

The Guided Team Discussion: A Standardized Process and Approach for Team-based Reflection and Management in Early Stages of Qualitative Data Collection

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ABSTRACT

Pressure exists in health services research for teams to collect and synthesize qualitative data rapidly. Lacking is a standard process to aid team-based debriefings during the early stages of data collection in real time. We propose a systematic team-based process and template for use during the data collection phase of qualitative studies and demonstrate the utility of the approach using a Veteran's Administration evaluation study. Guided Team Discussion (GTD) can improve the efficiency of team debriefing through a facilitated process that standardizes discussion format and sharing of learnings amongst the team on recently completed interviews. Notetaking of team debriefings is facilitated by the GTD template, which links team discussions to particular interviews and study time points. The GTD would be useful to researchers and clinicians who conduct health services studies with qualitative methods that require rapid recruitment and synthesis of results and to standardize notetaking of team debriefings.

KEYWORDS: Interview debrief, team analysis, qualitative methods, template, reflexivity

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Qualitative methods provide tools for understanding and improving healthcare systems by illuminating the complex, interwoven nature of care delivery (Jeffries et al., 2019; Scanlon et al., 2020; Weiner et al., 2011; Wood et al., 2020). They can reveal insights to improve healthcare delivery across roles (Qasba et al., 2022), settings/locations (Ramirez et al., 2022), and time (Arena et al., 2022; Sofaer, 1999). Yet, the value of qualitative studies may be undermined by the resources required to rigorously conduct such studies. Traditionally, qualitative data are dense, requiring time to collect, understand, and interpret into findings and recommendations (Pope et al., 2000). Experienced personnel are needed to recruit participants, collect and manage data, and complete analyses (Crabtree & Miller, 2022). Funds are needed for transcription and trained personnel (Frankel & Devers, 2000; Silverio et al., 2020). In addition, the need to rapidly inform policy and practice can constrain methods and challenge researchers (Abraham et al., 2021; Hodson, 2020; Skillman et al., 2018; St George et al., 2023).

To address these burdens, qualitative researchers are developing rapid analysis methods that increase efficiency while maintaining rigor. A systematic review of rapid qualitative evaluation methods in healthcare (Vindrola-Padros et al., 2021) found the most frequent reason cited for the use of rapid methods was "...the need for the quick turnaround of findings to inform decision-making, programs, or service delivery" (p. 17). For example, Rapid Qualitative Analysis (RQA) was recently used to understand healthcare needs during emergencies, like the recent Ebola or COVID-19 public health crises (Goulding et al., 2022; Johnson & Vindrola-Padros, 2017; St George et al., 2023; Vindrola-Padros et al., 2020). Yet, there is a lack of consensus on methods for rapid data collection and reporting findings. Analyzing interview audio recordings instead of transcripts to eliminate waiting for transcription was used with these investigations of public health crises, although others argue that qualitative rapid analysis methods are best used with transcribed data (Hamilton, 2020). Additionally, rapid qualitative approaches are recommended for certain study designs. For instance, Rapid Ethnographic Assessment Methodology, Quick Ethnography, and Rapid Assessment Process are recommended when using an anthropological study design (Beebe, 2001; Bentley et al., 1988; Handwerker, 2001; Vindrola-Padros & Vindrola-Padros, 2018). No rapid qualitative approaches have methods targeting efficiencies in team-based processes during data collection (e.g., while interviews are on-going) using any study design or methodology.

Though demonstrated as advantageous for implementation studies, periodic reflection templates and processes have not been documented outside of implementation studies and involve discussion with site key personnel, not within the data collection team (Finley, Frankfurt, et al., 2024; Finley et al., 2018; Geraci et al., 2022; Harvey et al., 2002; Livorsi et al., 2023; Melhado et al., 2023; Nancarrow et al., 2015). We agree with Abraham and colleagues, who noted that "...[t]he continued development of novel analytic techniques is important, as qualitative analysts require innovative tools to overcome the multiple—and sometimes unanticipated—challenges inherent in contemporary evaluation" (Abraham et al., 2021, p. 142).

