



# Rapid Ethnographic Assessment

TOOLKIT FOR UNDERSTANDING IMPLEMENTATION CONTEXT  
ON SHORT TIMELINES

JULY 2023

# GETTING STARTED

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## What is REA

REA stands for rapid ethnographic assessment (National Cancer Institute, 2020). The goal of REA is to understand what a culture is like from the insider's perspective by gathering information within a short time frame to promote action (Nevedal et al., 2021; Rashid et al., 2019).

REA has its roots in classic, or conventional, ethnography and shares many of its principles, assumption, and procedures (Whitehead, 2022). More than a methodology, ethnography has distinctive attributes of ontology and epistemology.

Often used in social science research, ethnography is a holistic approach to the study of cultural systems and of sociocultural contexts, processes, and meanings within those systems. It is an open-ended, emergent learning process that relies heavily on qualitative methods, especially fieldwork, but can also include quantitative methods. Chapter 2 in this toolkit contains more about key features of ethnography.

## Who is this toolkit for?

This toolkit is designed for researchers with knowledge of implementation science and qualitative methods. Because REA is a team-based approach, a group with complementary skills and expertise in both areas can be effective at using this toolkit and applying the methodology. If implementation practitioners are interested in REA, we recommend that they partner with qualitative methods experts who can guide rigorous data collection, analysis, and interpretation.

## Why use REA?

REA can be an effective method in implementation science research (McCullough et al., 2015), and serve to:

- **Capture, document, and encourage reflection on implementation processes**, especially those centered on individual interactions
- **Observe and document fidelity** to interventions and understand the implementation context of one or multiple settings
- **Understand the reasons an intervention may have been adapted to a particular context.** REA enables capturing nuances in the environment and people's motivations and actions
- **Learn about diverse stakeholders' perspectives**, especially those often overlooked (for example, frontline health care professionals or administrative staff)
- **Uncover unseen determinants of implementation**, meaning features of the setting that people who work in it use but "take for granted" and may no longer notice
- **Assess effectiveness** of implementation strategies (McCullough et al., 2015) and gain insights that can be quickly applied to improve design and implementation of interventions.

## **When to use REA?**

REA takes the key features of ethnography and adapts them to short timelines and a need for quick, actionable results (Vindrola-Padros, 2021). The main goal of using REA in implementation science is to efficiently gather data to understand barriers and facilitators (determinants of practice) in the clinic context. A secondary goal is to document flows of people, work, and communication to identify opportunities for evidence-based implementation strategies. Achieving both goals requires a deep-rooted grasp of the culture and experience of a clinical context. This toolkit is your introduction to using REA to support success in implementation science projects.

## **What is included in this toolkit?**

This toolkit introduces the REA methodology for application in implementation studies. We provide a general background that highlights some of REA's core tenets, examples from the implementation science literature, and practical guidance to help you use REA in your work.

## **How should I use this toolkit?**

This toolkit gives you foundational principles, methods, and tools for using REA effectively. The content is organized in stand-alone sections that can be read and applied on their own but are especially helpful when used in the context of the full methodology. That is because REA is an immersive, multi-method approach based on unifying principles and activities that should be efficiently combined and coordinated to obtain good results. Still, we intend the information we provide to prove useful in the “real world” where various constraints can affect how the toolkit is read and REA employed – keep reading to learn how you can streamline and speed up your review of toolkit material and get started with REA!



## TABLE OF CONTENTS

---

INTRODUCTION	<u>05</u>
ROOTS OF REA IN CLASSIC ETHNOGRAPHY	<u>11</u>
PLANNING THE REA	<u>16</u>
REA DESIGN AND METHODS	<u>20</u>
DISSEMINATION OF FINDINGS	<u>31</u>
APPENDIX	<u>33</u>
REFERENCES	<u>35</u>
ACKNOWLEDGMENTS	<u>40</u>

# INTRODUCTION

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Essentials of REA and this toolkit [06](#)

Key features of REA [06](#)

Questions that REA can address [07](#)

Examples of ethnographic approaches in implementation science [08](#)

How is REA conducted? [08](#)

Assumptions of REA [09](#)

Final considerations before using REA [09](#)

Remember [10](#)

Our principles and goals for the REA toolkit V 1.0 [10](#)

[\*Return to Table of Contents\*](#)

# Essentials of REA and this toolkit

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If you do not have the time and resources to read the full toolkit, here are the essential sections — the minimum you need to know to apply REA. We strongly recommend that you read these parts before launching your project:

- Key features of REA
- How is REA conducted?
- ROOTS of REA IN CLASSIC ETHNOGRAPHY
  - o Ethnography: Rendering a cultural scene
  - o Participant observation Practical considerations
- Combining qualitative data collection methods Foundations of data analysis in REA
- Foundations of data analysis in REA
  - o Foundations of data analysis in REA: Triangulation
  - o Foundations of data analysis in REA: Iteration
  - o Combining iteration and sequencing in data analysis

## Key features of REA

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**Being “objective” is not the goal** → **You learn through connections with people and their stories**

**Building rapport with informants is crucial** → **Relationships yield high quality data**

- Generates efficient preliminary insights that promote action
- Can be done when time is limited: Rapid feedback can require as little as 4 days to 6 weeks, on average (Hamilton, 2013)
- Uses rigorous data collection methods in fieldwork, to ensure quality and trustworthiness
- Is primarily qualitative and combines multiple methods (for example, interviews and observations)
- May incorporate rapid qualitative analysis (e.g., rapid template analysis) or quantitative data and methods (e.g., administrative records, surveys) (Gertner et al., 2021; Palinkas and Zatzick, 2019)
- Can be a foundation for mixed-methods studies (Palinkas and Zatzick, 2019)



## How can I establish relationships in a short period of time?

**Start building rapport before your research begins!** Continue your engagement throughout the study.

**Secure warm introduction.** How you are introduced to the scene is an important first step in building trust

**Inside stakeholders** can provide helpful input into project design and data collection (Rashid et al., 2019). For example, if clinical staff participate in the REA, it is crucial to obtain buy-in, before starting, from clinic leaders and other gatekeepers such as a nurse manager who controls access to nursing staff.

## Questions that REA can address

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### REA can address questions such as:

- What meaning does a process have for people, and how does that meaning influence their actions?
- What words or images do people use to describe their values, behaviors, and motivations?
- How are those words, images, or ideas translated and adapted across cultural contexts (for example, across departments, clinical teams, patients, and community members)?
- where do things get “lost in translation”?
- What are the unintended consequences when a “standard” process is used in a particular setting?
- How do people use technology in their work?

Throughout the toolkit, you will find questions, prompts, explanations, and examples to give you a solid foundation in REA as you consider or prepare to apply it. Keep reading to learn more about this work and help you decide if conducting an REA is right for your project.

## Examples of ethnographic approaches in implementation science

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The literature offers multiple illustrations of using ethnographic approaches in implementation science, especially when studying clinical settings (Bunce et al., 2014). Some examples include:

- Identifying context and determinants of implementation (barriers and facilitators) (Palinkas & Zatzick, 2019)
- Capturing external facilitation as an evidence-based implementation strategy (Reisinger et al., 2019) Informing measurements in a follow-up study (Palinkas and Zatzick, 2019; Holdsworth et al., 2020)
- Gathering user preferences to improve the intervention (Palinkas and Zatzick, 2019; Holdsworth et al., 2020)
- Evaluating success in implementation of clinical innovations (Bunce et al., 2014)

### Additional resources

**For an overview:** “A scoping review of the use of ethnographic approaches in implementation research and recommendations for reporting” (Gertner et al., 2021)

**For a focus on rapid ethnography and an applied clinical case study:** “Rapid Assessment Procedure Informed Clinical Ethnography (RAPICE) in Pragmatic Clinical Trials of Mental Health Services Implementation: Methods and Applied Case Study” (Palinkas and Zatzick, 2019).

