

*Conversation as a mechanism of change: a cross-case analysis*

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*Abstract**Conversation as a mechanism of change: a cross-case analysis*

**Background:** Health care researchers and other attempting to implement changes in health care settings often find that interventions do not progress as expected. In particular, unexpected conversation emerges. The purpose of this paper is to elucidate the role of conversation in shaping interventions and the role of interventions in shaping conversation.

**Method:** Using observational data drawn from across studies from a fourteen-year program of descriptive and intervention studies undertaken to understand and assist primary care practices to initiate and sustain improvement changes, we develop a theoretical argument for the role of conversation in implementing health care interventions through several iterations of cross-case analysis.

**Results and Discussion:** Our analysis indicates that conversation in health care organizations plays a surprisingly important role in the success of attempts to implement interventions aimed at improving health care delivery. Interventions can profitably be thought of as conversation generators and enhancers and that this takes place in the context of the practice's relationship system. Conversation in health care organizations is challenging because of information asymmetries and the need for confidentiality, among other things. Within health care institutions, sensemaking and learning are critical and often overlooked, and conversation is essential for effective sensemaking and learning to occur. The likelihood of intervention success will increase if the role of conversation is considered in the intervention design and implementation. We recommend several actions as strategies for using conversation to leverage improvement: evaluate existing conversation and relationship systems, evaluate the potential of an intervention to generate good conversation, look for and leverage unexpected conversation, use conversation to help people manage uncertainty, use the intervention to reorganize relationships, build social interaction competence, and create time and space where conversation can unfold.

**Conclusions:** Conversation is challenging in health care organizations because of information asymmetries and the need for confidentiality, among other things. Within health care institutions, sensemaking and learning are critical, and conversation is essential for effective sensemaking and learning to occur. The generation of productive conversation should be considered as one of the foundations of implementing change efforts.

*Conversation as a mechanism of change: a cross-case analysis**Introduction*

Conversation is ubiquitous in organizations, but is easily overlooked for its potential role in the success of attempts to implement interventions aimed at improving health care delivery (see Table 1 that follows the stories below)<sup>8</sup>. During the course of our fourteen-year program of research we noted an assortment of puzzling events that brought the pivotal role of conversations in interventions to our attention. The three stories below illustrate the types of events we observed.

Practice 42

Stone Wall Clinic, owned by a large hospital network, is a small two physician practice in a suburban setting, which, on the surface, appears to be doing well. The physicians and office manager initially seemed excited to be part of the ULTRA study (Using Learning Teams for Reflective Adaptation) and were hopeful the Reflective Adaptive Process or RAP meetings would improve some “small interpersonal problems.” We were also optimistic about how the RAP process would enhance the relationships. We were stunned when, after only the first few RAP meetings, the intervention and the relationships hit a stone wall. Belligerent conversations were breaking out everywhere. Dr. Malice began complaining aloud about staff issues and inconsistent and unhelpful meetings with his partner, Dr. Bulldog. The office manager created disruptive conversations throughout the practice including arguing with the RAP facilitator and frequently deflecting practice problems to the hospital network. Dr. Bulldog said the RAP meetings detracted from generating revenue and weren’t productive and then complained that he worked harder than everyone else. Staff began talking more about all of their problems but not at

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the RAP meetings out of fear of potential repercussions from the physicians. Within weeks, the RAP sessions were abandoned and the doctors ceased talking with each other.

### Practice 39

Stillwater Family Medicine was a three physician practice with a receptionist and a medical assistant. Just prior to beginning the ULTRA study, they purchased a pediatric practice about 10 minutes away but decided to do ULTRA only at the Stillwater site. Prior to the first RAP meeting, a new office manager was hired, there was some conflict between the medical assistant and receptionist, little sharing of information, and a lack of team decision-making. For example, Dr. Push wanted more patients steered to Dr. Hinder while staff wanted patients directed away from him because it disrupted patient flow. As expected, early in the RAP meeting process, one of the staff indicted the doctors for their different disruptive styles. We were stunned when, by the fifth meeting, the RAP team was handling 2-3 issues every week. The doctors seemed quite comfortable letting staff speak up and voice disagreement and listened as staff members made suggestions. We discovered there were many conversations going on outside of RAP that were helping the work of the RAP team. Even more surprising is that two years later, the practice is still having RAP meetings every 2 weeks and has expanded these to include the second site.