There is a lack of team-based process methods and tools that are flexible to help researchers respond and adapt when rapidly collecting and synthesizing information about the dynamic landscape of healthcare in complex health systems. To address this gap, we developed and tested a systematic process, the Guided Team Discussion (GTD), for facilitated interview team debriefings during qualitative data collection. The GTD adds a tool to the toolbox for facilitating team reflection and debriefing during data collection conducted in a compressed time period (e.g., over a few weeks to month). The GTD can improve recruitment efforts and interview guide refinement based on learnings from the field (iterate) through use of a systematic team-based process to (1) debrief and reflect upon qualitative data in real-time (synthesize and reflect), and (2) standardize the discussion format during debriefings linked to interviews and study time points (notetaking). We believe it maintains the rigor stemming from the traditional qualitative method of

in-depth interviewing and accounts for the dynamism of multiple interviewers rapidly and simultaneously collecting data without making compromises upon analyses (e.g., choosing not to rely on transcripts for analysis).

Background

The Veterans Health Administration (VA) is the largest integrated healthcare system in the United States (U.S.). It provides healthcare for approximately 9 million military Veterans annually across 1,255 facilities located in every state, district, and U.S. territory (Veterans Affairs, 2023). Evaluating healthcare delivery in such a system is challenging because of the large number, variations, and complexities across VA employee roles, patient populations, workflow processes, clinical departments, and facility locations, and within a national infrastructure of systems. For instance, there are diverse VA care delivery sites (community clinics in urban, rural, or highly rural locations, and medium to large-sized medical centers), types of medical providers (specialists, subspecialists, and generalist providers), and services provided (preventive, procedural, and surgical services and treatment) to adult patients of all ages. Processes to facilitate qualitative data collection and synthesis based on large, complex settings are needed to ensure relevant questions about care delivery are asked and answered in an actionable timeframe.

Parent Project Background and Methods

The authors developed and piloted the GTD systematic process while conducting a one-year quality improvement evaluation aimed at identifying and understanding current strategies for providing high-quality, high-volume VA cardiology, gastroenterology, and oncology specialty care. In collaboration with our VA operations partners, the Office of Specialty Care and Office of Veteran Access to Care, we conducted a rapid evaluation focused on identifying (1) effective strategies, and related challenges, barriers, and facilitators, to providing high-quality, high-volume specialty care within VA, (2) key contextual factors impacting specialty care demand, supply of VA care, and use of non-VA community care, and (3) supply-demand specialty care team staffing models for future VA piloting. A rapid approach to data collection and analysis was necessary to inform national specialty care resource allocation decision-making. The evaluation was granted non-research determination. Evaluation participants provided verbal informed consent prior to participation.

The evaluation required a large qualitative team (9 staff) to rapidly recruit and conduct in-depth interviews with key informants in three specialties (cardiology, gastroenterology, and oncology) located at nine VA sites based in different regions of the US. The evaluation team was composed of a doctoral-level qualitative methodologist (GS), an analytic team lead (JY), study interviewers (SB, LS, KS, AM), and analysts (ML, JB, LS [KS and LS were both interviewers and data analysts]). JB was the GTD principal facilitator and note taker with backup from ML as needed.

We conducted 41 semi-structured interviews with key informants (15 cardiology, 11 gastroenterology, and 15 oncology) at nine VA facilities over 4 months (May-August 2020). Key informants included clinicians and staff involved in the delivery of specialty care and divisional and facility level administrators and leadership. Interview guides were developed to understand decision-making, and processes, around specific core specialty care services or procedures National Program Directors identified as high-volume referrals to community care (for instance, Cardiology provider's referring veterans to community care for stress tests and cardiac rehabilitation). We employed a rapid matrix approach to data analysis (Hamilton, 2020) which

involved completing templated summaries for each interview and then transferring the summarized data to a matrix, or table, in which columns were a priori categories or domains based on interview questions and rows represented data from each templated interview summary. Interview summaries and the matrix table were initially tested and modified by the analytic team through a team consensus process; new categories and subcategories were later added based on feedback from operational partners and insights gained through the GTD process.

Guided Team Discussions

We developed the GTD template and systematic process while studying VA specialists' decision-making and processes for referring patients to community care. The team was challenged by how to facilitate analysts' understanding and collect highlights of interview data concurrently as initial sense-making ideas arose.

Methods

The authors developed, modified, and piloted the GTD. We describe the GTD process for generalized use and potential refinement, not to share specific results from the project wherein the team developed the GTD.