## How is REA conducted?

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REA is conducted via repeated, intense interactions with clinic-based stakeholders (e.g., with an implementation team). These interactions include site visits (which we refer to as “visits”), in which those leading or advising on the REA go to the clinic to learn about its culture, physical layout, workflows, communications, and interactions. Visits including meeting with internal stakeholders.

- Visit length and frequency depend on a variety of factors such as time, resources, and access.
- Visits are part of an overall effort to **build relationships with local stakeholders**. Relationship-building ideally starts early in REA launch and may continue after its conclusion to support solving problems surfaced during visits.
- Activities during visits can include observations, interviews with clinic staff, and review of documents such as huddle cards or patient brochures. To optimize visit time, activities such as document review can occur before or after the onsite visit.
- Ackerman et al. (2017) is an example study that used site visits to understand processes for implementing a patient portal.



## Assumptions of REA

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- Meaningful relationships can be created in a short time with a predisposition to partnership and curiosity about the “field” — the clinical setting, its people, and context. Geographic proximity helps but see the section on **digital ethnography** for resources that support remote engagement.
- Researcher reflexivity is important. It serves to recognize the positionality of the team, power dynamics, and social capital that might influence data collection, and requires reflection on how to acknowledge and mitigate imbalances.
- Multiple visits and engagements may be possible, but boundaries of the field such as access to the clinic and its context are subject to change.
- Understanding how to create and sustain meaningful relationships **before the visit** is important pre-work.
- Change can be tracked through short, intense visits over time or during critical times, for example, through observation of monthly clinic leadership meetings or staff trainings. Further questions and methods can be explored to be sure what is captured during these short visits represents routine or standard practice and is not a one-off.
- Understanding complex dynamics and relationships is based on **being open to new knowledge** from the field that goes beyond what was planned or previously understood. Even as the REA aims to address specific problems or questions, **cultivating this openness** is crucial to allow for unexpected findings.

## Final considerations before using REA

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Is REA truly the right method for your project? Below are key considerations for deciding about and planning to use REA methodology:

- **Breadth versus depth of data.** REA collects a breadth of data to capture features of a clinical setting quickly. It does not involve long-term immersion in the culture of the clinic.
- **Representativeness and sampling.** Participants (for example, frontline staff in a mental health clinic) will likely not be representative of an entire population (e.g., all mental health professionals), but rather reflect key roles and activities in the clinic being studied.
- **Engagement by a research team.** REA is a team-based method to get rapid results. It’s difficult for an individual to effectively do multimethod, rapid-turnaround research. Forming a team to conduct the REA is a critical step.
- **“In and out” researcher versus long-term engagement.** REA often requires repeated, intense visits or interactions with the site over a relatively short period, rather than continuous, long-term involvement. Make sure a rapid approach suits your research question.

## Remember

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- **Make time for reflective practices.** This means researchers and others engaging in the REA should set aside adequate time to reflect on their beliefs, values, questions, and judgements during the research process. This is an important aspect of the work and should not be shortchanged by a tight timeline.
- **Pay attention to research governance and ethical principles.** Responsibility and ethics are especially important in REA because fieldwork is involved. Some questions to ask include Who is supervising the research? What documents, if any, collect key principles of the project and its conduct in the field? What are the implications of onsite projects for clinic staff (e.g., privacy, autonomy, impact on performing daily tasks)?

## Our principles and goals for the REA toolkit V.1.0

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REA relies on foundational ethnographic principles. We adopt a critical, questioning stance toward the structures, institutions, and power relations that shape the setting and culture we enter. Our toolkit **enables and promotes surfacing structures and their effects** (a key goal of ethnographic practice). We support centering health equity as REA data are collected and analyzed to uncover implementation determinants and believe this focus is critical to success. By optimizing evidence-based intervention implementation, we can **identify barriers to health equity and improve population health through more effective care delivery.**

[Return to Table of Contents](#)

# ROOTS OF REA IN CLASSIC ETHNOGRAPHY

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Ethnography: Rendering a cultural scene	<a href="#"><u>12</u></a>
1. Participant observation	<a href="#"><u>12</u></a>
2. Fieldwork and fieldnotes	<a href="#"><u>14</u></a>
3. Long-term engagement	<a href="#"><u>14</u></a>
4. Revealing social relations and cultural norms of a group of people	<a href="#"><u>15</u></a>
5. Holistic approach	<a href="#"><u>15</u></a>

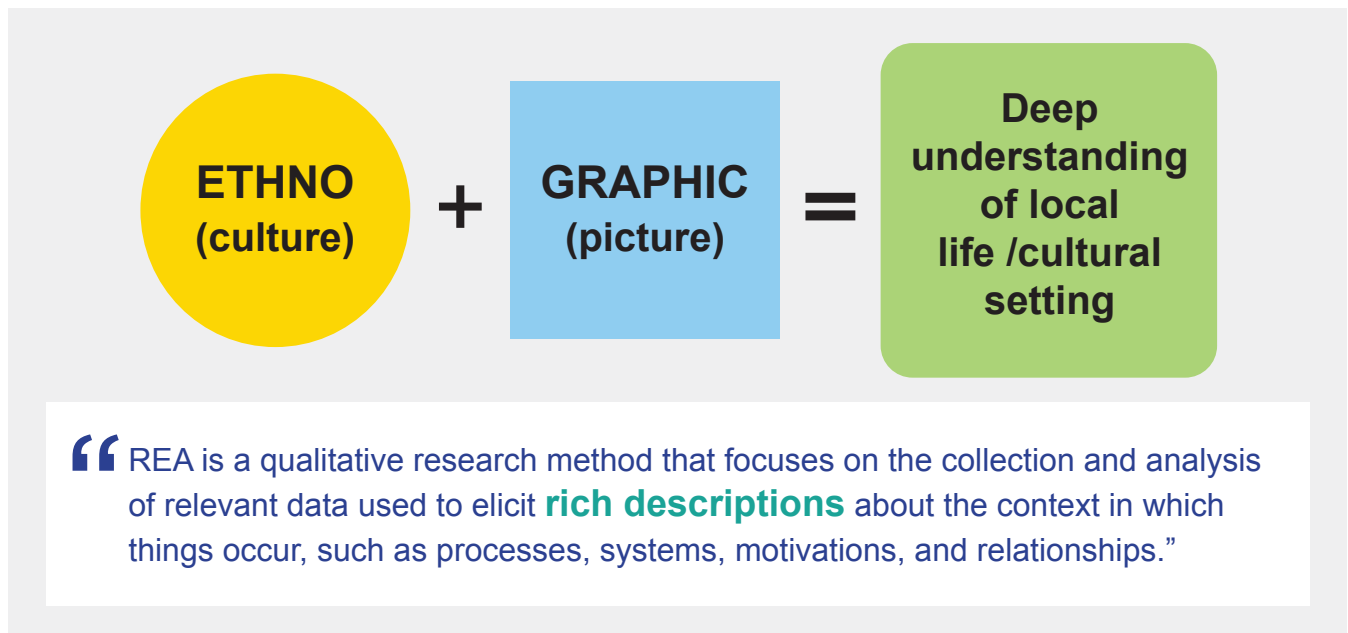
[\*Return to Table of Contents\*](#)

# Ethnography: Rendering a cultural scene

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REA rests on the rich foundation of classic ethnography whose main goal — it is worth repeating — is to learn from people (insiders) about their culture and cultural knowledge (insider meanings) (Green et al., 2012). Below are the core tenets of ethnography. They still apply in REA but are adapted to a shortened timeline and a team-based approach

1. Participant observation
2. Fieldwork and fieldnotes
3. Long-term engagement
4. Goal of revealing social relations and cultural norms of a group of people
5. Holistic approach



## 1. Participant observation

**Participant observation** is different from observation — you enter a scene and do what others in the setting do. The critical stance in Shah’s quote below is part of the epistemology of ethnography and REA (Shah, 2017).