### Practice 34

Camp Kommand Family Medicine is a large practice occupying two floors of a professional building in suburbia. The long-time office manager (OM) closely directs all operational matters for the practice, and seeks to maintain stability so doctors can just focus on doctoring. She has a no-nonsense, command and control, directive style that rewards staff according to her vision of the smoothly operating medical office. With suggestions from the ULTRA facilitator, the practice formed a RAP Team consisting of OM, Dr. Krunch, and key midlevel supervisors. The latter consisted of individuals closely connected with OM, but, unfortunately, also seen as 'her favorites' among the large practice staff. The RAP team initiated constructive conversations. While these conversations brought forth some new and helpful ideas, OM would often reframe issues to fit her agenda and stifle the emergence of truly creative ideas. At the same time, however, a general distrust of the RAP team and 'what they were up to' rippled through the practice leading to fear that RAP team activities might endanger some jobs. These unanticipated

conversations became so disruptive that OM asked the facilitator to meet separately with the rest of the practice to address these fears and provide reassurance.

The purpose of this paper is to discuss the role of conversation in shaping interventions and the role of interventions in shaping conversation, and to identify aspects of this interdependency that are important in efforts to implement significant change in health care organizations.

Our team has engaged in a program of research to understand and assist primary care practices to initiate and sustain improvement changes. This program of research included both descriptive and intervention studies, as noted in Table 1.

(Table 1 about here)

This program of research began with two descriptive studies, one largely quantitative and focused on the clinical encounter (DOPC) and the other largely qualitative and focused on the organization and structure (P&CD). A careful analysis of these two cross-sectional studies resulted in the design of an intervention to enhance cancer screening (STEP-UP). The implementation strategy incorporated the use of facilitators and a tool kit of tactics and it focused on the tailoring of each intervention to the specific practice in question. The interventions had a significant [1] and sustained effect [2] on cancer screening rates. Nevertheless, there was wide variation in response to the intervention with some practices making large enhancements and others not changing at all. This was an unexpected outcome.

Therefore, we undertook a secondary analysis to better understand the discrepancy and this resulted in an organizational change model [3]. This model supposes that change requires action, and a particularly important action is conversation [4]. The four elements of the Change Model for Quality Improvement in Primary Care Practice are 1) motivation of key stakeholders, 2) resources for change, 3) motivators outside the clinic, and 4) opportunities for change. Also critical are the dynamic interdependencies among these elements. Conversation can be a primary vehicle for making the elements and their interdependencies visible and salient, thereby enhancing the likelihood that an intervention will be effective.

This work led to the design of an intervention study focused on enhancing the quality of relationships among members of a practice [5]. In our attempts to implement this intervention we focused on tailoring the intervention to the practice and on building relationships. Over time the role of conversation emerged as an important facet of the practice environment.

Through an examination and comparison of diverse and unanticipated responses of clinics to our interventions, we began to notice some similarities among events, and, to recognize occasions when an intervention qualitatively changed conversations in a clinic. For instance, in Practice 34 and Practice 42 our intervention did not progress as expected because unanticipated conversations emerged. Sometimes conversations changed the effect of our interventions for the better in ways we did not expect, as in Practice 39 where unanticipated conversations were generated and changed the relationship system in positive ways. Upon further reflection we came to more fully appreciate that it is often through conversations that relationships are constituted, and that conversations are often the mechanism for relationship change. It is important to note that relationships shape conversations, and conversations may also shape interventions. In the clinics described above, relationships within the clinics changed as a result of conversations initiated by our intervention attempts. We now propose that interventions can profitably be thought of as conversation generators and enhancers and that this takes place in the context of the practice's relationship system. We further propose that the likelihood of intervention success will increase if the role of conversation is considered in the intervention design and implementation.