GTD Systematic Process

The authors participated in the GTD process during weekly analytic meetings. The GTD facilitator led the structured team discussions about interviews completed during the previous 7-10 days. Based on experience with conducting semi-structured interviews, the team agreed upon three main questions to guide the discussion (see Attachment):

1. What was the key content you learned from this participant (or main points from interview)?
2. How did the interview go? Is guide refinement needed?
3. Is there any information shared that we should follow-up on (including new people we should talk to)?

All team members participated in the discussion, asked clarifying questions, and reflected on completed interviews. Interviewers referred to their interview notes while debriefing the team for a GTD. The methodologist and analytic lead provided institutional contextual information, kept the team aware of the interview objectives, and fine-tuned recruitment efforts based on shared data. The facilitator documented the discussion points, any decisions made, and actions taken for each interview using the GTD template. GTD templates were saved by meeting date in a study folder accessible to all team members. During data analysis, completed GTD provided notes on the timing of interviews, dates associated with emerging ideas, and team discussions/decisions/actions about recruitment or guide changes. Codes and their definitions identified during GTDs were added to the code book.

Field Experiences

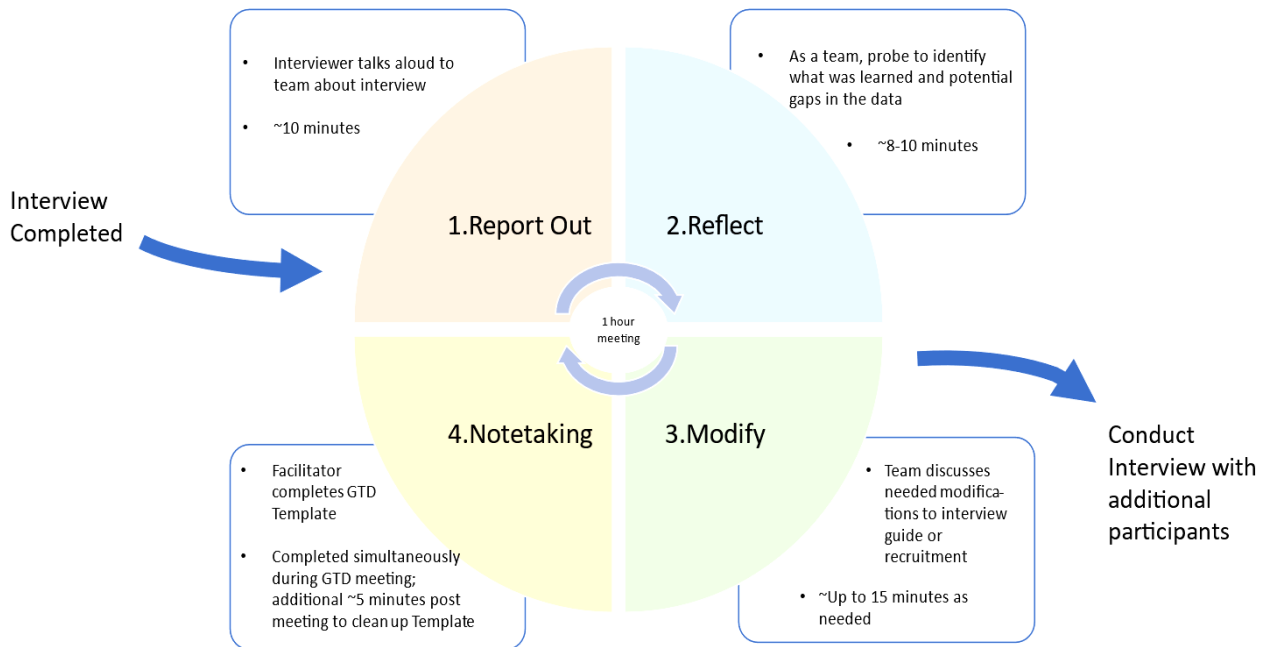
Thirty-four of the 41 interviews (~45 – 60 minutes in duration) were debriefed by GTD processes during 17 (1 hour) meetings over 5 months (83% in total [see Challenges of GTD Process for explanation]; GTD templates were completed for interviews with 10 Cardiologists, 11 Gastroenterologists, and 13 Oncologists).