*“Participant observation enables us to literally turn things on their head. It enables us to challenge received wisdoms and produce knowledge that previously had no space in the world, was confined to its margins, was silenced. Engaging in participant observation is thus a profoundly political act, one that can enable us to challenge hegemonic conceptions of the world, challenge authority, and better act in the world.”*

However, it's difficult to do true participation in clinics and hospitals...

**“Negotiated interactive observation”** is a balance of intimacy and distance — an alternative in clinic settings (Wind, 2008):

*“The concept of participant observation is based on a number of assumptions, particularly that the ethnographer will become one of ‘them’ to be able to follow the steps belonging to the accepted ethnographic research practice of doing fieldwork. The character of fieldwork in highly specialized healthcare systems does not fit well with this assumption. I suggest that we need to rethink the concept of participant observation and I propose negotiated interactive observation as a more appropriate way to describe ethnographic fieldwork in a setting such as the hospital or the clinic.”*

*Because full participant observation cannot be done in health care systems,  
**REA provides a range of methods to promote understanding.***

## 2. Fieldwork and fieldnotes

### Key characteristics of fieldwork:

- Involves “being there” — being around for unscheduled moments and conversations, which are often when key insights are learned or shared
- Requires being embedded in the setting over time Demands entering with cultural humility
- Involves a range of methods — video diaries, mapping, in-depth interviews, informal interviews — to gather information
- May include **design probes**, a self-documentation method in which users observe and reflect on their everyday lives and experiences, followed by documenting the experience, for example in writing

### Key characteristics of fieldnotes:

- They are a written account of participant observation recorded during or immediately after the observation
- They include descriptive, reflective, and reflexive statements (i.e., they document fieldwork, but also include reflections, questions, and emotions related to the observation)
- Best practices include keeping a vocabulary list of new terms learned in the field and trying to capture verbatim snippets

## 3. Long-term engagement

Ethnography is about breadth and depth of information and involves **long-term engagement**:

- Goal: Bring out the insider’s perspective
- Essential feature: Build rapport, trust and relationships
- Requirement: Multiple contacts with people over time

### Modifications for REA:

- Brief full immersions to capture many perspectives at once
- **Maximization of opportunities for relationships** before, between, during, and after engagements, since rapport and trust are hard to build during REA

## 4. Revealing social relations and cultural norms of a group of people

This central purpose of ethnography involves noting power hierarchies and social **obligations and the importance of strong and weak social ties**. Key questions of this principle are:

- What are the unstated rules and assumptions?
- What values guide action, and inaction, in this context?
- How might potentially harmful actions actually be survival strategies? What functions do they serve? What may appear to be barriers in the clinic might be serving a function that is important to understand **before strategies to address the barriers can be effective**. An example is digital workarounds or shortcuts that staff develop that become barriers to using complex IT tools as intended.



The goal of REA remains to **understand the culture, norms, activities, and social relations of a group of people**, but that goal is tailored to a certain locale (e.g., hospital), a shortened timeline, and a narrower focus (e.g., unearthing barriers to widespread adoption of a new treatment).

## 5. Holistic approach

Ethnography is holistic. Taking a holistic approach means that:

- You look at the cultural scene as a whole, noting details about all aspects of a process or clinic
- You follow the trail, going where key informants or your own field observations take you
- You have a willingness to depart from an a priori protocol (while keeping in mind your research question)
- You capture the complete context of a person's world or social milieu.

he value of a holistic approach is that being present and seeing the dynamics within a context may guide you toward barriers that stakeholders may not tell you about or even recognize.

[Return to Table of Contents](#)

# PLANNING THE REA

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When to use REA	<a href="#"><u>17</u></a>
Key questions to guide REA planning	<a href="#"><u>18</u></a>
Practical considerations	<a href="#"><u>19</u></a>

[\*Return to Table of Contents\*](#)



## When to use REA

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REA is useful when:

1. Understanding context for implementation is key.
2. Little is known or understood about the problem or situation.



**Fieldwork is necessary to understand what is going on, and serves as a foundation for further qualitative work.** For example, REA can reveal how the contextual characteristics of hospitals and skilled nursing facilities can affect patient readmissions (Ayele et al., 2021).

3. Researchers need access to hidden or vulnerable populations. For example, REA can help identify gatekeepers in a clinic and the community it serves to help secure that access.



This point refers to both the “community” formed by health care workers within a clinic and the larger community served by the clinic.

4. The method is acceptable to stakeholders, and researchers have access to the clinic and personnel. In one example, REA was conducted to quickly understand the impact of the COVID-19 pandemic on mental health services delivery at a trauma center (Palinkas et al., 2022).
5. An intervention needs to be culturally relevant before implementation. For example, clinicians must be open to adopting new tools, or the proposed intervention has to be acceptable to diverse patients.
6. Researchers have the skills and resources to apply the method and analyze results, for example, they are able to collect, store, and analyze different data types. Because REA has a limited scope, it is often used when lengthier studies would be too expensive (e.g., community development projects) (Sangaramoorthy and Kroeger, 2020).



**REA is useful when conditions 1 to 6 (especially 1 to 2) are present, timeline for inquiry is short, the problem or topic is narrowly defined and the setting is well identified.**

[Return to Table of Contents](#)

## Key questions to guide REA planning

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Once REA has been determined to be the most appropriate methodology, a series of questions can help project teams look carefully at their research questions and goals to organize REA activities. Those questions are:

What do I need from the REA?

- What are my questions? What do I want to learn about implementation in the clinic?
- What are my goals for the project? Do I want to identify and prioritize barriers to implementation? Align strategies to barriers? Help clinical insiders design more effective workflows?



What do I need from the REA?

- A literature review, an environmental scan, or a survey can provide initial information, suggest questions, and help inform additional activities.

**Why do I need an insider perspective?** The answer to this question will be another “check” on whether REA is the most fruitful method for your project. **The REA allows you to learn:**

- How the insiders define and frame the problem.
- **Whose voices are included and whose voices are left out.** This aspect applies to both defining the issue or problem and planning the REA (e.g., deciding who you should talk to).

How can I best capture the insider perspective? Your team should discuss:

- What **activities** will be part of the REA and **who will conduct them?**
- What is the **timeline and how does it influence the REA scope?**

Where am I in the project and how can REA be useful?

- **Start of the project:** REA has a developmental/formative role. REA may help explore actual and potential barriers to implementing an evidence-based intervention so that clinic teams can proactively identify strategies to overcome barriers.
- **Project is ongoing:** REA allows for course corrections. An example is the implementation of a new patient-facing initiative that is not going well and no one knows where to find the source of the problems. REA can help identify hidden challenges and leverage insiders’ wisdom to solve them.
- **Regardless of project status, ask:** Who is **funding the work**, and for **what purpose?** What kind of evidence do the funders need or want, and how should these priorities **guide the work?**



Your responses to these questions will help define the REA scope and dissemination plan.

