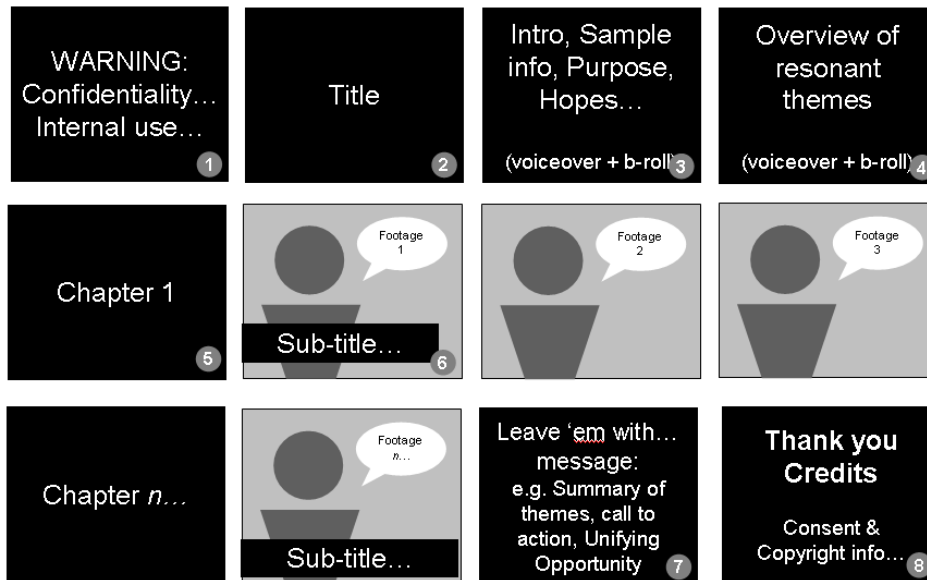
The cost for professional video editing is approximately $80-100 per hour; each video usually requires 10 to 15 hours of professional editing. Variables that impact cost of using a video editor include camera and video editing software compatibility, scope of the final video product, degree of professional presentation desired, and amount of advance content editing.

Share the draft video with multiple stakeholders in editing sessions. Stakeholders must be comfortable with the key messages, agree on actionable opportunities, and approve how both are presented.

Finalize the video when it has received approval. The editor can make DVDs or web links in a variety of formats, depending on its intended use. Work with a multi-media specialist to understand formatting options based on your needs.

Step 4. Produce additional deliverables

In addition, consider creating supporting materials, such as a PowerPoint presentation that includes information about:

- Sponsors
- Objectives
- Data collection methods
- Definition of ethnography
- Sampling process
- Analysis
- Findings (key takeaways and learnings)
- Hypotheses for further study and testing
- Ideas for small tests of change or for pilots
- Recommendations

Kaiser Permanente often produces PowerPoint reports addressing issues not illustrated in the final video. For example, these presentations contain insights we gained from interviewing staff; we often omit these from video so nothing distracts from the patient perspective.

These supplemental reports also often include recommendations. Adding too much text to videos can render them less compelling, so we use additional ways of sharing recommendations. A key question in relation to identified opportunities is, "How might we as an organization address this?" Thinking in terms of 'how might we …?" encourages idea generation ideas for small tests of change or pilot projects to improve care.

Remember … Think small. Think simple.

Video ethnography teams often feel that they could make several videos from the hours spent in the field. Be pragmatic. Make the most important video first, then consider if you have the time and resources to make more. Resist the temptation to make longer videos, too. In our experience, ideal videos are 5 to 8 minutes in length; longer ones are not as well received or broadly shared. Leaders and busy clinicians need to receive key messages quickly and with impact.

Finally, as is the case with small tests of change, the key to a successful video ethnography project is to avoid letting a goal of perfection or a large scope get in the way of a completed project. Small and simple is good enough when it communicates important findings in a compelling way.

Section 6
Case Study

Improvement for patients with heart failure enrolled
in Kaiser Permanente Southern California Region
Transitional Care Program

Video Ethnography project plan: To develop insights from patients on how we might improve the Transitional Care Program at South Bay Medical Center in Kaiser Permanente's Southern California region.

