

Using Qualitative and Mixed Methods Research to Strengthen Implementation Science

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Objectives

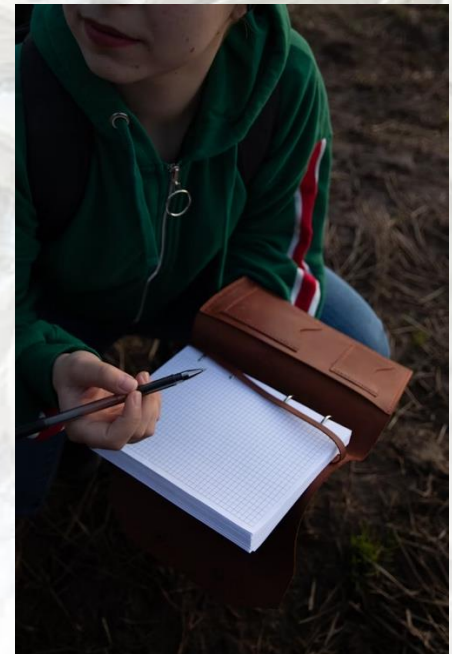
- Understand strengths & limitations of qualitative methods
- Understand how qualitative methods are used in IS
- Introductory understanding of mixed methods in IS
- Know where to find resources on using qualitative approaches in IS



<https://globalhealthdata.org/qualitative-approach/>

1. Overview of qualitative methods
2. Qualitative methods in IS
3. Strengths and limitations of qualitative methods
4. Brief overview of mixed methods in IS
5. Example of rapid qualitative approach (STEER)
6. Example of mixed methods approach (Missouri Harm Reduction)

- Methods for studying human behavior and experience (from anthropology and sociology)
- Multiple potential purposes:
 - In-depth understanding
 - Interpretation of social phenomena
 - Holistic representations of complex social systems
 - May be used to generate hypotheses



- Characteristics of qualitative approaches:
 - Often inductive
 - Naturalistic – drawn from people in their natural settings
 - May involve deep engagement for extended time (weeks, months, years-long field studies)



January	February	March
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April	May	June
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July	August	September
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October	November	December
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Common methods

- Key informant or one-on-one interviews
- Focus groups
- Observation
- Document review and analysis

Other methods (not discussed):

- Photo Voice
- Pile sorts
- Photo elicitation
- Rank order tasks
- Reflective journaling
- And many others

Individual perspectives
and experiences

Community perspectives
and experiences

Interviews

Focus Groups

What do you
want to know?

Document review

Observations

Organizational practices,
timelines

Individual and group
behaviors

- Developing tools (e.g. interview guide, focus group guide, document review template, observational recording form)

Draft

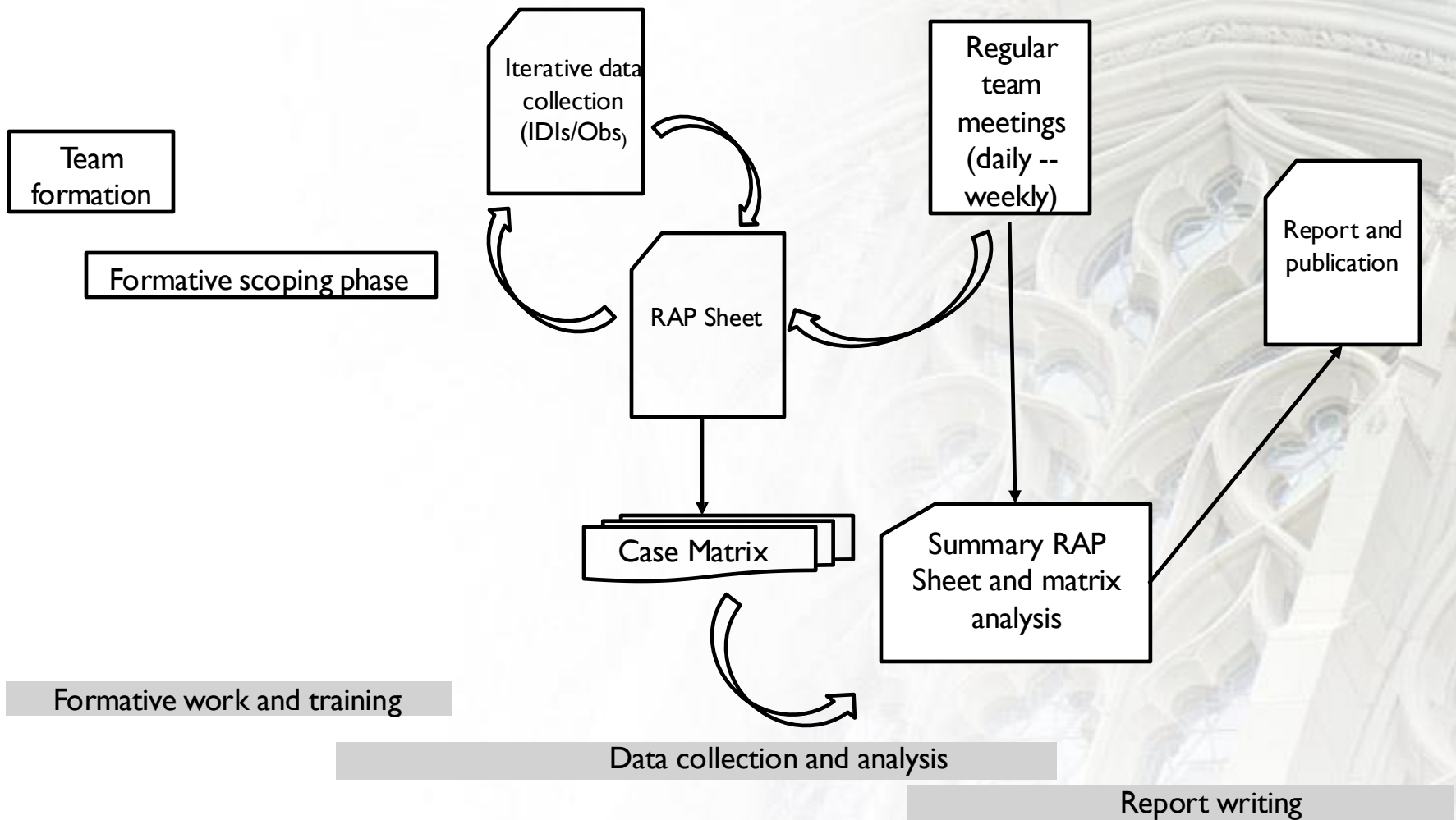
- Relationship building
- Key content
- Wrap up