## Practical Considerations

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What resources are available? REA is resource intensive, so planning should account for essential resources, such as:

- **Staffing:** Who will make up the project team?
  - o Ideally at least one person has good knowledge of qualitative methods to lead planning and execution of the REA.
  - o If possible, the internal project team working with researchers should include diverse clinic roles and perspectives.
- **Administration:** Is administrative support sufficient — on the research team and clinic side — to handle logistics?
- **Technology:** What digital tools are available to supplement site visits?
- **Data management, preparation, and storage:**
  - o What software is available or can be purchased for the project? Can data confidentiality be assured?
- **Budget:** What funds are available for everything from travel to sites to interview incentives?

[Return to Table of Contents](#)

# REA DESIGN AND METHODS

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How to use the Design and Methods section	<a href="#"><u>21</u></a>
Select approaches to qualitative data collection for use in REA	<a href="#"><u>21</u></a>
Combining qualitative data collection methods	<a href="#"><u>22</u></a>
Foundations of data analysis in REA	<a href="#"><u>23</u></a>
Combining iteration and sequencing in Data Analysis	<a href="#"><u>26</u></a>
Components of data analysis	<a href="#"><u>26</u></a>
Data analysis best practices	<a href="#"><u>30</u></a>
Conducting REA in the virtual world	<a href="#"><u>30</u></a>

[\*Return to Table of Contents\*](#)

## How to use the Design and Methods section

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This toolkit does not provide introductory training to the qualitative methods of REA. Instead, the goal is to **support selecting feasible and appropriate methods** for REA by presenting a menu of choices along with resources that your team can use to get started.

Start using the **Design** and **Methods** section by addressing these questions:

- What data collection and analysis methods do I plan to use?
- What are my criteria for choosing a data collection and analysis approach (e.g., overall feasibility, acceptability, or resources)?

**Remember:** REA is an immersive approach. Study design and methods should support in-depth learning about the culture of a clinical setting and the everyday lives and activities of the people in it. Because REA centers the insider perspective, the most important objective is **to learn from those inside the clinic — what they think is important and should be studied**. Clinic stakeholders are the experts about their own world.

The researcher's trained eye can help unearth implementation issues that may be invisible to insiders because they are part of their cultural settings. Therefore, **skills in observation and other qualitative methods are critical to the REA**. "Being there" and seeing what people do are at the core of this method. It may be important to clarify the expertise and perspective of the team involved in the REA as it pertains to the evidence-based intervention. This will surface potential bias.

## Select approaches to qualitative data collection for use in REA

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- Observations (Patton, 2015)
  - Techniques can include shadowing (McDonald, 2005), guided tours, or observations recorded by video, audio, or online
- Conversations (Cohen and Crabtree, 2006)
  - Interviews can be in-depth, and unstructured or semi-structured or informal Focus groups (Morgan, 1997)
- Periodic reflection method (Finley et al., 2018) Questionnaires (Pew Research Center, 2022)
- Documentary analysis (text or other media, artifacts such as huddle cards) (Cohen and Crabtree, 2006)
- Fieldnotes (Phillippi and Lauderdale, 2017) (written or audio)
- Taking photos (Wang & Burris, 1997) (e.g., using photovoice, a combination of photos and participant narratives)
- Making videos (of processes, tasks, the physical setting, and team dynamics). For an example, see video reflexive ethnography (Hung et al., 2018)
- Participatory visual methods (e.g., timeline mapping)

## Combining qualitative data collection methods

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Qualitative data collection methods can be combined in the REA in either of two situations. 1) The methods are **based on the same epistemological and ontological perspective** (Mik-Meyer, 2020). For example, focus groups and interviews might be combined because they are both framed by the phenomenological approach. Or 2) Combining methods is **appropriate to answering the research question**.

- **Common multimethod combinations** include fieldnotes with interviews and/or documents. For example, interviews and focus groups can be combined with fieldnotes, photos, and diaries. Or fieldnotes of participant observations can be combined with content analysis of organizational policies.
- **Potential challenges of multimethod REA** include: 1) the need for sufficient expertise in qualitative methods. 2) The time and resources to gather, store, and analyze multiple datasets.

Below are two examples of combining qualitative data collection methods for implementation research in clinical settings.

### **Example #1: Rapid Assessment Procedure Informed Clinical Ethnography (RAPICE) in Pragmatic Clinical Trials of Mental Health Services Implementation**

- **Study objective:** The Palinkas and Zatzick (2019) applied case study is actually two large-scale effectiveness-implementation hybrid pragmatic clinical trials in the acute care medical practice context. They are the Disseminating Organizational Screening and Brief Intervention and the Trauma Survivors Outcomes and Support investigations. Both trials aimed to influence clinical effectiveness for patient outcomes while targeting national trauma center implementation policies.
- **Methods:** Participant observation of clinical trial activities and team-organized policy summits. Fieldnotes and jottings were recorded during clinical trial activities, while logs were compiled at summits. Semi-structured key informant interviews were conducted with front-line providers during the trials.
- **Analysis:** Data from participant observations and semi-structured interviews were combined with policy discussion summaries and triangulated with results from a national trauma center survey conducted by the study team. Study team members iteratively reviewed data from these multiple sources using, in part, categories derived from the Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) framework (Glasgow et al., 1999). Both templated and immersion/crystallization analytic approaches were used to interpret the data (Borkan, 2022; Brooks et al., 2015).

## Example #2: Meaningful use in the safety net: a rapid ethnography of patient portal implementation at five community health centers in California

- **Study objective:** To understand the implementation of secure patient portals in safety net health care systems (Ackerman et al., 2017).
- **Methods:** Rapid ethnography (3 months) with visits at 4 California safety net health systems and in-depth interviews at a fifth. Visits included interviews with clinicians and executives, informal focus groups with front-line staff, observations of patient portal sign-up procedures and portal use data, review of marketing materials, clinic work, and a brief survey.  
Observations and informal interviews with staff took place during clinic tours.
- **Analysis:** An iterative, team-based method with interpretations adjusted with each new data source. After repeatedly reading interview transcripts, fieldnotes, and survey responses, the researchers met regularly to develop a coding framework that was applied to all data. All transcripts and notes were coded and group discussions held to identify key themes across sites.

## Foundations of data analysis in REA

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Data analysis methods should be consistent with the emerging, grounded, **bottom-up nature of ethnography** (Sangaramoorthy and Kroeger, 2020). The more open the data collection instruments, the more likely you are to discover unexpected insights and new knowledge. For example, interview guides with even a few broad questions allow for people to share and talk at length. Implementation analysis frameworks (e.g., the Consolidated Framework for Implementation Research, or CFIR) can help guide these questions.