We consider conversation to be a collective process in which meaning and organization are jointly created through the interaction of linguistic exchanges improvised in real time [6-9]. Conversation usually takes place through face-to-face interaction, but it may also occur in written mediums, as when conversation is mediated by technology in virtual on-line discussions [10] or through an electronic medical record (EMR).

In the remainder of this paper, we note that complex adaptive systems theory is a useful framework for conceptualizing healthcare organizations and for seeing the role of conversation in clinics. We clarify what conversation is, distinguishing it from notions such as instruction-giving and information-exchange, and specifying characteristics of good conversation and barriers to good conversation. We explore ways in which conversation can affect change in clinics by improving key organizational actions: sensemaking, learning, and reflection. Finally, we suggest specific activities for stakeholders as they seek to understand and use conversation

effectively as an important aspect of successful health care interventions. Throughout, we present observations from our own intervention studies aimed at improving clinics.

*The Role of Conversation in Family Medicine Practices as Complex Adaptive Systems*

Family practices as complex adaptive systems are constituted by nonlinear interdependencies within a network of diverse agents [11-14]. The relationship systems among agents lead to self organization and emerging order and are the key properties that define these systems [5, 15-17], which therefore have structures, processes, and functions that resemble living organisms more than they resemble machines. Because a complexity view acknowledges fundamental uncertainty in the unfolding of system change, we must broaden our conception of interventions beyond core actions and outcomes. We must consider dynamic patterns, interrelated processes and relationships, and be open to unintended and unpredicted consequences. Because complex adaptive systems theory recognizes the centrality of interdependency and connectivity in the organization of systems, it suggests that we design interventions that attend to the quality of relationships within a practice and between a practice and its environment.

From a complexity view, relationships among practice members are critical and it is largely through conversation that relationships are constituted. Conversation becomes the mechanism by which relationships evolve and conversation supports self-organization and emergence. In addition to building and maintaining cohesion, conversation can also facilitate disruption and change by creating opportunities for new properties to emerge in a system as we saw in Practice 39. Conversation that has gone bad can also block productive change as we saw in Practice 42.

*Defining Conversation in Clinics: What Conversation is; What it is Not*

The literature on conversation leads us to the conclusion that a definition of conversation requires three concepts: collaboration, meaning making, and improvisation. First, conversation is a social act of collaboration [9, 18]. Spoken or written turns, or comments, are traded back and forth, and each turn relates in some way to the turn before it. These verbal exchanges are often amplified and clarified through non-verbal signals such as facial expressions, hand gestures, and body posture. Because neither the sequence, allocation, or content of conversational turns are

pre-specified, participants must make an implicit agreement to collaborate by trying to understand one another and to be understandable to others [6, 18, 19].

Second, exchanges between participants lead to collectively generated ideas, the meaning of which arises in the interaction among turns [20]. Thus, rather than information being simply passed intentionally and without change, meaning is created as conversation is jointly constructed.

Third, understanding among individuals can not be assumed because conversation is not scripted, but is collectively improvised. Neither ritualized nor random, it falls somewhere in between [6]. Some aspects of conversation are pre-determined and have become predictable by historical usage and convention [21]. For example, in the standard medical history-taking sequence the physician inquires about symptoms, the patient responds, and the physician acknowledges and evaluates [22]. At the same time, every conversation is unique and unpredictable in its unfolding. Patterns of relating and meaning continuously emerge from infinite configurations of situations and participants locally adapting themselves to contingent conditions [6].

Conversation can be distinguished from instruction-giving and information exchange in which ideas are passed around but not created; or speeches, in which talk time is monopolized and turn taking is nonexistent. Talk that is unidirectional, with all turns allocated to one party, does not qualify as conversation because it is not jointly constructed. Such is often the case during large group meetings. Also, talk that elicits no real meaning is not conversation. An example is the highly ritualized sequence of, “Good morning, how are you?” “I’m fine, how are you?” We participate in these rituals so often that we make no new meaning from them. Thus, in our conceptualization these types of relatively empty exchanges are not considered as conversation.

