Dr. Palinkas, and so briefly, I’ll just share that this seminar is sponsored by the Center for Methods and Implementation and Prevention Science, our qualitative methods innovation program at the Yale School of Public Health, our Department of Social and Behavioral Sciences, and the Yale Child Study Center and our NIH T32 training grant for implementation science research methods. And so our qualitative methods innovation program, this is the second seminar that we’ve had, we’re deeply grateful and lucky to have Prof. Palinkas here. So he’s a distinguished professor of social policy and this Suzanne Dworak-Peck School of Social Work at the University of Southern California. He holds secondary appointments in anthropology and public health sciences at USC. And as a medical anthropologist myself, Dr. Palinkas’ contributions to the field of implementation science have allowed for younger scholars like myself and others to robustly integrate ethnographic and other innovative methods to help illuminate and improve and inform healthcare delivery.
Among many innovations, he’s developed and packaged the rapid assessment procedure for clinical ethnography, and he worked to develop and make accessible important approaches to improve the implementation of brief interventions for trauma survivors, for adolescents accessing mental health services and for mental health services that more recently are deployed in acute care settings during COVID. And so his current research encompasses the implementation of child and adolescent mental health services, the sustainment of prevention programs and initiatives and effects of climate change on vulnerable populations. And I’m sure he’ll share with us some of the new ideas and projects that he has on his mind. And we look forward to discussions about that during and after the talk. And so we’re deeply appreciative of him taking the time to come all the way here and spend the day with us. And so, I’ll hand it over to him. The title of his seminar is Innovations and the Use of Mixed Methods and Implementation Research. Well, thank you, Ashley.
In fact, last time I was here was almost 50 years ago, and that was even before there was a Yale School of Public Health. Oh, wow. So it is exciting to be able to be here and to spend this time with you all. I was asked to talk about some of the things we’ve been working on with respect to the use of mixed methods in implementation research. And so what I will focus on is, just to give you a brief overview about how mixed methods have been used in implementation research, and then highlight three particular projects that I’ve been working on that illustrate the use of these methods in addressing important issues related to implementation of evidence-based interventions, policies, and programs. So let me first start by talking about what mixed methods are. And typically we call them at a particular methodology, even though we have methods implies plural. It is a methodology for collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies. The idea being that when you combine
the two sets of methods, you're able to get a much better understanding of a research problem than either research approach alone. In combining the methods, which is the key element to a mixed method, as opposed to a multi-method study. It's not merely parallel play where you have somebody who's doing the quantitative study and somebody doing the qualitative study with no interaction. It's really based on the interaction. So in a sense, you can think of it as a model of, as well as a model for interdisciplinary and even transdisciplinary research. It also allows you to simultaneously answer confirmatory and exploratory questions, thereby you can both generate a theory and verify it in the same studies. The elements of mixed methods depend on both the structure, the function, and the operation. So in terms of the structure, how you connect the data in a mixed method study may depend on timing and the weight and authority that you assign to each type of method. You can collect the data simultaneously as so that you're collecting both quantitative
and qualitative data at the same time. Or sequentially, where you use one method followed by the other. You can also vary the priority that you assign to each method, so that if you’re giving priority the qualitative method, it’s indicated by QUAL being in capital letters. And similarly, if you’re giving priority to the quantitative methods, the QUAN is in capital letters, or you can give equal priority to both methods, even though there are some people who think that’s not really possible. The other aspect of mixed methods is the iterative process of data collection and analysis, so that you may begin with quantitative methods to collect the data and analyze it leading to the collection or analysis of qualitative data, which leads to further quantitative data collection and analysis. This chart shows you the five major uses of mixed methods in implementation research. Similar to the typology of mixed method designs that Creswell and Plano Clark, who written the stamp, the bible of mixed method research.
There are five major types of mixed method uses in implementation science. Convergence, where you are corroborating data from different sources to come to either similar conclusions or the quantization of qualitative data. Complementarity intends to understand a phenomenon more completely by focusing on the breadth of understanding through quantitative analysis but a depth of understanding through qualitative analysis. Expansion is often used to help explain the findings from one study. So you may get a finding from a quantitative analysis of a survey that produces unexpected results follow that up with a qualitative study to come to some explanation to answer the question why a quantitative study alone is not designed to answer. We also use mixed methods for exploration and development. Oftentimes, we will use qualitative methods to identify the way to ask questions in a survey or to develop hypotheses to be tested. A framework that guides that hypothesis testing, and then the quantitative methods
to test the hypothesis or validate the framework.