Aim: Improve 30-day re-hospitalization rate from 15.7% to 10% and improve reliability of program bundle of care measures from 61% to 95% over six months. Bundle includes assessment by inpatient nurse, home health nurse visit within 48 hours after hospital discharge, and outpatient care manager assessment within 1 week after hospitalization.

The challenge: This medical center had low performance on some of the program measures. Staff morale was somewhat diminished; they felt that perhaps their patients were just sicker than in other areas. Most importantly, the leadership and staff at this medical center were eager for a new way to drive improvement and decided to focus energies on applying the Rapid Improvement Model approach led by Kaiser Permanente improvement advisors.

What we did: To prepare for a kick-off meeting for this improvement project, we:
• Interviewed and videotaped multiple members who had experienced the program
• Created a 10-minute video
• Used the video and learnings for the project at a kickoff meeting for the quality improvement work to motivate and guide the work; also used the video throughout the improvement work with leadership and teams engaged in quality improvement; video also used across the medical center to raise awareness of patient needs and concerns
• We also interviewed and observed staff members and conducted an online survey of staff experience to which 38 staff/leaders responded and complemented the video ethnography with the data from other sources

Sample and time frame for video ethnography assessment:
• In-depth, semi-structured interviews in homes, outpatient clinic, and at the bedside in the hospital: 7 patients, 3 family caregivers
• Shadowed staff and observed 6 different program processes (home health nurse visit, inpatient nurse assessment, inpatient education, outpatient pharmacist visit, outpatient social worker visit, outpatient nurse visit, phone call to family caregiver, etc.)
• Interviewed 7 staff including physicians, program managers, social worker, care manager, pharmacist, and home health nurse (including 1 group interview)

Team and timeframe: We began planning for the video ethnography component of the improvement project in September and shared the completed video and project learning at the improvement project kick-off meeting in November.

What we learned: Patients and their family caregivers value the program intervention. Patients and families find that the disease is complex and that the hospital is a difficult place to learn.

Medication in particular was a key area of uncertainty and identified as a key opportunity area. Several patients and their family caregivers were unclear about medication management, which they accurately understood to be central to managing heart failure.

One patient explained: "When I first came out of the hospital I wasn't clear on why I'm taking 6 different types of heart medication. I had a visit with a home health nurse but she asked me for a list of my medications and I didn't have it on hand. I asked, 'don't you have that list?' If she had, then I wouldn't be in question about why I'm taking all these medications."

Related to the patient's experience, a home health nurse told us that she didn't have the information she needed: "it's like sometimes we're going in blind." Discharge instructions were not specific enough, and the home health nurses didn't have access to the electronic health record system while in the patients' home. Interviews with patients, staff, and program managers, along with a staff survey and pharmacist review, all clearly pointed to the fact that the medication reconciliation process was not comprehensive enough. Home health nurses did not have an accurate list for medication reconciliation; sometimes they had no list at all and sometimes they had two differing lists.

Results: Small tests of change were agreed upon and started day the day after the video was shown at the kick-off meeting for this improvement project. Home health nurses and a pharmacist started conducting medica-tion reconciliation over the phone when the nurse was in patient's home. The pharmacist accessed the electronic health record, and the nurse reviewed the medications the patient had at home side by side with the patient while the pharmacist joined the conversation telephonically. Together, the nurse, patient, and pharmacist conducted same-time comprehensive medication review and reconciliation.

This small test of change was coupled with other tests of change and a great deal of improvement work. The improvement work catalyzed by the video ethnography and other preparatory work was highly successful and a key to reducing readmissions at South Bay Medical Center from 13.7% to 9% in 6 months and improving reliability of the program bundle. Same-time home health, pharmacist, and patient medication reconciliation was subsequently spread across multiple medical centers throughout Kaiser Permanente and featured in several national reports on promising approaches for improving transitions in care for patients. The video from the ethnographic work is now used for training all new Transitional Care Program staff and for educational purposes across Kaiser Permanente.

For more information on Kaiser Permanente Southern California Region's Transitional Care Program, contact:

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Section 7
Additional References and Resources

For templates and examples and more information, go to:
http://www.kpcmi.org/news/ethnography/index.html

There is little written material about video ethnography for quality improvement; however, there is a strong academic literature on ethnography, a vast body of literature on quality improvement, and an emerging group of consulting practices conducting video ethnography. We've listed some sources for additional reading or consultation.