While it is tempting to equate conversation with face-to-face forms of communication, our definition of conversation includes written exchanges when they are characterized by the necessary conditions of collaboration, meaning making, and improvisation. Increasingly, conversation is mediated through technology and occurs in written form, sometimes asynchronously and sometimes virtually [23, 24]. The particular nature of computer-mediated conversation seems to affect aspects of discussion differently than face-to-face conversation. For instance, greater equity, greater task focus and less socio-emotional focus have all been

associated with computer-mediated conversation [25]. In primary care the emergence of EMRs offer exciting opportunities for virtual conversations involving patients, physicians, and practice staff.

*Good Conversation: Conditions, characteristics, and barriers*

Not all conversation is good conversation. Some even argue that much of our daily talk within organizations does not qualify as conversation, but is instead information exchange or formulaic, ritualized exchange [26]. In our own research we have heard many times, in interviews with clinic members, variations on the following theme: “We talk all the time in this clinic.” We are often struck by how much of that talk seems to fail to create new meaning for practice members. As with other professional organizations, talk that goes on in clinics can lack imagination and can be recursively uncreative, generating few new ideas, knowledge, questions, or actions .

Good conversation typically requires time, space, and trust. Conversational context emerges when participants know each other well enough to behave with sensitivity toward one another and to pace the discussion appropriately. Good conversation depends on diverse partners being responsive in their interactions [20] with empathetic listening, paying attention, questioning each other, suspending assumptions, and expecting and dealing with misunderstanding. Good conversation is deep and rich, and comes about when topics are broad, relevant, and personally meaningful to participants. Clear, specific goals can keep talk focused on the topic rather than on the speaker or the listener. At the same time, valuing “big, broad questions” allows goals to develop and change, and may help a clinic stay energized, forward-moving and grounded in its values and mission [27]. In Practice 39, the physicians’ willingness to let staff speak up and voice disagreement and to listen as staff members made suggestions, likely contributed to the success of the RAP intervention.

Gratton and Ghoshal [27] identified three types of conversation that may be particularly beneficial to health care interventions: disciplined debate, creative dialogue, and intimate exchange. Disciplined debate can be a source of vigorous questioning, ensuring that relevant information is available within a group. Intimate exchange supports trust-building through the display of emotions that establishes authenticity and mutual appreciation. Creative dialogue is

deeply grounded in facts, but also in the hopes and aspirations of everyone present. Appreciative inquiry is an additional conversational research method found to enhance change efforts [28].

As in other professional organizations, patterns of interaction within healthcare clinics tend to become routinized in “systematically-organized modes of talking” called *discourses* [21]. Discourses are necessary and helpful in that they give expression to the meanings and values of an organization. But dominant discourses also create a barrier to good conversation by their propensity to colonize and overpower other ways of thinking, acting, and conversing; and thereby decreasing the ability of clinics to change [3, 21]. The situation seems to be exacerbated in healthcare organizations, which tend to be siloed by specialty, each with their own dominant discourses between which few ties are forged [29, 30]. This may have been operating in Practice 34 where the RAP team consisted mostly of mid-level supervisors affiliated with the controlling office manager.

A particularly negative effect of the tyranny of dominant discourses is their tendency to dampen the diversity of perspectives essential for good conversation. Diversity can also be dampened when people are overly polite. Although politeness moves are necessary and act as a lubricant for conversation, they can also be a barrier to conversation if people engage in them because they are worried, because trust has not developed, or if large power differentials make people overly-wary [31]. Too much agreement too quickly can shut down conversation, thus limiting conflict, respectful argumentation, and diversity of ideas needed to create and evaluate opportunities for change [32]. A sense of certainty on the part of clinic leaders can stop good conversation because even though clinic members may perceive that a particular matter needs more discussion, they may act as though the matter is settled because they believe there to be little sense in discussing it [33]. Finally, conversational capacity can be diminished when participants fail to engage in empathetic listening, because listening is often the main behavior of people engaged in conversation. People may fail to listen empathetically when they think they know what others will say, assume agreement, focus on themselves instead of focusing on a topic, or tune out because they don't perceive that they will get a turn [34].