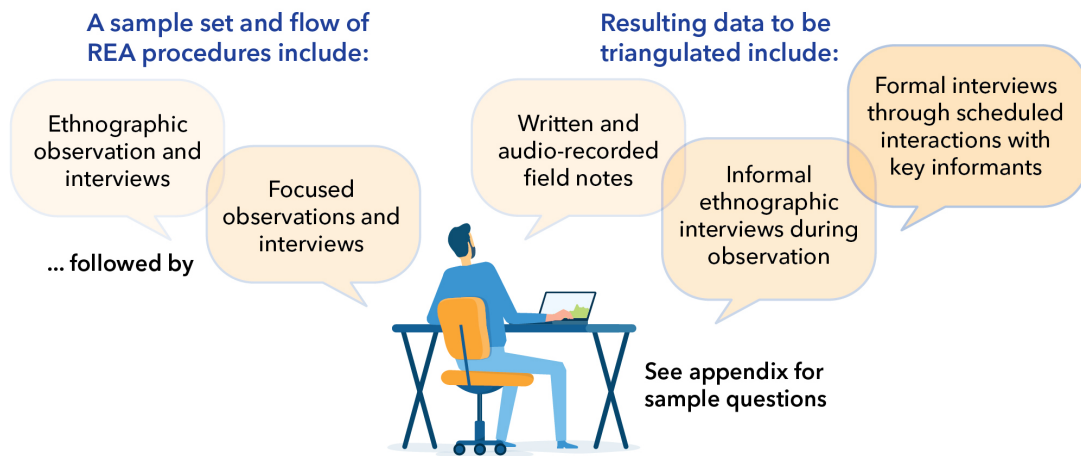
Two *processes* are key to data analysis in REA: triangulation and iteration. Data analysis has four *components*:

- Debriefing and memoing
- Data condensing and data reduction
- Data interpretation
- Data representation

## Processes of data analysis in REA: Triangulation

**Triangulation** refers to using a variety of research methodologies to study the same phenomenon. Triangulation uncovers different aspects of a phenomenon, including different perspectives gathered through complementary methods that aid in **enhancing the trustworthiness of findings, reducing bias, and achieving saturation** (Carter et al., 2014)

- Regardless of the data collection methods, **triangulation is an essential feature of REA.**
- Triangulation can involve qualitative and quantitative data. However, the focus in this toolkit is on **triangulating qualitative** data collected by complementary methodologies (Farmer et al., 2006).



### ASK people what they do



Use formal or informal interviews, or focus groups

### OBSERVE what people do



Use participant observation (variations can include shadowing, or touring)

### LEARN about the context of what people do



Use secondary data, such as basic metrics about the clinic, huddle cards, workflows, leadership communications, organizational history, and policies

- **For the ethnographic approach and triangulation to work**, data collection activities should be chosen from 1 of the 3 categories above.
- **Achieving triangulation by sequencing or combining these steps** can take several forms and be planned or decided based on circumstances (e.g., if interviews are delayed, use observations or document analysis instead).
- **Member checking or member reflections is an important step.** Asking people if what you think you are seeing matches their understanding of the issue can help with trustworthiness and triangulation (Birt et al., 2016).



## Processes of data analysis in REA: Iteration

- **Iteration or an iterative approach** refers to a “loop-like pattern of multiple rounds of revisiting the data as additional questions emerge, new connections are unearthed, and more complex formulations develop along with a deepening understanding of the material” (Srivastava, et al., 2009; Berkowitz, 1997).
- **Iteration is not a mechanical process.** It is an opportunity for reflection (Srivastava and Hopwood, 2009; Berkowitz, 1997):

*“Reflexive iteration is at the heart of visiting and revisiting the data and connecting them with emerging insights, progressively leading to refined focus and understandings.”*  
(Srivastava and Hopwood, 2009).

- **Three questions help frame iterative data analysis**
- What are the data telling me? (How am I understanding the data? Am I engaging with the epistemology and ontology of the REA? (Srivastava and Hopwood, 2009; Berkowitz, 1997).
- What is it I want to know (according to objectives and original questions)? (Srivastava and Hopwood, 2009; Berkowitz, 1997).
- What is the dialectical relationship between what the data are telling me and what I want to know (refining the focus and linking back to the original questions)? (Srivastava, et al., 2009; Berkowitz, 1997).

Iteration is applied to the triangulation procedure in the figure.



### Data collection is completed by:

- asking people about what they do;
- observing what they do; and
- learning about context — ideally, by going through at least two rounds of iteration

### Two rounds of iteration:

For example, you can start by learning about the clinic and the community it serves, observe key activities, interview people about what was observed (you may uncover other observation opportunities), key informants to talk to, and policies to read and understand

### Team members debrief:

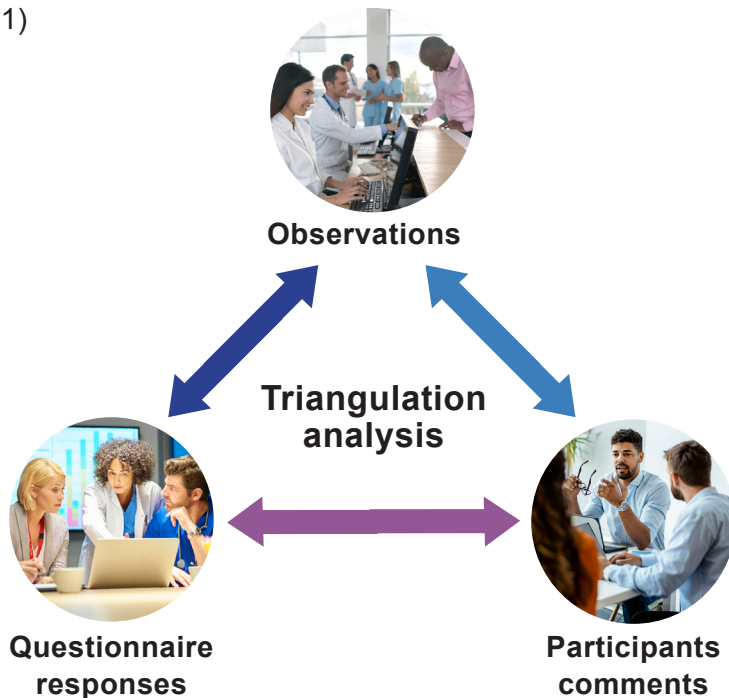
Team members involved in data collection get together to debrief, collect more data, and debrief again



Each team member analyzes a set of observation fieldnotes, discusses procedures and any insights found so far, and uses the understanding and refined tools (e.g., code lists, templates) to analyze more fieldnotes

## Combining iteration and sequencing in data analysis

Example (Heath, 2001)



## Components of data analysis

- [Debriefing and memoing](#)
- [Data interpretation](#)
- [Data reduction](#)
- [Data representation](#)

### Debriefing and memoing

#### Debriefing:

- Budget debriefing time. Depending on the timeline and intensity of data collection, you may want to debrief more frequently to allow for rapid course corrections.
- Talk and process information with the team, such as your reflections on data collection activities (e.g., issues with access, or interview glitches) (Birks et al., 2008).

*“Communicate and triangulate what is being learned across team members, data sources, and data collection methods”  
(Sangaramoorthy and Kroeger, 2020)*

- **Avoid predicting or assuming ideas or explanations.** Focus on the data. Even if you are using an explanatory framework, don't dismiss new or unexpected findings because they don't seem to "fit."
- **Document debriefing sessions**

**Memoing:**

Process of writing reflective notes about the data.

**Used at any point in the analysis process** to capture ideas, initial data interpretations, reflection on context, and thoughts on next analytic steps.

**Memos can:**

- Be viewed as "notes to self" so initial data insights aren't lost
- Allow you to be in constant dialogue with emerging themes from the field
- Be structured or unstructured (an example of structure is including summaries of data collection events, such as focus group sessions)
- Be circulated among team members to capture others' preliminary impressions and reactions
- Be written after each data collection episode or batch (e.g., memos after every 2 of 10 interviews may be a reasonable pace)

At each step in the process, team participation and exchange, iterative analysis, and reflective writing can help with surfacing themes, critically examining emerging findings, and combating bias.

## Data condensation and reduction

### Data condensation

Emerging patterns across all data collection episodes are presented in a skimmable format (e.g., a Word cloud) (<https://www.betterevaluation.org/en/evaluation-options/wordcloud>) to help team members see, understand, and discuss preliminary insights.