And then finally, we may use it for sampling, so that oftentimes on the basis of quantitative data,

we may select participants for qualitative study,

either focus groups or semi-structured interviews.

We can also reverse the process and use qualitative data

to create categories

that can then be compared quantitatively,

which I will show you later.

Each of those functions carries with it

a variation of timing of data collection,

so it may be sequential or concurrent.

And the analysis can occur both,

or the mixing of the data can occur both in data collection

through convergence or analysis and interpretation

through the other methods

or throughout through the sampling.

And they may involve the combination of equal weights of quantitative and qualitative data

or priority being given to one or the other.

Now, how to decide which function to use.

I usually recommend that when you’re seeking answers

to the same question,

use convergence as a strategy for mixing the methods.
When you’re seeking answers to related questions, you may use it for the purpose of complementarity to gain a comprehensive understanding. When the findings based on one method raises questions that can answer be answered by the other method, the function is expansion. When the findings based on one method are prerequisite for the use of another method, such as developing a survey, then that’s development. And when one method can use to define or identify participant samples for collecting and analyzing data, representing the other method, that is sampling. There are three ways of mixing quantitative and qualitative data. You can merge the data in which you bring the two types of data to develop your results. You can connect the data where you take one data from one method to generate and assist the two types of data to obtain your results. Or you can embed the data, as is typically the case in randomized controlled trials where qualitative data may be used to help explain the process.
by which an intervention works or implementation occurs. And the quantitative data can be used to describe the outcomes. How is that different than merging? Pardon? How is that different than merging? Okay, a good example of merging the data would be triangulation of quantitative and qualitative data, whereas embedding the data is each dataset has a different function. They’re asking different sets of questions, whereas merging the data is asking the same question. I understand. Okay. And in fact, as the next slide shows, we often use them, for example, in implementation research.
to measure intervention or implementation outcomes
in the qualitative methods, as I said earlier,
to measure process. Or we can use the qualitative methods
to explore the steps of the intervention
and generate a conceptual model
along with testable hypotheses,
and then test those hypotheses
with the quantitative methods.
Many times we use the quantitative measures
to examine the content of an intervention
or its implementation and the qualitative methods
to examine the context in which it occurs.
We can use the quantitative methods
to incorporate the perspectives of the researcher
and the qualitative methods to incorporate the perspectives
of our collaborators, usually the consumers
of the interventions that we’re implementing.
And then finally, we often use one set of methods
to address the limitations of the other.
So in implementation research, for example,
when the unit of analysis is a clinic or organization
and issues of power may be compromised
by these limited number of available clinics for analysis,
then validating or confirming the results
from a quantitative analysis using qualitative data is another rule that mixed methods can play. So I'm gonna tell you how these methods were mixed in three particular studies. The first being a study that we did on the development of a measure of sustainment of prevention programs and initiatives, a study that was funded through the National Institute Drug Abuse, where we merged and connected data using a structure beginning with qualitative data collection and an analysis to develop a quantitative scale, testing that quantitative scale, and then evaluating predictors of sustainment using qualitative comparative analysis. The functions being development of a scale or instrument, convergence of qualitative data from different data sets. And expansion, using the qualitative data to explain quantitative findings. The second study is an implementation of evidence-based interventions for screening and brief treatment of post-traumatic stress disorder and substance use disorders in patients presenting in trauma centers. There we embedded and merged the data in a randomized,
what was it, pragmatic clinical trial
with a focus on quantitative data collection
and simultaneously qualitative data collection
for complementarity and sampling.
The third, I forgot to put the title in,
is a study looking at the impact of the COVID pandemic
on policy and practice implementation
of mental health services for children and adolescents
where we merged the data collecting both quantitative
and qualitative data for the purpose of convergence.
From the first study, we were able to, you know,
we focused on the fact that government agencies like SAMHSA,
Substance Abuse Mental Health Services Agency
fund hundreds of projects that are designed
to deliver drug and HIV prevention programs
as well as mental health services like suicide prevention
and treatment of conduct disorders.
But being able to sustain these programs,
even though they’re explicitly told to include a plan
for sustainment in the project application
is always an open question because generally we have no way
of determining the likelihood of sustainment
or providing feedback and to agencies
that are trying to sustain their programs.
So the aim of this project was to look at core components of sustainment and how they relate to one another across times, so that we can increase the likelihood of providing useful information that will result in successful sustainment of these programs. In this particular project, we designed a measurement system for monitoring and giving feedback within SAMHSA and then pilot testing the predictability of that system and its feasibility and acceptability. So in this study, we essentially began with a series of qualitative interviews with 45 participants of 10 different SAMHSA funded programs. And we collected information using traditional semi-structured interviews, a free list exercise, which is often used in anthropology to identify semantic domains that are relevant to the people that we're working with or studying. And then a checklist of the consolidated framework of implementation research. The results from each of those forms of data collection were then merged to identify relevant domains of sustainment for SAMHSA funded grantees.
We use those domains to create a scale known as the sustainment measurement system scale. It had 42 items, one subscale describing sustainment outcomes, and then six scales describing determinants of sustainment.