*Key Actions: Sensemaking, Learning*

In a complex adaptive system it is through sensemaking and learning that improvements occur. These in turn emerge from the system of relationships and can be mediated through good conversations [35, 36].

*Sensemaking.* In order for practice clinicians and staff to embrace change, it is critical that they be able to make sense of the purpose of the change (e.g., clinical reminders will promote better outcomes for patients with diabetes). “Sensemaking is a diagnostic process directed at constructing plausible interpretations of ambiguous cues that are sufficient to sustain action” [4]. Sensemaking is “an issue of language, talk and communication” [37]. Through conversation, people make sense of the circumstances in which they “collectively find themselves and of the events that affect them” and they create the basis for action to deal with those circumstances and events [38]. Practice staff and clinicians may fully understand the specifics of an improvement change (such as preventive care reminders) but it is through conversations that staff produce a shared vision of how change will improve care of their patients and will enhance real adoption of the change. Through conversation people organize their group thinking about a problem, jointly develop possibilities for coordinated action within and between systems, check assumptions, and facilitate decision-making that leads to action [4]. Accepting and implementing core interventions may require practice members to make sense of their new situation. Through conversation, practice members make sense of improvement changes and possible new identities [i.e. who am I in this situation?]. Such collective sensemaking might take the form of narrative storytelling used to interpret a surprising event. Sensemaking narratives “tend toward the nonlinear, with multiple story tellers/creators contradicting and interrupting, justifications offered, multiple possibilities presented, and dilemmas delineated” [39]. Such conversations were typical in the evolution of the RAP team in Practice 39.

*Learning.* In order to adopt change, a practice must modify its perceptions, beliefs, actions, and behaviors. Language is the medium through which humans think, and conversations are the medium through which individuals think together [7, 18] and through which organizations learn. When practice members converse with each other, they learn about their own thoughts and ideas and they collectively generate new ideas. Successful adoption of change has been found to be associated with conversations and collective learning processes in

healthcare teams [40]. Unfortunately, learning is often blocked in health care organizations by the ways that the members are socialized and by existing routines and status relationships, and this in turn blocks conversation and successful implementation of change. Thus, it is less important to understand and tell others what to do than to create an organizational environment in which learning is highly valued and in which people listen to and respect insights and understandings that are different than their own [41, 42]. Creating an environment in which learning is highly valued was part of the impetus for the use of RAP team in ULTRA.

*Recommendations for Enhancing the Role of Conversation in Improving Interventions*

Stimulating and supporting good conversation suggests a set of specific actions that can be undertaken in primary care practice to enhance relationships and increase the likelihood that positive change will be initiated and maintained. Practice members should attend to generating productive conversation as one of the foundations of their change efforts. We suggest the following actions as strategies for using conversation to leverage improvement change.

1) *Evaluate existing conversation and relationship systems.* Conversation is an ongoing aspect of clinic life that continuously shapes the way members perceive their environment, their patients, and their tasks. Pre-existing relationships can be a barrier or a facilitator of intervention attempts. Intervention change agents must determine to what extent these relationship systems are likely to encourage productive conversation. They shouldn't overestimate their ability to predict the conversational potential of a practice, and instead continually observe, assess, and evaluate [43]. When relationships are strong and conversation is thriving, these should be leveraged to support change.

2) *Evaluate the potential of an intervention to generate good conversation.* Potential interventions vary in the likelihood they will generate good conversations, and it is important to assess the potential for both anticipated and unanticipated conversations. Key questions implementation designers should consider include: Are there activities in the intervention that

seem designed to generate conversation? What aspects of the intervention might create barriers to good conversation? How might good conversation clarify and accelerate the change process? Do elements of the intervention initiate rich encounters? Does the intervention process facilitate relationship building and the key organizational actions of sensemaking and learning?