Experience in Developing GTDs

The focus of the GTD discussions changed over time. Early data collection discussions focused upon study design, recruitment, and quality of information collected during interviews with key informants and other participants. Once the interview guide and recruitment strategies were refined, the GTD centered around data content, identifying potential matrix (sub)categories, and synthesizing understanding across interviews. For instance, team insights regarding cross-site comparisons were not gained until several months of GTDs were completed--representing a developing understanding of the data collected.

The GTD process systemized and added rigor and consistency to the data collection and early stage of the analysis process. The team developed the GTD process to achieve the following two goals: (1) reflect, synthesize, and iterate—to establish a process that facilitated team-based revision, modification, and sharing of contextual knowledge during a rapid pace of interviewing; and (2) document—create a standard process and template to capture notes on team discussions. These goals were met by following four GTD steps to report out, reflect, modify, and note take (Figure 1). The steps were followed for each interview debriefed by the GTD process. The team leaders (the project manager and qualitative methodologist) used GTDs to inform their answers to questions from institutional stakeholders about “what are you hearing?” following key informant interviews.

Figure 1
Guided Team Discussion Process



GTD Steps 1 – 3 were followed to achieve the goal of Reflect, Synthesize, and Iterate:

1. Step 1 – Report out – The interviewer talked aloud to the team about an interview’s content. GTD facilitator guided the team discussion following the GTD Template questions (see Attachment).
2. Step 2 – Reflect – Team members asked questions of the interviewer to identify what was learned and potential gaps in the data collected during that interview.
3. Step 3 – Modify – Team members discussed any needed modifications to the interview guide or recruitment efforts based on what was learned from the interview.

To achieve the goal of documenting, the GTD facilitator completed Step 4.

4. Step 4 – Notetaking – Facilitator notes on the GTD Template the team discussions, decisions, and actions associated with that interview.

We found that the GTD process supported data collection in multiple and important ways. GTD helped the project manager target snowball sampling recruitment efforts based on a developing understanding of local contexts at sites and among specialties. As an example, one GTD elicited new information from an interview with an RN who coordinates telehealth care for veterans in need of GI care in highly rural settings. The team learned that another RN worked closely with the GI provider to coordinate care in the community for homeless veterans. The GTD Template noted for the interviewer to “...get contact information for [RN and GI provider named]”. This type of new recruitment leads was noted in the Template’s “Team Discussion” section and provided a reference for updating the study recruitment tracking log. GTD further helped the team identify the revisions to the interview guide. Based on initial interviews with key informants, the team learned contextual details that allowed refinement of interview guide questions. For instance, initial GTDs identified that interviewers needed more time to adequately cover the interview guide

content, and there was some confusion in portions of the guide's phrasing. Having the team of interviewers present during GTDs allowed the analytic team (interviewers, analysts, and Analytic Lead) to reach a consensus on interview guide modifications and simultaneously notify interviewers of the modifications. Additional benefits included providing feedback on conducting interviews. With interviewers reporting on how well the interview guide worked during GTDs, the discussion gave an opportunity for the team to consider changes to probes or nuances of questions to support high-quality data collection.

The team found a particularly helpful aspect of the GTD process was the sharing of content knowledge to build contextual understanding across the team. The GTDs allowed interviewers to inform team members of contextual information and local processes at study sites and specialties gathered during initial interviews. Sharing subject matter expertise among team members was beneficial to identify and remediate gaps in the team members' knowledge or understanding of specialized topics (e.g., clinical specialties) and unique contextual factors (e.g., institutional history), since team members had varying levels of tenure and experience with the institutions and understanding of the specialties studied. This process enhanced interviewer knowledge of healthcare policies for the institution and region. The sharing of contextual (medical and institutional) knowledge amongst the interviewing team was instrumental in supporting the rapid pace of high-quality data collection. Finally, on a few occasions, the GTDs identified missing pieces of information from an interview and provided the qualitative methodologist an opportunity to suggest a follow-up question be asked of the interviewee. This could occur in a prompt fashion since the interview content was discussed in a GTD within a week and a half of the interview. The timing may have enhanced recall and likelihood of a response from the interview participant.