BOOKS AND ARTICLES

Basics for beginners

Program Evaluation: Methods and Case Studies (8th edition) by Emil J. Posavac and Raymond G. Carey.
This excellent guidebook provides a practical introduction to the skills, attitudes, and methods required to evaluate programs, including excellent chapters on qualitative methods and ethics.

Qualitative Data Analysis by John V. Seidel
Qualis Research, Qualis@qualisresearch.com, www.qualisresearch.com
ftp://ftp.qualisresearch.com/pub/qda.pdf
An essay on the basic processes in qualitative data analysis (QDA). It is a simple introduction for the newcomer.

What Are Standards Of Rigor For Qualitative Research?, by Gery W. Ryan, RAND Corporation
http://www.wjh.harvard.edu/nsfqual/Ryan%20Paper.pdf
Explains goals and measurement techniques for qualitative research. Compares qualitative research methods to quantitative research methods.

Ethnographic Research: A Key to Strategy by Ken Anderson
A short Harvard Business Review article that describes how Intel has used ethnography to inform strategy and long-term planning.

Specific topics of interest

The Ethics of Using Quality Improvement Methods in Health Care. Ann Intern Med. 2007;146:666-673.
This article discusses ethical requirements for a project to be classified as QI and/or human subjects of research.

Rapid Assessment Process by James Beebe
This book outlines the process, promise, and pitfalls of Rapid Assessment Process—a program evaluation technique that uses fieldwork and ethnography to provide high-quality research in a fraction of the time taken by traditional ethnography.

Data Collection Methods: Semi-Structured Interviews and Focus Groups by Margaret C. Harrell and Melissa A. Bradley, RAND Corporation
http://www.rand.org/pubs/technical_reports/2009/RAND_TR718.pdf
This RAND guide includes an overview of semi-structured interviews and focus groups, two techniques that are commonly used in policy research and applicable to many research questions.

Readings with a more academic focus

Analyzing Social Settings: A Guide to Qualitative Observation and Analysis (Sociology) by John Lofland and Lyn H. Lofland
Academic techniques of gathering, focusing, and analyzing qualitative data

Guide to sampling for qualitative projects
http://www.statistics.gov.uk/about/services/dcm
/downloads/AW_Sampling.pdf
This is a guide to sampling for qualitative research, and many of the same principles apply for QI purposes (with some relaxation of rigor).

Organizational Ethnography: Studying the Complexity of Everyday Life by Sierk Ybema (Editor), Dvora Yanow (Editor), Dr Harry Wels (Editor), Dr Frans H Kamsteeg (Editor) A collection of essays from leading scholars in organizational studies. The essays explore the special problems faced by organizational ethnographers, from questions of gaining access to research sites to various styles of writing ethnography, the role of friendship relations in the field, ethical issues, and standards for evaluating ethnographic work.

LINKS TO ORGANIZATIONS AND CONSULTING FIRMS

Consulting groups specializing in strategic ethnography

1. Point Forward
 www.pointforward.com
Point Forward helps customers develop insights and innovation based on ethnographic research. They pride themselves on crossing disciplinary boundaries, digging deep and challenging conventional wisdom.

2. IDEO
www.ideo.com/
IDEO (pronounced "eye-dee-oh") is an award-winning global design firm that takes a human-centered approach to helping organizations in the public and private sectors innovate and grow.

3. Ethnoworks
ethnoworks.blogspot.com
New dynamic consulting group with extensive experience working with Ascension Health and other organizations.

Other organizations of interest

1. Parc, a Xerox Company
http://www.parc.com/work/focus-area/ethnography/
Parc works closely with global enterprises, entrepreneurs, government agencies and partners, and other clients to invent, co-develop, and bring to market game-changing innovations by combining imagination, investigation, and return on investment for their clients.

2. Intel
http://papr.intel-research.net/index.htm
Intel's PaPR lab uses social science methods, qualitative and quantitative, to generate insights, models and demonstrations that help reframe 'what matters' to internal and external partners.

3. Ethnographic Praxis in Industry
http://www.epiconference.com/
The Ethnographic Praxis in Industry Conference (EPIC) aims to create a collaborative venue where those practicing their ethnographic training in the corporate setting can benefit from mutual support and sharing information.

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