3) *Look for and leverage unexpected conversation.* Complex adaptive systems theory suggests that existing conversations will take unexpected directions and change agents need to capitalize on the positive potential of unexpected conversations and manage potentially negative conversations that they did not predict and can not control. They should be on the lookout for how the intervention *is* changing conversation and for how it potentially *could* change conversation, given that the relationships in the practice and the intervention are unfolding together. They should also be open to the unique circumstances of fortuitous happenings that occur as conversations are collectively improvised [6]. For instance, in Practice 34 the RAP facilitator was able to manage the unexpected conversations occurring outside of RAP that might have undermined the intervention.

4) *Use conversation to help people manage uncertainty.* In these turbulent times uncertainty is a constant feature of the primary care landscape, and will be exacerbated by serious change efforts. Significant change often requires interruption of established discourses and conversational patterns as well as modification of perceptions, beliefs, actions, behaviors, or even identities [40]. Intervention strategies must stimulate conversation that will help people prepare for, make sense of, and reflect on the anxiety and uncertainty that role change creates.

5) *Use the intervention to reorganize relationships.* Interventions can often be designed to change how often people talk to one another, what they talk about, and the ways in which conversation unfolds. The intervention should promote conversation among new discussants and create new meaningful discourse. In Practice 39 the RAP process began with participants from the initial practice and evolved to include at first selected individuals and then integrated the second site into a single set of conversations.

6) *Build social interaction competence [44].* Acknowledging that conversation is a critical component of all interventions, change agents should help people associated with an intervention (insider stakeholders and outside stakeholders) pay more attention to conversation. It is important to assist practice members to seek feedback about their conversational efforts and teach them to utilize strategies that might enhance conversation, such as inviting respectful

argumentation, disciplined debate, creative dialogue, and intimate exchange [27]. They should facilitate people's understanding of conversational barriers so that they might develop strategies for tearing them down; for instance, by inviting diversity and engaging in empathetic listening. In Practice 39, the intervention encouraged the doctors to respond positively to staff' criticisms, disagreement, and suggestions and enabled the RAP team to explore new ideas that might otherwise have been stifled as was seen in Practice 42.

7) *Create time and space where conversation can unfold.* Most practices feel that protecting time for conversation is not practical in the hectic primary care environment. Nonetheless, rich conversation is a critical part of adapting an improvement change and making it successful. Given the dynamic, recursive, and iterative nature of change, a critical task of the change agent is to create and protect time and space for conversation to unfold. Practice 39 was diligent in protecting time for conversation not only during the intervention, but was still protecting time at 3-year follow-up. "Meetings take time from the doctor's schedule, but they are an important function of this office. I don't see us not having these meetings."

### *Discussion and Conclusions*

The analysis developed here is grounded in both theory and empirical observation. While the primary efforts were directed toward family practice clinics, we feel that our understandings of the interdependencies among clinics, conversation, and interventions apply across all kinds of health care organizations. Health care organizations, because they are complex adaptive systems, are all fueled by conversation. If we are attempting to enhance the way that cardiac surgical teams learn new procedures, or help hospitals develop new patient safety protocols, or help nursing homes provide more sensitive care to residents, then we need to recognize that the conversation among stakeholders will be critical to the success of our efforts. Table 2 summarizes our key findings.

*Insert Table 2 here.*

There are several key take home lessons that transfer across implementation efforts and across many different kinds of health care organizations.

Health care organizations are tough places because they are places where it is hard to have a conversation. Conversation is challenging because of information asymmetries and the need for confidentiality, among other things. Within health care institutions sensemaking and learning are critical and often overlooked, and conversation is essential for effective sensemaking and learning to occur. If we want to intervene in the way health care organizations do business, then we must pay attention to the role of conversation in implementing interventions effectively.

We are not going to be able to deliver the best health care to the most people unless we can recognize and enhance the interdependence of conversation and interventions. Because interventions influence conversation and because conversation influences interventions health care stakeholders must develop the capacity to use conversation and interventions together in improving health care.