GTD Process for Early Stages of Analysis

The GTD process facilitated early analysis. The GTD process was instrumental in developing an early understanding of the breadth and depth of data collected and provided early feedback and interim findings to operational partners. Interviewers identified what the participants believed to be key features and hindrances to providing specialty care. It allowed initiation of the analytic process during data collection as a team, and led to a more expedited, informed, and productive formal analytic process (e.g., early identification of themes across interviews, identification of potentially salient differences between sites and respondent types and informed the code book/matrix for analysis). As an example, debriefing an interview with an oncology social worker, the team discussed and documented (on the GTD Template) ways in which specialty service lines were being "flexible" and variable in staffing community care coordination. As a result, a new subcategory ("community care structure/staffing") was added to the matrix. This insight during a GTD was the spark of an idea that (through analysis of the entire data set) resulted in the finding that oncology used a range of effective workflow and staffing approaches in meeting the needs of veterans living far from a VA medical center. By synthesizing information during data collection, it also gave an opportunity for team members to reflect upon and try to neutralize assumptions about the factors involved in the specialists' decision-making for referrals to community care. The role of GTD was additive to (but not replacing) matrix analysis. In summary, by using the GTD Template and process, the team's analytic thoughts were (1) captured in "real-time," (2) linked to a particular study participant and when the insight or understanding occurred in the data collection timeline, (3) suggested new analytic categories and subcategories for use in matrix analysis, and (4) identified preliminary findings or data points that could be reported to key stakeholders.

Notetaking

To enhance the trustworthiness of findings, researchers are expected to maintain records of discussions and decisions made while conducting qualitative studies (Wolf, 2003). Qualitative teams are encouraged to maintain notes on discussions that lead to modifications in study design, interview guide content, coding (including identification of codes), and discussions on data interpretation. It can be challenging to consistently collect important aspects of team discussions while teams are busily sampling, recruiting, and interviewing participants before more formal coding and analysis begins. A standard note-taking template may help. We found the GTD Template and process created a structured, yet flexible, team-based process to take notes linked to the individual interview and recruitment phase that prompted the discussions. Previously, our team practiced noting discussions and decisions made during code team meetings using memo functions contained in the qualitative data management software, yet a standardized template and process for notetaking during recruitment and collection of data (inclusive of timing and rationale) were missing until we developed and piloted the GTD Template and process.

See Table for how the GTD process was used for the example VA study and example notetaking from a GTD in May 2020.

Table 1

Example Application of Guided Team Discussion Process and Notetaking

GTD Goals	GTD Steps*	Step Description	Application in Example VA Study & An Example GTD (May 2020)
Reflect, Synthesize and Iterate	1. Report Out (~10 minutes)	Interviewer talks aloud to team about interview	<ul style="list-style-type: none"> • Interviewer used interview notes and recollection to answer GTD Template’s 3 main questions** about a recent interview • Contextual information (role and site) reported <p>Example GTD:</p> <ul style="list-style-type: none"> • “Office of Rural Health (ORH) has funded sites to have at-home and center-based cardiac rehab programs. The Program requires FTE. Once funding is lost, cannot support the program. Interviewee talked about needing staff and type of staff needed. Everything is on hold now due to COVID.” <p><i>Early in data collection phase:</i></p> <ul style="list-style-type: none"> • Interviewer and team reflected on what was learned for VA region, local processes, and type of specialist interviewed for team-based knowledge acquisition • Relevant institutional history and policies discussed • Follow-up question(s) drafted for any missing information from an interview. Interviewer contacted participant to ask follow-up question(s) if needed • Team discussed any preconceived assumptions about site and/or respondent type <p><i>Additional in later data collection phase:</i></p>
	2. Reflect (~8 minutes)	As a team, probe to identify what was learned and potential gaps in the data	<p><i>Early in data collection phase:</i></p> <ul style="list-style-type: none"> • Interviewer and team reflected on what was learned for VA region, local processes, and type of specialist interviewed for team-based knowledge acquisition • Relevant institutional history and policies discussed • Follow-up question(s) drafted for any missing information from an interview. Interviewer contacted participant to ask follow-up question(s) if needed • Team discussed any preconceived assumptions about site and/or respondent type <p><i>Additional in later data collection phase:</i></p>