### Data reduction

- Data are shortened and then analyzed by choosing how the data should be emphasized, downplayed, or set aside. Choices can be guided by themes that emerged from the data, along with your project's goals and questions (Berkowitz, 1997).

Two techniques of data reduction are:

- Immersion: Reading or viewing the text (transcripts, fieldnotes) or other collected materials multiple times to gain a broad understanding of the data.
- Coding: Systematic grouping of data into units of meaning that are given labels, also known as codes, that are sorted into concepts and categories. In REA, coding requires training or experience in qualitative methods and ideally is done by at least 2 people.

*“Data condensation refers to the process of selecting, focusing, simplifying, abstracting, and/or transforming the data that appear in the full corpus (body) of written-up field notes, interview transcripts, documents, and other empirical materials. By condensing, we’re making data stronger.”*

## Data interpretation

In REA, data are most often interpreted through thematic analysis. **Thematic analysis** is a method for identifying, analyzing, organizing, describing, and reporting themes found within qualitative data (Sutton and Austin, 2015). With thematic analysis:

- Codes are combined from 1 or more data sources to present findings of qualitative research in a clear and meaningful way.
- Practical steps include thinking about the information in context: How, when, where, and how often?
- Researchers categorize relationships among data, for example:
  - o Things that happen together
  - o The order things tend to happen
  - o Things that cause other things
  - o Things that prevent other things from happening
- Be sure to note data gaps or outliers: How should they be interpreted? How do they affect interpreting results and drawing conclusions?

Displaying qualitative data effectively can aid REA teams to organize and interpret information quickly. While narrative text with quotes is traditionally used to make sense of ethnographic data, other techniques can reveal patterns and relationships among large volumes of information (Sangaramoorthy and Kroeger, 2020; Abramson and Dohan, 2015). Moreover, creative data representation can help to communicate preliminary findings to diverse stakeholders. The table below summarizes common types of data displays. See the Appendix for examples and citations.

Types of Visual Displays and Purposes (Verdinelli, 2013)

Visual display	Purpose
<b>Box display</b>	To highlight a specific narrative considered important and frame it in a box
<b>Decision tree modeling</b>	To describe options, decisions, and actions
<b>Flow chart</b>	To illustrate directional flow and show pathways of different groups
<b>Ladder</b>	To represent the dimensions of the progression of certain phenomenon through time or to show levels or stages
<b>Matrix</b>	To cross two or more dimensions, variables, or concepts of relevance to the topic of interest
<b>Metaphorical visual display</b>	To depict in a metaphorical way the topics or themes found

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More ideas can be found here:

[https://www.betterevaluation.org/en/rainbow\\_framework/describe/visualise\\_data](https://www.betterevaluation.org/en/rainbow_framework/describe/visualise_data)

## Data analysis best practices

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- Decide how to analyze qualitative data based on available tools (e.g., qualitative software, Microsoft Excel or Word) and team members' skills.
- Start the analysis as soon as the data are available. Be sure to document all methods and decisions, and keep your documentation up to date.
- Let early analysis insights inform instruments and ongoing field activities. For example, if you realize that a barrier emerging from early analysis should be explored further in your remaining interviews, add a question to the interview guide to uncover and understand the barrier and its potential patterns.
- **Remember that the analysis is iterative, and team based.** Continue to engage all team members and perspectives in each phase to support inclusiveness and enhance the richness of the analysis.
- Consider sharing analytic categories and emerging themes with clinic partners as a form of member checking (Birt et al., 2016).



## Conducting REA in the virtual world

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- If in-person visits to clinics where the REA is planned are not possible, or you have time limits or other constraints, **digital tools and techniques can help complete the project.** Building rapport with the site may be more challenging and require additional thoughtful planning.
- Meetings with the site before the project starts can help establish relationships, while site
- stakeholders' input into finalizing the REA design is most important (for reasons of practical feasibility and relationship building).
- Common data collection activities include interviews, focus groups, and field work/observations, and may be completed via digital tools, but require special attention to:
  - o Technology skills and coordination with project team members
  - o Technology skills, access, and support for participants
  - o Ethical considerations (i.e., privacy and confidentiality)

[Return to Table of Contents](#)

# DISSEMINATION OF FINDINGS

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Planning for dissemination [32](#)

Means of dissemination [32](#)

[\*Return to Table of Contents\*](#)

# Planning for dissemination

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## Questions for planning to disseminate findings from the REA:

What is going to be disseminated (for example, preliminary or final results)? If you're working on a multisite study, which clinic(s) will be receiving study results or reports?

- Who is the audience? Think more broadly than a clinic's staff and leadership. For example, will you send results to patient groups or representatives, other clinics in the same catchment area, the community the clinic serves, or implementation practitioners and researchers?
- If you have been in contact with clinic stakeholders, consider involving them at this stage. What do they need to know, and in what form? What other users can they suggest?
- What are key findings and main takeaways? Different aspects may be emphasized for different audiences. Strategic and internal political considerations might affect what is most relevant for your audience.
- How will the findings (if known) be used?
- Consider including lessons learned or recommendations from your findings (Carpenter, 2012).

## Means of dissemination

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### How do I disseminate REA findings? (Carpenter, 2012)

- What are the most effective channels to reach your audience?
- Keep in mind that a combination of methods or channels could optimize dissemination (e.g., a comprehensive report can be coupled with a one-page summary and presentation)
- Which of the available methods would be feasible and realistic?
- Consider costs, timeline, staff availability, plus limitations unique to each organization Possible dissemination means and channels include (but are not limited to): Publications
- Reports
- Websites and other electronic communications Presentations at meetings and conferences Person-to-person communications
- Formal collaborations or informal networks
- Newsletters

[Return to Table of Contents](#)



# APPENDIX: REA Sample Tools & Resources

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## Resources for digital REA

### General

- [Collaboratively generated list of methods for field work during a pandemic](#)
- [Asynchronous remote communities for researching distributed populations \(ARC\)](#)
- [Ethics and digital health](#)
- [Visual Tools for Collaboration video on remote collaboration and Miro](#)
- [Digital Ethnography Initiative, Department of Social and Cultural Anthropology, University of Vienna](#)

### Focus groups

- [Online Focus Groups: How Do They Work?](#)

### Intervention design

- [Creative Informatics Guide for Online Events – Fingerprint — University of Edinburgh](#)
- [Tips & tools for facilitating remote user research, see resources](#), see resources

### Literature

- “Insights for conducting real-time focus groups online using a web conferencing service” (Kite and Phongsavan, 2017)
- “Using Zoom Videoconferencing for Qualitative Data Collection: Perceptions and Experiences of Researchers and Participants” (Archibald et al., 2019)

[\*Return to Table of Contents\*](#)

## Sample ethnographic interview questions

<b>GRAND TOUR</b>	Could you describe a typical day at this office?
<b>MINI TOUR</b>	Could you describe a typical patient encounter?
<b>TASK</b>	Describe how you would use ProCRCScreen
<b>EXAMPLE</b>	Could you give me an example of workflow?