In the next phase of the study, we evaluated the validity and reliability of the scale by collecting data from 200 SAMHSA grantees representing 145 different organizations that were funded. What we found was a measure that had pretty high inter-item reliability of 0.93, but varying degrees of reliability generally satisfactory for each of the subscales. We were also able to distinguish the difference between each of the predictors as well as outcomes of sustainability, particularly the outcomes and whether the program continued to exist, but were adapted and continuing to exist in the same form. And then in the third phase of the study, we used the methodology of qualitative comparative analysis to identify pathways of predictors associated with sustainment.
And we found that as a unit, there were two combinations that were significant predictors. So essentially what you're doing is taking the quantitative data that we had collected from the 200 participants in the 145 programs, and then use the qualitative structured qualitative process known as QCA to identify community responsiveness and organizational capacity when combined with the CFIR process domain or community responsiveness and organizational capacity when combined with coalitions, networks, partnerships. So the reason why this was of interest to us is because while frameworks like the CFIR can identify domains of factors that are predictive of successful sustainment, they don’t prioritize those domains. And the priority assigned to them may vary from one context to the next. Larry, can I just ask, I mean, wouldn’t you prioritize them based on the strength of their association? Or maybe I’m not fully understanding. Like, so the strength of association alone, you know,
this predicts for your outcome. But the reality is that they don’t exist independently,
they exist in combinations. And the QCA is able to mirror that
or to take that into account.
<v Participant>Thanks.</v>
Can you talk a little bit more about the
process of QCA?
I could.
Essentially, it takes a series of configurations.
So the advantage to QCA
is that you can work with limited samples,
as few as eight to 10, for example.
And it can take either quantitative or quali-
tative data.
The outcome can be either categorical
in which it can be one form of QCA,
I’m blanking on the type now.
Or it can be inter an interval level measure,
which it’s a fuzzy-set analysis.
But it essentially identifies necessary
and sufficient characteristics or conditions
by which combinations of variables
predict the outcome variable.
I could give an entire lecture on QCA,
but since we’re getting short on time here,
I thought I’d move on
to what I really wanted to spend time on,
which is a technique now,
which is a mixed method approach to collect-
ing information
and analyzing it in a much shorter period of time than typically occurs in most implementation research.

