
The study’s investigative team used the evidence-based Consolidated Framework for Implementation Research (CFIR) to guide our analytic approach and development of data collection instruments.

<table>
<thead>
<tr>
<th>CFIR Domains and Summaries</th>
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<tbody>
<tr>
<td><strong>Intervention Characteristics</strong></td>
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<td>Intervention characteristics, which are the features of an intervention that might influence implementation. Eight constructs are included in intervention characteristics (e.g., stakeholders’ perceptions about the relative advantage of implementing the intervention, complexity).</td>
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<td>How different aspects of the program will make it work or not work in this health care system.</td>
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CFIR Domain #1: Outer setting

1. How well do you think the proposed interventions will meet the needs of the Black birthing people served by Temple Health System (In what ways will the intervention meet their needs?)

2. How do you think the Black birthing people served by Temple Health System will respond to the interventions?

3. What barriers will the Black birthing people served by Temple Health System face to participate in the interventions?

CFIR Domain #2: Characteristics of individuals

4. How do you feel about the proposed interventions being implemented at Temple Health System and specifically within your department/clinic/setting? (Do you have any feelings of anticipation? Stress? Enthusiasm? Why?)

CFIR Domain #3: Intervention characteristics

5. What kinds of changes or alterations do you think you will be needed to make to the interventions work effectively at Temple Health System? (For your stakeholder group? For others?)

6. Are there components that should not be altered? (Which ones?)

CFIR Domain #4: Inner setting
7. How do you think your organization’s culture (general beliefs, values, assumptions that people embrace) will affect the implementation of the interventions? (Can you describe an example that highlights this?)

8. To what extent are new ideas embraced and used to make improvements at Temple Health System in your department/clinic? (Can you describe a recent example?)

9. Can you describe a recent quality improvement initiative or an implementation of a new program you were involved with at Temple Health System? (e.g. Healthy Workforce Initiative? Can you describe the new initiative/program and the motivation to improve/implement it? What factors helped make it successful/fail? What was your involvement? Were people happy with the outcome/initiative? Can you tell me about how leaders were involved? Who? Their roles? How did they help/hinder?)
Appendix 2. Qualitative Rigor and Validity

Sufficient validity and rigor are critically important in establishing the credibility of qualitative research.⁵ It is essential that the criteria used to evaluate rigor are consistent with the epistemological underpinnings of the specific methodology being used.⁶-⁸ Our research team used standard procedures in evaluating “trustworthiness”, which is often referred to as validity in quantitative work. The evaluation of trustworthiness and rigor is built around the four central criteria of (1) credibility; (2) dependability; (3) transferability; and (4) confirmability, which were used to establish rigor in this current study.⁹ We ensure the rigor of our process by utilizing specific strategies that are consistent with the qualitative research tradition. These strategies include member checking, peer debriefing, assessment of saturation, and triangulation. We also created a detailed audit trail and robust descriptions of our process, all of which are well established strategies to increase rigor and trustworthiness in qualitative research.⁵ Finally, the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist guided all stages of our research process.¹⁰ COREQ, similar to CONSORT for RCTs, is a 32-item checklist that helps qualitative researchers ensure they are utilizing best practices in research. COREQ was used to guide this study.
Appendix 3. Recruitment and Consenting Process

We recruited participants using purposive sampling, through the medical school and hospital, along with referrals from community partner organizations. Potential participants were identified during collaborative meetings between study investigative team members and faculty/nursing staff from Temple University’s School of Medicine, inpatient departments, outpatient clinics, and private physician practices. Potential participants were also drawn from community partner organizations who had previously worked with patients and had indicated interest in being contacted for studies.

The study investigative team contacted the potential participants via phone or email to make them aware of our voluntary research study. Temple University’s IRB waived the requirement to consent in writing. If the potential participant was interested, they were sent an IRB-approved informed consent and given the opportunity to read, review and have their questions answered before consenting or declining to participate. Additionally, at the beginning of the actual focus group, the consent was read out-loud and participants had the opportunity to ask questions, as well as to continue, or terminate their involvement in the study.