## Examples of qualitative data representation

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- Boxed display: “Negotiating the Politics of Identity in an Interdisciplinary Research Team” (Lingard et al., 2007)
- Decision tree modeling: “Complementary and Alternative Medicine for Children’s Asthma: Satisfaction, Care Provider Responsiveness, and Networks of Care” (Freidin and Timmerman, 2008) Flow chart: “Storying Childhood Sexual Abuse” (Draucker and Martsolf, 2008)
- Matrix: “Discourse Tracing as Qualitative Practice” (LeGreco and Tracy, 2009)
- Metaphorical visual display: “Reproductive Decisions for Women with HIV: Motherhood’s Role in Envisioning a Future” (Barnes and Murphy, 2009)
- Modified Venn diagram: “Mapping the Processes and Qualities of Spiritual Nursing Care” (Carr, 2008)
- Network: “Homebirth as Systems-Challenging Praxis: Knowledge, Power, and Intimacy in the Birthplace” (Cheyney, 2008)
- Taxonomy: “Developing a Theory from Complexity: Reflections on a Collaborative Mixed Method Participatory Action Research Study” (Westhues et al., 2008)
- Arrays: “Beyond text: Using arrays to represent and analyze ethnographic data” (Abramson and Dohan, 2015)

[Return to Table of Contents](#)

# REFERENCES

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- Abramson, M.C., & Dohan, D. (2015). Beyond text: Using arrays to represent and analyze ethnographic data. *Sociological Methodology*, 45(1), 272-319
- Ackerman, S. L., Sarkar, U., Tieu, L., Handley, M. A., Schillinger, D., Hahn, K., Hoskote, M., Gourley, G., & Lyles, C. (2017). Meaningful use in the safety net: a rapid ethnography of patient portal implementation at five community health centers in California. *Journal of the American Medical Informatics Association*, 24(5), 903-912. <https://doi.org/10.1093/jamia/ocx015>
- Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom Videoconferencing for Qualitative Data Collection: Perceptions and Experiences of Researchers and Participants. *International Journal of Qualitative Methods*, 18, 1609406919874596. <https://doi.org/10.1177/1609406919874596>
- Ayele, R., Manges, K. A., Leonard, C., Lee, M., Galenbeck, E., Molla, M, Levy, C., & Burke, R.E. How Context Influences Hospital Readmissions from Skilled Nursing Facilities: A Rapid Ethnographic Study. (2021). *Journal of the American Medical Directors Association*, 22(6), 1248-1254.e3. doi.org/10.1016/j.jamda.2020.08.001.
- Barnes, D. B., & Murphy, S. (2009). Reproductive decisions for women with HIV: motherhood's role in envisioning a future. *Qual Health Res*, 19(4), 481-491. <https://doi.org/10.1177/1049732309332835>
- Berkowitz, S. (1997). *Analyzing qualitative data*. Arlington, VA: Division of Research, Evaluation and Communication, National Science Foundation. <http://www.nsf.gov/pubs/1997/nsf97153/start.htm>.
- Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing*, 13(1), 68-75. <https://doi.org/10.1177/1744987107081254>
- Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qual Health Res*, 26(13), 1802-1811. <https://doi.org/10.1177/1049732316654870>
- Borkan, J. M. Immersion–Crystallization: a valuable analytic tool for healthcare research. (2022). *Family Practice*, 39, 785–789 <https://doi.org/10.1093/fampra/cmab158>
- Brooks J, McCluskey S, Turley E, & King N. (2015). The Utility of Template Analysis in Qualitative Psychology Research. *Qual Res Psychol*, 12(2):202-222. doi: 10.1080/14780887.2014.955224.
- Bunce, A. E., Gold, R., Davis, J. V., McMullen, C. K., Jaworski, V., Mercer, M., & Nelson, C. (2014). Ethnographic process evaluation in primary care: explaining the complexity of implementation. *BMC Health Services Research*, 14(1), 607. <https://doi.org/10.1186/s12913-014-0607-0>

- Carpenter, D. (2012). *Dissemination Planning Tool: Exhibit A from Volume 4*. <https://www.ahrq.gov/patient-safety/resources/advances/>
- Carr, T. (2008). Mapping the processes and qualities of spiritual nursing care. *Qual Health Res*, 18(5), 686-700. <https://doi.org/10.1177/1049732307308979>
- Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncol Nurs Forum*, 41(5), 545-547. <https://doi.org/10.1188/14.Onf.545-547>
- Charani, E., Tarrant, C., Moorthy, K., Sevdalis, N., Brennan, L., & Holmes, A. H. (2017). *Understanding antibiotic decision making in surgery—a qualitative analysis*. *Clinical Microbiology and Infection*, 23(10), 752-760. <https://doi.org/10.1016/j.cmi.2017.03.013>
- Cheyney, M. J. (2008). Homebirth as systems-challenging praxis: knowledge, power, and intimacy in the birthplace. *Qual Health Res*, 18(2), 254-267. <https://doi.org/10.1177/1049732307312393>
- Cohen, D., & Crabtree, B. (2006). *Qualitative Research Guidelines Project*. Robert Wood Johnson Foundation. <http://www.qualres.org/HomeInte-3595.html>
- Draucker, C. B., & Martsof, D. S. (2008). Storying childhood sexual abuse. *Qual Health Res*, 18(8), 1034-1048. <https://doi.org/10.1177/1049732308319925>
- Emerson, R. M., Fretz, R. I., & Shaw, L. L. . (2011). *Writing ethnographic fieldnotes*. 2nd ed. Chicago, The University of Chicago Press.
- Farmer, T., Robinson, K., Elliott, S. J., & Eyles, J. (2006). Developing and implementing a triangulation protocol for qualitative health research. *Qual Health Res*, 16(3), 377-394. <https://doi.org/10.1177/1049732305285708>
- Finley, E. P., Huynh, A. K., Farmer, M. M., Bean-Mayberry, B., Moin, T., Oishi, S. M., Moreau, J. L., Dyer, K. E., Lanham, H. J., Leykum, L., & Hamilton, A. B. (2018). Periodic reflections: a method of guided discussions for documenting implementation phenomena. *BMC Med Res Methodol*, 18(1), 153. <https://doi.org/10.1186/s12874-018-0610-y>
- Freidin, B., & Timmermans, S. (2008). Complementary and alternative medicine for children's asthma: satisfaction, care provider responsiveness, and networks of care. *Qual Health Res*, 18(1), 43-55. <https://doi.org/10.1177/1049732307308995>
- Gertner, A. K., Franklin, J., Roth, I., Cruden, G. H., Haley, A. D., Finley, E. P., Hamilton, A. B., Palinkas, L. A., & Powell, B. J. (2021). A scoping review of the use of ethnographic approaches in implementation research and recommendations for reporting. *Implementation research and practice*, 2, 2633489521992743. <https://doi.org/10.1177/2633489521992743>.
- Glasgow RE, Vogt TM, & Boles SM (1999). Evaluating the public health impact of health promotion interventions: The RE-AIM framework. *American Journal of Public Health*, 89, 1322–1327.
- Goodall, H. (2000). *Writing the new ethnography* / H.L. (Bud) Goodall. Jr. AltaMira Press.