So in the context of the next study I’m going to describe, we developed a process known as a Rapid Assessment Procedure-Informed Clinical Ethnography or RAPICE for short. And RAPICE essentially takes two traditions, the RAPICE assessment procedures, which is a way of collecting and analyzing information in a short period of time with clinical ethnography, a traditional approach to understanding clinical issues or issues of clinical significance by having clinicians act as ethnographers or participant observers. This was intended to meet the requirements for time-efficient data collection in pragmatic trials, clinical trials where you want to have minimal participant burden and collect qualitative data fairly quickly. The key to this is that rather than being done by a single individual, it’s done as a team. So the interaction between ethnographically trained clinicians or community members act in the role of participant observers.
And then you have a clinically trained social scientist who acts as a mixed method consultant or analyst. It’s that combination that occurs in a series of steps that is intended to provide some consistency or rigor to the process of data collection and analysis. So, why do we use RAPICE? If we were to do it the way that ethnographers were traditionally done, it could take up to a year just to become familiar with the setting, learning the language usually done alone and collecting a lot of data, not all of which is particularly relevant to the kind of questions that we ask in implementation science. It also provides a balance between the role of the participant and the role of the observer. So oftentimes we find in ethnography, someone playing more of a role of one versus the other and having an imbalance. And the benefit of ethnographic research, which is to combine perspectives that of the insider or emic perspective and that of the outsider, or etic perspective. In doing so, the advantage to RAPICE is that it empowers study participants this particularly valued for underrepresented groups.
It is now assisting in moving the field of implementation science to addressing health equity in a way that it wasn’t able to before because those who are the survivors of disparities are, have equal weight, carry equal representation in the process of data collection and analysis. We now have two versions of RAPICE. One for clinical settings and one for community settings.

The process of doing it begins with a participant observer or observers who conducted formal interviews, do site visits and clinics or communities, and they may interact with study participants, attend meetings, observe clinical procedures, and collect data through informal and semi-structured interview with participants.

They record that data through field notes, through logs of data collection activities, field jottings, and they can digitally record semi-structured interviews for later transcription.

This information is then presented to the mixed method consultant who reviews it and queries the participant observers to gain a better insight into the data and its context. It may also enable the consultant...
to ask additional questions that the observer hadn’t thought to ask, for example, and in an iterative fashion, enable further data collection.

In the next phase, depending upon the context, what resources you have available to mixing the methods.

The qualitative data can be subjected to two phases of analysis. The first being immersion crystallization, where you get a holistic representation of the setting, the activities, the phenomenon of interest, followed by a more focused thematic content analysis and perhaps a template analysis if you’re doing comparisons across settings or across groups of individuals.

The participant observer develops a preliminary interpretation of the meaning and significance of that data organized in terms of a set of apriority themes based on the interview guide or emergent themes that come from the data collected and a description of their inner relationships. The mixed method consultant does something very similar. And then the two, the participant observers and the consultant identified points of convergence and divergence,
and then go through a process of reaching consensus in much the same way that a team approach to qualitative data analysis occurs. If it’s not achieved, follow up interviews or returns to the field site may be necessitated to collect additional data. If it is achieved, the consultant may recommend identification of disconfirming cases in which additional data collection occurs. In the end, the interpretation of the study findings is presented to the participants to confirm validity and comprehensiveness equivalent to member checking in qualitative data analysis. Analyzing the qualitative data using RAPICE is then integrated with quantitative data to provide a comprehensive understanding of implementation process and outcomes. That way we can use that information as I will explain later, to improve the likelihood of successful outcomes. In two studies where we applied the RAPICE approach, we used both the clinical ethnography and the community ethnography version. The first study used the clinical ethnography to look at interventions.
targeting post-traumatic stress disorder comorbidity in trauma care settings.

And this gives you sort of a justification or the rationale for why we did this study because each year between the main and a half million two and a half million people require inpatient hospitalizations due to injuries, but they also carry with them frequently multiple comorbidities including PTSD, alcohol and drug abuse problems, depression, chronic medical conditions that are endemic to this population. So the aim of this study was to enhance the implementation of evidence-based screening and interventions for PTSD and comorbidity and national trauma center implementation policies recommended by the American College of Surgeons. The focus of this study was on implementation outcomes using the RE-AIM framework. Reach, effectiveness, adoption, implementation and maintenance.