Potential participants had to be at least 18 years of age and speak and write in English fluently. They also needed to have access to a smartphone, tablet, or computer in order to participate via Zoom or other virtual platforms. If the participant met all other criteria but did not have access to a device, the research team lent a device and
wandering access point (for WiFi access) to the participant. Of note, no participants needed to use the research team's devices.

Finally, participants needed to meet the criteria for one of these six collaborator groups: 1) Attending physicians and midwives; 2) Residents; 3) Nurses; 4) Support staff including medical assistants, certified nursing assistants, surgical technicians and front desk staff/unit clerks; 5) Community-based clinicians, including doulas, lactation consultants and psychotherapists; 6) Patients. Health system participants included clinicians and support staff who care for and interact with birthing people from pregnancy through the first year postpartum (e.g., obstetricians, family practice physicians and nurses, intensive care nursery staff) in order to fully represent the wide breadth of providers/staff that affect the experiences of birthing families. To the extent possible, we sought to have a balanced sample within each group. For example, inpatient and outpatient nurses, first through fourth year residents, attending physicians from Obstetrics, Internal Medicine and Family and Community Medicine, mix of community doulas, lactation specialists and therapists, etc. For the nursing collaborator group, we intentionally avoided inclusion of nurse managers to minimize power dynamics among participants and to avoid direct supervisors being in the same group with their reporting employees.
Appendix 4. Analytic Process

The **first** step of the research analysis process involved convening our entire research team to collaboratively design a data collection and analysis process that captured and honored the knowledge and lived experience of all team members.

The **second** analytic step of the rapid analysis involved the use of a templated summary table which the investigative team developed prior to the focus groups. This summary table was designed to match the interview guide used in the focus groups and captures the deductive aspects of the process. This summary table also included sections to record key observations, quotations and reflections relating to the data collection episode (i.e. the specific focus group). During the actual focus group, the facilitators led participants through the questions, while notetakers observed and recorded relevant information in the electronic templated summary table. In this way, early analytic processing was occurring during the actual collection of data. Additionally, member checking and ensuring accuracy was done throughout each focus group and summaries of this data were shared back with the participants at the conclusion of all six focus groups.

The **third** analytic step in the process involved facilitators and note takers reviewing each deidentified recording and transcript. During this time, team members were noting key issues, quotations, and engaging in preliminary coding. Once each team member completed this
individually, the research team re-convened to review the data as a team. This meeting occurred within 7-10 days of when the initial focus group was completed. During this process, the team attended to both deductive elements of the analysis (i.e. content that emerged directly related to the CFIR questions that were asked) as well as inductive elements (i.e. additional content that emerged that was not asked about and not initially expected). This team-based approach, that utilized both written analysis and spoken analysis, allowed our team to leverage the expertise and knowledge of all team members, not only those with traditional research training.

The **fourth** analytic step of the rapid analysis involved the two primary facilitators reviewing the analysis from the previous step. The text data was coded and then cross-referenced for any similarities and, or discrepancies. Words and phrases were identified and patterned and shared back with the research team for further discussion, until the research team could define and organize the information. (Johnson 2018; Saldana, 2016; Yin, 2015). This step typically was completed within 2-3 weeks of the initial focus group.

The **fifth** analytic step involved consolidating data across the six stakeholder teams, and patterning similarities and differences. This information was used to create a visual display in a matrix format. This allowed our team to identify commonly occurring themes, compare across groups and to share with our community advisory board for review and further guidance. The matrix was designed to capture several pieces of data: broad themes or categories, subthemes,
and supporting quotes. These finds were shared with the community advisory board at the end of analysis.
APPENDIX REFERENCES:


The authors provided this information as a supplement to their article.

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