- Green, J. L., Skukauskaite, A., & Baker, W. D., *Ethnography As Epistemology*. (2012). [https://www.researchgate.net/publication/257927928\\_Ethnography\\_as\\_epistemology\\_An\\_introduction\\_to\\_educational\\_ethnography](https://www.researchgate.net/publication/257927928_Ethnography_as_epistemology_An_introduction_to_educational_ethnography)
- Hamilton, A.B. (2013). [https://www.hsrd.research.va.gov/for\\_researchers/cyber\\_seminars/archives/780-notes.pdf](https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/780-notes.pdf)
- Heath, L. Triangulation: methodology. (2001). In N. J. Smelser & B. Baltes (eds.), *International Encyclopedia of the Social and Behavioral Sciences*. pp. 23.
- Holdsworth, L. M., Safaeinili, N., Winget, M., Lorenz, K. A., Lough, M., Asch, S., & Malcolm, E. (2020). Adapting rapid assessment procedures for implementation research using a team-based approach to analysis: a case example of patient quality and safety interventions in the ICU. *Implement Sci*, 15(1), 12. <https://doi.org/10.1186/s13012-020-0972-5>
- Hung, L., Phinney, A., Chaudhury, H., & Rodney, P. (2018). Using Video-Reflexive Ethnography to Engage Hospital Staff to Improve Dementia Care. *Glob Qual Nurs Res*, 5, 2333393618785095. <https://doi.org/10.1177/2333393618785095>
- Kite, J., Phongsavan, P. (2017). Insights for conducting real-time focus groups online using a web conferencing service. *F1000Research*, 6, 122-122. <https://doi.org/10.12688/f1000research.10427.1>
- LeGreco, M., & Tracy, S. J. (2009). Discourse Tracing as Qualitative Practice. *Qualitative Inquiry*, 15, 1516 - 1543.
- Lingard, L., Schryer, C. F., Spafford, M. M., & Campbell, S. L. (2007). Negotiating the politics of identity in an interdisciplinary research team. *Qualitative Research*, 7(4), 501-519. <https://doi.org/10.1177/1468794107082305>
- Livingston, J. (2012). *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic* Duke University Press.
- McCullough, M.B., Chou, A.F., & Solomon, J.L. et al. (2015). The interplay of contextual elements in implementation: an ethnographic case study. *BMC Health Serv Res* 15, 62. <https://doi.org/10.1186/s12913-015-0713-7>
- McDonald, S. (2005). Studying actions in context: a qualitative shadowing method for organizational research. *Qualitative Research*, 5(4), 455-473. <https://doi.org/10.1177/1468794105056923>
- Mik-Meyer, N. (2020). Multimethod qualitative research. In (pp. 357-374). [https://www.researchgate.net/publication/348651286\\_Multimethod\\_qualitative\\_research](https://www.researchgate.net/publication/348651286_Multimethod_qualitative_research)
- Miles, M. B., & Huberman, A. M. . (1994). *Qualitative data analysis: An expanded sourcebook* ((2nd ed.) ed.). Sage Publications, Inc.
- Miles, M. B., Huberman, A. M., Saldana, J. (2019) *Qualitative Data Analysis A Methods Sourcebook*, fourth edition, p12.

- Morgan, D. (1997). *Focus Groups as Qualitative Research*. SAGE Publications, Inc. <https://doi.org/10.4135/9781412984287>
- National Cancer Institute. (2020). DCCPS Qualitative methods in implementation science. In.
- Nevedal, A. L., Reardon, C. M., Opra Widerquist, M. A., Jackson, G. L., Cutrona, S. L., White, B. S., & Damschroder, L. J. (2021). Rapid versus traditional qualitative analysis using the Consolidated Framework for Implementation Research (CFIR). *Implement Sci*, 16(1), 67. <https://doi.org/10.1186/s13012-021-01111-5>
- Palinkas, L. A., & Zatzick, D. (2019). Rapid Assessment Procedure Informed Clinical Ethnography (RAPICE) in Pragmatic Clinical Trials of Mental Health Services Implementation: Methods and Applied Case Study. *Adm Policy Ment Health*, 46(2), 255-270. <https://doi.org/10.1007/s10488-018-0909-3>.
- Palinkas, L.A., Engstrom, A., & Whiteside, L. et al. (2022). A Rapid Ethnographic Assessment of the Impact of the COVID-19 Pandemic on Mental Health Services Delivery in an Acute Care Medical Emergency Department and Trauma Center. *Adm Policy Ment Health* 49, 157–167. <https://doi.org/10.1007/s10488-021-01154-2>
- Patton, M. Q. (2015). *Qualitative research & evaluation methods : integrating theory and practice*.
- Phillippi, J., & Lauderdale, J. (2017). A Guide to Field Notes for Qualitative Research: Context and Conversation. *Qual Health Res*, 28(3), 381-388. <https://doi.org/10.1177/1049732317697102>
- Pew Research Center. (2022). *Writing Survey Questions*. Pew Research Center <https://www.pewresearch.org/our-methods/u-s-surveys/writing-survey-questions/>
- Rashid, M., Hodgson, C. S., & Luig, T. (2019). Ten tips for conducting focused ethnography in medical education research. *Med Educ Online*, 24(1), 1624133. <https://doi.org/10.1080/10872981.2019.1624133>
- Reisinger, H. S., McCullough, M. B., Martin, L. A., Hamilton, A. B., & Finley, E. P. (2019). *Ethnography As A Catalyst For Innovation In Implementation Science: Dynamic Methods For Complex Interventions QUERI Implementation Network Cyberseminar*, [https://www.hsrd.research.va.gov/for\\_researchers/cyber\\_seminars/archives/3584-notes.pdf](https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/3584-notes.pdf)
- Sangaramoorthy, T., & Kroeger, K. (2020). *Rapid Ethnographic Assessments: A Practical Approach and Toolkit For Collaborative Community Research*. <https://doi.org/10.4324/9780429286650>
- Shah, A. (2017). Ethnography? Participant observation, a potentially revolutionary praxis. *Hau: Journal of Ethnographic Theory*, 7(1), 45–59.
- Srivastava, P., & Hopwood, N. (2009). A Practical Iterative Framework for Qualitative Data Analysis. *International Journal of Qualitative Methods*, 8(1), 76-84 <https://doi.org/10.1177/160940690900800107>
- Verdinelli, N. I. S. (2013). Data Display in Qualitative Research. *International Journal of Qualitative Methods*, 2(1), 359-381.



- Sutton, J., & Austin, Z. (2015). Qualitative Research: Data Collection, Analysis, and Management. *Can J Hosp Pharm*, 68(3), 226-231. <https://doi.org/10.4212/cjhp.v68i3.1456>
- Vindrola-Padros, C. (2021). *Rapid Ethnographies: A Practical Guide*. Cambridge: Cambridge University Press. doi:10.1017/9781108623568
- Visualize data. Methods and processes. *Better Evaluation*, <https://www.betterevaluation.org/en/evaluation-options/wordcloud>. Accessed October 28, 2022
- Wang, C., & Burris, M. A. (1997). Photovoice: concept, methodology, and use for participatory needs assessment. *Health Educ Behav*, 24(3), 369-387. <https://doi.org/10.1177/109019819702400309>
- Westhues, A., Ochocka, J., Jacobson, N., Simich, L., Maiter, S., Janzen, R., & Fleras, A. (2008). Developing theory from complexity: reflections on a collaborative mixed method participatory action research study. *Qual Health Res*, 18(5), 701-717. <https://doi.org/10.1177/1049732308316531>
- Whitehead, T.L. (2002). What is Ethnography? Methodological, Ontological, and Epistemological Attributes. Cultural Ecology of Health and Change, Ethnographically informed community and cultural assessment research system (EICCARS) working paper series. <https://static1.squarespace.com/static/542d69f6e4b0a8f6e9b48384/t/56495b19e4b0bfd3ce24605d/1447648025111/EpiOntAttrib.pdf>
- Wind, G. (2008). Negotiated interactive observation: Doing fieldwork in hospital settings. *Anthropol Med*, 15(2), 79-89. <https://doi.org/10.1080/13648470802127098>
- Word Cloud. Methods and processes. *Better Evaluation*, <https://www.betterevaluation.org/en/evaluation-options/wordcloud>. Accessed October 28, 2022

[Return to Table of Contents](#)

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*[Return to Table of Contents](#)*