And so what we did was collect both qualitative data.
546 00:32:32.730 --> 00:32:36.644 using the RAPICE methodology of having clinicians

547 00:32:36.644 --> 00:32:41.644 act as participant observers and work with myself

548 00:32:43.140 --> 00:32:47.700 to interpret or analyze the data that they collected,

549 00:32:47.700 --> 00:32:49.890 as well as quantitative data

550 00:32:49.890 --> 00:32:54.660 through the National Trauma Center Behavioral health surveys

551 00:32:54.660 --> 00:32:58.346 to identify or create a matrix

552 00:32:58.346 --> 00:33:02.205 of American College of Surgeons policy

553 00:33:02.205 --> 00:33:04.233 and its implementation,

554 00:33:05.370 --> 00:33:08.640 so that the different reach categories

555 00:33:08.640 --> 00:33:12.993 were assessed using both quantitative and qualitative data.

556 00:33:13.948 --> 00:33:18.570 At the same time, we were also using the qualitative data

557 00:33:18.570 --> 00:33:21.464 that we collected through RAPICE

558 00:33:21.464 --> 00:33:26.464 to create categories of implementation quality.

559 00:33:26.623 --> 00:33:31.020 So the qualitative data became quantified

560 00:33:31.020 --> 00:33:34.350 in the assigned scores based on dimensions

561 00:33:34.350 --> 00:33:39.176 of the intervention itself, the leadership engagement,

562 00:33:39.176 --> 00:33:43.830 the adherence to regulatory standards.

563 00:33:43.830 --> 00:33:47.550 So, we had four categories of implementation quality.

564 00:33:47.550 --> 00:33:50.970 Excellent, good, fair and poor.

565 00:33:50.970 --> 00:33:54.564 When we combined the good

566 00:33:54.564 --> 00:33:59.564 and excellent forms of implementation,

567 00:34:00.997 --> 00:34:05.997 what we found is essentially no difference

568 00:34:06.684 --> 00:34:11.684 in the scores that were assigned

569 00:34:12.360 --> 00:34:14.860 to individuals post-treatment

570 00:34:16.500 --> 00:34:21.500 indicating very poor clinical outcomes in conditions
where the implementation of the guidelines was,

actually, it’s the exact opposite, we got great outcomes under good and excellent implementation,

very poor outcomes as indicated by the disparity between the two sets of measures under conditions of fair and poor implementation.

The finding was that the clinical outcomes associated with implementing these guidelines for screening and treating PTSD and comorbid conditions produced much better outcomes when their implementation quality was good or excellent than when it was fair or poor.

So finally the third study is that had to do a, as I said, with the impact of the COVID pandemic on child and adolescent mental health and practice implementation.

As you know, mental health issues have become of increasing concern in child and adolescent populations even before the pandemic.

When the pandemic occurred, those concerns skyrocketed.