Document		<ul style="list-style-type: none"> • Team discussed insights regarding cross-site and respondent-type comparisons • Codes identified and linked to data collected as relevant (e.g. “Follow-up appointment_in VA”)
	<p>3. Modify (~7-10 minutes)</p> <p>Team discusses any needed modifications to interview guide or recruitment</p>	<p>Example GTD:</p> <ul style="list-style-type: none"> • “Cardiac rehab went for 3-4 years. [Site A] was able to get their VA to support the Program. [Site B--the interviewee’s home site] did not find ongoing support. [Site A] pitched it to their leadership.” • <i>As needed:</i> Recruitment strategy and log updated by Project Manager to tailor continuing recruitment efforts • <i>As needed:</i> Interview guide revised to address gaps <p>Example GTD:</p> <ul style="list-style-type: none"> • “[Methodologist]-guide is eliciting the things we need. Want to think about re-interviewing participants once we get the analysis going. This will be very focused questions. How is a site pulling off home-based cardiac rehab? What are the barriers to support financially? Are they using economic data? It has been described as cost effective. [A different interviewee] said COVID has given the opportunity to do all visits virtually. This may change process of how things work and address barriers (distance and space). • May follow-up with [Site A] (through email) – what was your pitch to leadership to sustain this? Determine what works and doesn’t work. Delve deeper into the cost analysis if it’s perceived to be cost effective.”
	<p>4. Notetaking (simultaneous during discussion plus ~5 minutes post-meeting to clean up typographical errors)</p> <p>Facilitator notes team discussions, decisions, and actions</p>	<ul style="list-style-type: none"> • GTD Template pre-populated with recent interview information specifics prior to GTD meeting (e.g., participant #/role, specialty, interviewer initials, date of interview) • Facilitator takes detailed notes onto GTD Template about team discussion • Decisions and actions are detailed and linked to team discussion and meeting date • Facilitator saves GTD Template by meeting date in study folder <p>Example GTD:</p> <ul style="list-style-type: none"> • Noted above in Table

Note. *Steps are repeated for each interview conducted
 **See Attachment - Guided Team Discussion Template

Challenges of the GTD Process

Some interviews were not discussed during the first half of the GTDs. This occurred because the facilitator did not prompt interviewers on which interviews had been recently conducted, resulting in the omission of some interviews during GTD meetings. This issue was remedied by the GTD facilitator prepopulating the GTD Template's demographic information with recently completed interviews before team meetings.

As with team debriefing during coding and analysis, there is bias introduced when one person shares their thoughts about the data they have collected or analyzed. This is a particular risk with the GTD process since the interviewer debriefs each interview. We attempted to handle this bias by practicing reflexivity (Rankl et al., 2021) and paying close attention to data sharing that countered other data or the team's developing interpretation. The team worked to ensure no data were discounted following the established validation strategy to attend to disconfirming data during data analysis (Creswell & Poth, 2018; Mays & Pope, 1995, 2000). Further, the understandings stemming from GTDs were always understood and represented to institutional partners as preliminary. Ultimately, we chose to err on the side of gains from enhanced team communication and learning during data collection instead of protecting against the potential introduction of bias from team debriefings. Yet, the absence of a methodology is a limitation. The importance of considering the introduction of bias, or a potential limit upon data richness, from team-based debriefing is particularly salient for exploratory research questions and methodologies (and may be less impactful when using an explanatory study design, such as was used in the example VA study). We describe herein a novel product created to fill a need while conducting research, and we did not adopt a methodology to guide the work while piloting it. Consideration of the GTD from a methodological perspective is worthy of consideration in future assessments of the GTD process.

We anticipate that if other research teams utilize the GTD process, limitations in the current template design and/or developed process may be identified. Modifications to the GTD may be needed based on study design or methodology. As an example, pragmatic research with a rapid analysis approach may not need the amount of debriefing included in the GTD process as a study that uses grounded theory methodology may need. Also, editing the GTD Template to have few to no prompts for interview debriefings for an exploratory study design may be needed to maintain the organic nature of sense-making in these types of studies. The GTD Template is modifiable to meet study needs.

Discussion

Evaluating care delivery within large healthcare systems is a worthwhile endeavor. It can facilitate understanding of the complexities and processes of care delivery and resource usage across a system that may improve care for many (Segal et al., 2019). Processes are needed to facilitate understanding of data collected in near real-time (reflect and synthesize), focus data collection efforts (iterate), and create standardized notetaking of team discussions (note-taking) to ensure questions are asked and answered timely with rigor. The GTD Template and process can meet these demands.