Conversation is really hard. It's easy to say, "The issue is communication", and it's easy to say "We have to talk to each other". But it is hard to collaborate, make meaning and improvise. It is difficult to create good conversation and avoid the barriers to good conversation. Even though conversation is hard, we really have to do it if we want to deliver good health care.

Health care and health care organizations are often perceived to be in a crisis and to need significant interventions in order to lift them out of their crisis. An unexpected, but powerful lever for change in health care organizations is conversation. Our analysis shows how conversation might be understood and used to make a difference in the health care environment in which we live.

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**Table 1: A Fourteen-year Federally-Funded Program of Research to Understand Primary Care Practice Change**

Project Name (Acronym)	Project funding Source & Dates	Project Description
Direct Observation of Primary Care ( <b>DOPC</b> )	NCI R01 CA60862 (PI, Stange) 1994-1997	Cross-sectional descriptive study of 4454 patient visits to 138 physicians from 84 practices in Ohio using surveys, chart audits and direct observation of visits
Prevention & Competing Demands in Primary Care ( <b>P&amp;CD</b> )	AHRQ R01 HS08776 (PI, Crabtree) 1996-1999	Ethnographic comparative case studies of 18 practices in Nebraska using participant observation and depth and key informant interviews
Study To Enhance Prevention by Understanding Practice ( <b>STEP-UP</b> )	NCI 2R01 CA60862 (PI, Stange) 1999-2000	Group randomized intervention trial of 80 Ohio practices using a facilitator to help practices select and tailor strategies from a cancer prevention toolkit.
Insights from Multimethod Practice Assessment of Change over Time ( <b>IMPACT</b> )	NCI 3R01 CA60862 (PI, Stange) 2001-2004	Secondary data of STEP-UP to understand why some practices made substantial changes and others none, and to create a theoretical change model.
Using Learning Teams for Reflective Adaptation ( <b>ULTRA</b> )	NHLBI R01 HL70800 (PI, Crabtree) 2002-2008	Group randomized intervention trial of 60 NJ & PA practices using the IMPACT model and a facilitated a “Reflective Adaptive Process” (RAP) to enhance relationships & cardiovascular disease care.

**Table 2. Conversation Summarized**

<b>Definition of Conversation</b>	<b>Emphasize Characteristics of Good Conversation</b>	<b>Avoid Barriers to Good Conversation</b>	<b>Recommendations for Enhancing the Role of Conversation in Improving Interventions</b>
<p>What it is</p> <ul style="list-style-type: none"> <li>• Collaboration</li> <li>• Meaning making</li> <li>• Improvisation</li> </ul> <p>What it is not</p> <ul style="list-style-type: none"> <li>• Instruction-giving</li> <li>• Information exchange</li> <li>• Speeches</li> <li>• Talk that elicits no real meaning</li> </ul>	<p>Pre-conditions</p> <ul style="list-style-type: none"> <li>• Time</li> <li>• Space</li> <li>• Trust</li> </ul> <p>During conversation</p> <ul style="list-style-type: none"> <li>• Responsive interaction</li> <li>• Diversity of perspectives</li> <li>• Focus on topic</li> <li>• Clear goals and openness to “big ideas”</li> </ul> <p>Types of conversation</p> <ul style="list-style-type: none"> <li>• Disciplined debate</li> <li>• Creative dialogue</li> <li>• Intimate exchange</li> </ul>	<ul style="list-style-type: none"> <li>• Professional identities</li> <li>• Dominant discourses</li> <li>• Entrenched routines</li> <li>• Lack (dampening) of diversity</li> <li>• Failure to listen</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate the potential of an intervention to generate good conversation</li> <li>• Look for and leverage unexpected conversation</li> <li>• Use conversation to help people manage uncertainty</li> <li>• Use the intervention to physically reorganize relationships</li> <li>• Monitor and manage the facilitators’ participation</li> <li>• Build social interaction competence</li> <li>• Create space within which conversation can unfold</li> </ul>