The increase was very dramatic, so that there were reports that up to half of the population of children, adolescents living in the United States
594 00:35:53.250 --> 00:35:58.250 were experiencing symptoms of severe depression and anxiety.
595 00:35:59.880 --> 00:36:01.740 Visits to emergency room
596 00:36:01.740 --> 00:36:05.220 for mental health crises skyrocketed.
597 00:36:05.220 --> 00:36:10.220 Yet the understanding of how to respond to these issues
598 00:36:12.499 --> 00:36:15.892 by mental health service systems was very limited.
599 00:36:15.892 --> 00:36:17.547 So the intention of this study
600 00:36:17.547 --> 00:36:21.090 was to look at the impact of the pandemic
601 00:36:21.090 --> 00:36:25.680 on implementation of policy and practices at the state level
602 00:36:25.680 --> 00:36:28.950 for preventing and treating mental health problems
603 00:36:28.950 --> 00:36:30.630 in this population,
604 00:36:30.630 --> 00:36:34.380 and then look at the current need and demand for services
605 00:36:34.380 --> 00:36:37.440 as well as the capacity to deliver them.
606 00:36:37.440 --> 00:36:40.380 And how state mental health authorities
607 00:36:40.380 --> 00:36:44.250 were addressing these needs and demand
608 00:36:44.250 --> 00:36:47.006 with a particular focus on telehealth
609 00:36:47.006 --> 00:36:49.863 and its use to deliver services.
610 00:36:51.030 --> 00:36:55.440 So while the last study relied on the RE-AIM framework
611 00:36:55.440 --> 00:36:58.500 to evaluate implementation outcomes,
612 00:36:58.500 --> 00:37:02.430 this study utilized the consolidated framework
613 00:37:02.430 --> 00:37:07.290 for implementation research to look at the process
614 00:37:07.290 --> 00:37:11.403 of implementing evidence-based policies and practice,
615 00:37:12.660 --> 00:37:16.860 We began with conducting semi-structured interviews
616 00:37:16.860 --> 00:37:20.010 with 29 state mental health authorities
and representatives from 21 randomly selected states, and then using a subgroup of those as participant observers in their respective states. So they were not only involved in collecting data in their states, but also assisting us in the analysis of that state data. So, this is a community ethnography approach. We also stratified the data according to two criteria, level of unmet need for services as described by a study that was done two years prior to this study, and the positivity rate for the coronavirus at the time that we conducted this study, which was in the fall of 2020. What we found, and part of this data involved, you know, looking at features of the qualitative data and comparing them across the categories of states based on unmet need for mental health services as well as coronavirus positivity. And some of it was used to provide in-depth understanding of the process of implementation. So what you see here is, even though we had 21 states, the increase in demand for services was high in all of the states.
that fell in the high positivity, high level of unmet need,
whereas the lowest rate of increase in demand occurred in states with low levels of positivity and low levels of unmet need,
which is pretty much what you would expect.
In terms of capacity, we found that in states with high positivity and high unmet need, the decrease in capacity occurred much higher in those states than in states with low unmet need.
So we found a disparity in the supply and demand for mental health services through this study.
In that states with high positivity and high unmet need had the highest increase in demand.
for mental health services, but the lowest capacity for delivering those services.
When we look at the barriers and facilitators to implementation using the CFIR domains, we found issues related to telehealth that presented challenges.
to the state mental health authorities, such as limited access to broadband or internet technology needed for telehealth, like laptop computers, reluctance to participate, especially among families because they were unfamiliar with the practice or not comfortable using the technology.
preferred face-to-face interactions.
At the same time, facilitators included Medicaid waivers to allow billing for services, provider training for its use, information for families on how to use it and grant funding to provide client access, either through expanding access to the internet or access to the technology.

We also found that many providers intended to continue using these telehealth or virtual mental health services because it resulted in fewer appointment cancellations or no-shows, greater family engagement and reduce time traveling to provide services.

So I’m just gonna end with a description of some of the new things that we’re doing. One of the potential for using RAPICE and other kinds of mixed methods is not just documenting implementation process and outcomes, but actually facilitating implementation as a strategy, much like any of the other strategies that we employ to ensure successful implementation.

So a formative evaluation, you know, judges the worth of a program while the program is in progress, it can be conducted at any phase of a study and it focuses on the process itself, but it can influence the outcomes.
if there’s feedback from the process of conducting the formative evaluation. So its main purpose is to detect deficiencies in implementation as soon as possible, so that adjustments can be made to ensure better outcomes.

And it’s, you know, the kind of preliminary research that you do is also considered formative, but this is something completely different. This is formative evaluation. This kind of evaluation can be done either by members of the research team who have knowledge about the intervention and performance expectation or can be done by independent observer who provides so-called objective assessments. But perhaps the best approach like RAPICE is to include both in the process of evaluation. This diagram gives you an idea of how that would work.

In a randomized controlled trial where you’re evaluating an intervention and it’s implementation, you can influence and potentially improve the outcomes at the next data collection point, so that the outcomes are optimal, optimally constructed by the time the trial ends. So there are a number of methods
that are out there for doing this.