We developed the GTD systematic team-based process based on facilitated processes, similar to periodic reflections for implementation studies (Finley et al., 2018). GTD facilitated understanding and supplied opportunities to iteratively improve the caliber of data collection, target recruitment efforts, and share learnings amongst the data collection team. GTD expands upon periodic reflections by applying the process to a new setting (evaluation of healthcare delivery

instead of implementation research) and enhances the data collection process and analytic understanding. We believe GTD offers a standardized facilitated process of team reflection during data collection and a process to document team discussions and insights during rapid data collection and early stages of analysis for complex (multisite and multispecialty) qualitative studies.

Learning Health Systems (LHS) is an approach to improving quality and delivery through healthcare teams working to improve their health system (Agency for Healthcare Research and Quality). A LHS, by definition, functions within a complex health system. It is an approach designed to harness data from multiple sources within the health system to rapidly design, evaluate, and implement changes based on the evaluation and assess the impacts on the quality and delivery of healthcare (National Academy of Medicine, n.d.). The GTD can provide a standardized process and documentation tool for LHS teams. It could be used as a team-based process and tool for organizational learning and engaging stakeholders (components of the “bodies of work” of LHSs in the LHS Consolidated Framework (Easterling et al., 2022)) or used with several LHS construct themes as defined by Rajit and colleagues (Rajit et al., 2024). Munoz-Plaza and colleagues followed an LHS approach to assess care delivery within Kaiser Permanente in Southern California, serving 4 million members across 14 medical centers (Munoz-Plaza et al., 2016). They delayed edits to interview guides until initial interviews were transcribed and cited a lack of resources to include patients during their evaluation. The use of the GTD process and tool may have offered efficiencies to help integrate learnings for interview guide edits quickly and allow these authors to include patient interviews. In another study of a large integrated health system located across 3 states in the southern U.S. (with >14 million patients and >40 hospital locations), Eaton and coauthors conducted a study to inform an intervention on sepsis prevention (Eaton et al., 2024). They described iterative rounds of piloting and revising their interview guides based on “...research team members’ perceptions of the usefulness of the data collection instruments,” without noting how they documented and synthesized the team’s feedback (p. 4). An LHS approach is ripe for standardized processes to document rapid qualitative data collection efforts and facilitate team learning to ultimately improve care within the LHS. The GTD can fill these gaps in LHS research team processes as it uses a common team-based process (debriefing) and provides an easy-to-use tool to facilitate standard documentation of research team perceptions and decision-making.

Dissemination and Implementation (D&I) Science seeks to shorten the time needed to disseminate health-related evidence to its adoption by clinicians (practice) and impact health system policies (Kwan et al., 2022). Study designs and methods, like D&I science, that can shorten the 15-year average for research findings impacting healthcare delivery or policy (Khan et al., 2021) are needed. The use of D&I science in LHS studies has been noted (Trinkley et al., 2022). As described above, periodic reflections are one method used in implementation science studies. The RE-AIM framework is a widely adopted framework to guide the evaluation of D&I efforts within the healthcare (Buckler et al., 2024; Finkelstein et al., 2024; Glasgow & Estabrooks, 2018; McCarthy et al., 2024). The Implementation in RE-AIM (the “I”) gathers insights from the local context to understand how frontline staff and clinical settings view the program or intervention being implemented. The Rapid Implementation Feedback (RIF) report can help implementation teams condense and communicate information about local contexts, yet it is by D&I framework domains (Finley, Chrystal et al., 2024). The GTD is a worthy method for consideration in D&I studies since it provides, for any study design, a standardized team-based process method to efficiently capture team debriefings of qualitative data collected about local context from multiple interviewers. It captures and communicates relevant contextual factors across the interview team, like the RIF report, but adds standardized reflective and notetaking processes for any study design. It could also be used in addition to periodic reflections since the GTD is focused upon the research

team processes while the periodic reflections method is principally focused on understanding implementation fidelity at local study settings.

Future adaptations of GTD could include applications to mixed-methods studies to support systematic qualitative and quantitative team collaboration and integration in D&I science. Community-based participatory research (CBPR), grounded theory, and other methodologies with reflexivity built into their processes are additional applications for the GTD. As an example, having community partners included in the guided team discussion could operationalize community partner inclusion in knowledge creation during research and provide a valuable reflexivity check for the data collection team (see an illustrative CBPR example in (Garbers et al., 2020).