It's semi-structured interviews with participants,

investigators, service providers,

or ethnographic field observation.

But we're now working on using the RAPICE technique.

We're planning to do that in three major projects

that we've got underway now.

The first being implementation projects on prevention,

treatment, harm reduction

and recovery of opioid use disorders.

A research center that’s focused on developing

and implementing a multi-level intervention

to increase vaccination rates in under-resourced

communities

for HPV.

And then the third,

a stepped care approach to delivering mental health services

in the aftermath of climate related natural disasters,

extreme weather events,

focusing on wildfires in California and Australia

typhoons in small island developing states

in the Pacific.

So, that’s pretty much where we are.

I hope it gives you some ideas of the potentials

for not only using quantitative and qualitative methods,

but being a little creative in their use.
to address important problems related to implementation for use.

Ah, thank you so much.

So, we’ll open it up for questions and Mona hopefully we can hear it or whoever has questions.

There’s nobody online.

I have a question. So hopefully everybody online can hear the question.

So, thank you so much.

I really enjoyed hearing about the RAPICE technique.

It’s really eyeopening.

It reminds me a little bit of this idea of community based participatory research.

and I wonder to what degree that idea comes in,

in other words, the participant observers,

to what degree do they set the purpose for the research question versus just working under the forgetting now the name, the mixed methods consultant to kind of carry out the designing of the interview guides or analysis, et cetera.

So the community based version of RAPICE is much more explicit in that it does occur in the clinical ethnography as well.
But in both instances we've engaged community members or clinicians in identifying the questions to be asked, the issues to be addressed and participating in the analysis. So they, the term co-creation has become very popular these days. We have in a community setting adopted what’s called the community partner participatory research approach, so that it’s not just based in the community, but that the community members are equal partners. And we’ve used this not just in implementation studies, but recently we used it in New Orleans and South Louisiana to look at how community-based organizations in low income neighborhoods like the Lower Ninth Ward were and preparing for hurricane season during the COVID pandemic, how COVID had impacted their ability to prepare for and respond to an increased frequency of more severe hurricanes. That involved having a community advisory board from the community, help us design the interviews, identify people to interview, and then participate in the analysis of the transcripts.
from those interviews.

You know, as I said, one of the things that we see as a real value to RAPICE is that it empowers communities. Rather than simply being passive participants, they’re actively engaged in the process.

I’m curious to learn a little more in RAPICE, how are you following the quality of field observations and field notes and or, you know, from both ends,

from the mixed method consultant and also the participant observers

that might be newly trained in ethnography or like conducting interviews and writing field notes

How is of the process?

So the iterative nature of that is that we, on a regular schedule review field notes and any data that’s collected.

I then meet with the participant observers or the consultant meets with the participant observers

and queries them and makes recommendations at that point

about the kinds of information.

I mean, we begin, actually, I should say

begin actually by training them.
So the who, what, when, where, why observation, how to collect information, how to record it in field notes, what we expect to see in field notes, the different types of observation and reflection. And then we use the information, the analyst uses the information that is provided to them to ask additional questions to get a better understanding of what was observed or what was heard or seen. From the analyst standpoint, the check is, the member checking. So when we come up with a preliminary analysis, we present it to a group of clinicians who participated in this study, who were observed for example, or we presented to community members to get their reflections, to get their feedback. So in a member check, what the analyst does is review through a member checking process essentially. Any questions from the ethernet? This is like class, just a lot of black boxes. Okay, well, it’s one o’clock so I’m mindful that folks likely need to head off to their next thing. But please do let us know if you’re not on
any of our email lists or interested in learning more about our qualitative methods innovation program or just more about CMIPS, contact William Tootle. And yeah, you can join me one more time in thanking Prof. Palinkas for his wonderful talk. Yeah, so thank you, everyone. Thank you so much. I have so many questions. (chuckles) I guess that worked out okay in spite of the technical challenges. No, I think it was great. Yeah. I have to say that shared.