Recommendations for best practices for teams to manage qualitative data are established (Fernald & Duclos, 2005; Giesen & Roeser, 2020). Yet, they are focused on the middle to later stages of data collection and analysis once transcripts or summary forms are available and more formal analyses have begun. An established process for teams to maximize their ability to quickly adapt to capture all relevant data when multiple people are collecting data and sharing of information could be delayed or missed is particularly valuable. It is also helpful when there are a limited number of individuals to interview in an institutional role (e.g., the head of a specialty care department, such as a Chair of Cardiology). Further, GTD bridges the gap between interviewers and analysts by intentionally bringing these team members together to describe, reflect on and clarify data—especially beneficial when teams have different people collecting and analyzing data. We argue that the GTD process should be considered for researchers to gain efficiency during the recruitment and data collection phases of a study without sacrificing the interpretive value of their data.

Quality assurance or rigor is key to trustworthiness in qualitative research (Guba & Lincoln, 1989; Morse, 2015). Since qualitative research is an interpretive science, the validity of the process of sampling, data collection, analysis, and determining findings are important considerations. Using a structured process to document the research steps as well as reflections (to minimize biases) and decisions made by the researchers during multiple study phases can strengthen the trustworthiness of conclusions drawn from the data (Morse, 2015). Creswell and Poth (Creswell & Poth, 2016) emphasize the importance of incorporating several validation measures into the research process and suggest there are multiple strategies to accomplish it. Using an interpretivist theoretical perspective to qualitative research, Whitemore et al. (2001) argue for a reflective perspective, also called reflexivity (Haynes, 2012), from researchers to enhance the validation of the study design and findings. Their four main criteria for validation are credibility (Are the results an accurate interpretation of the participants' meaning?); authenticity (Are different voices heard?); criticality (Is there a critical appraisal of all aspects of the research?); and integrity (Are the investigators self-critical?). Reflexivity practices, especially within a team context, ensure rigor by encouraging open discussion and triangulation of various research team members' perspectives on the data collection and analysis at hand (Rankl et al., 2021). The ongoing deployment of reflexivity enables the ongoing accounting of different interpretations of data and the mitigation of biases, which the GTD process supports.

The GTD process and Template can provide a systematic team-based validation strategy for reflexivity in qualitative research studies, thereby enhancing the trustworthiness of results (Morse, 2015). It also facilitates reflection among the research team around their assumptions and biases present during data collection (described as confirmability—a measure of trustworthiness of the qualitative findings (Lincoln & Guba, 1985)), and efficiently captures team discussions associated with when and which data were discussed (as suggested for confirmability and dependability of qualitative analysis (Guba & Lincoln, 1989)). It facilitates timely sharing of

contextual information learned during data collection across a team of interviewers. As suggested by Creswell and Poth (Creswell & Poth, 2016), a validation strategy can “...embed opportunities throughout a study for writing and discussing connections that emerge with our past experiences and perspectives” (p. 260).

Implications

We found the main benefits of using GTDs were (1) improved effectiveness of data collection during the early stage of conducting interviews; (2) a defined systematic process to facilitate and document team discussions, including rationale, decisions and corresponding dates (amongst interviewers, qualitative methodologist/lead, and analysts); (3) a structure to facilitate synthesis of insights as part of a team’s analytic process; and 4) formatting that fits rapid data collection and reporting needs. Secondary benefits from GTD included (a) a systematic process to keep the interview team informed of revisions to the interview guide; and (b) facilitate targeted recruitment efforts. We believe the GTD can be used when studying any type of healthcare setting (such as primary care or urban or rural healthcare centers). A large team of interviewers may require scheduling longer GTD meetings to sufficiently debrief recent interviews.

Conclusions

The GTD team-based systematic process can be a valuable method to use in qualitative research. It helps researchers to be responsive to their early recruitment and data collection efforts, build understanding and maintain reflexivity amongst a team of interviewers and analysts during data collection, and consistently take notes of team discussions and decisions made. GTD is a novel and feasible method for use earlier in the research process than other published team-based methods. It operationalizes how qualitative teams can maintain rigor during data collection for any type of study using qualitative methods. GTD can maximize effectiveness and efficiency by employing a systematic approach when time constraints require large teams to work nimbly and efficiently to meet project aims.

Declaration of Conflicting Interests

The Authors declare that there is no conflict of interest.

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