Translate (if needed)

Pilot and Refine

- With research team members
- With target group

Overview: Data collection and analysis process



- To understand
 - Individual perspectives
 - Contexts
 - Implementation process and effectiveness
 - Mechanisms of change
- To inform
 - Design and implementation
 - Reflection on implementation processes
 - Theoretical development

Qualitative Research in Implementation Science working group, National Cancer Institute. Qualitative Methods in Implementation Science. White paper. <https://cancercontrol.cancer.gov/sites/default/files/2020-09/nci-dccps-implementation-science-whitepaper.pdf>

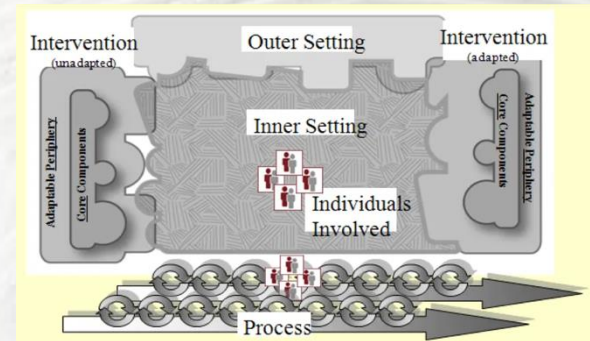
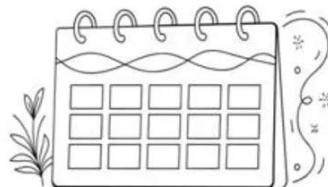
- Often deductive – barriers, facilitators, priorities



- Settings vary – clinic, hospital, community, urban, rural, public, private, schools



- Time frames vary – single, repeated



- IS has specific needs:
 - Rapid information to inform design, implementation and evaluation
 - Perspectives of clients, implementers, organizational leaders, community leaders, other individuals impacted by intervention
 - Utilization of multidisciplinary research team, often including implementers/practitioners



- When to use rapid analysis
 - Questions are appropriate (generally deductive)
 - Timely results are needed
 - Team has capacity
- When not to use rapid analysis
 - Exploring a new topic
 - Developing or refining a theory
 - Quantifying and analyzing specific themes, concepts in data
 - Don't have team resources (skills and/or time)

Commonalities of Rapid Approaches

- ❖ Triangulation of methods – e.g.,
 - ❖ Surveys
 - ❖ Qualitative interviews
 - ❖ Observations
- ❖ Triangulation of processes (often with multiple investigators) – e.g.,
 - ❖ Team based
 - ❖ Iterative



Data collection and analysis happen concurrently



Develop feedback loops to share findings and iterate inquiry



Occur with teams

Steps of Analysis

Template development (key constructs/content of questions)

Transcript summarized in templates

Summaries reviewed by team for rigor (see below)

Summaries transferred into matrix

Matrix analyzed and key results identified

Ensuring rigor:

Peer Debriefing and Support

Regular meetings for review

Multiple team members reviewing all materials;
Review by individuals with different points of view and knowledge bases

Strengths

- Nuanced information
- Deeper understanding of behaviors
- Explanatory stories
- Observations (what we see) can be combined with what people say about what we see

Limitations

- Varied experiences, beliefs and biases
- What someone knows
- Limited generalizability

Areas	Quantitative Research	Qualitative Research
Nature of Reality	Single reality	Dynamic and multiple realities
Goal	Test and confirm hypotheses	Explore and understand phenomena
Data collection methods	Highly structured – questionnaires, inventories, scales	Semi-structured – in-depth interviews, observations, focus groups
Design	Pre-determined, fixed design	Flexible and emergent
Reasoning	Deductive process to test hypothesis	Primarily inductive to develop theory or hypothesis
Focus	Outcome and prediction of causal relationships	More focused on process
Sampling	Largely random sampling	Purposive sampling
Sample size determination	A priori calculations	Data saturation
Sample Size	Relatively large	Small but studied in depth
Data Analysis	Variable based and use of statistical or mathematical methods	Case based and use descriptive or interpretative methods

Renjith V, et. al., A. Qualitative Methods in Health Care Research. Int J Prev Med. 2021 Feb 24;12:20. doi: 10.4103/ijpvm.IJPVM_321_19. PMID: 34084317; PMCID: PMC8106287.

- Using quantitative and qualitative methods to strengthen results
- Many designs
 - QUAL \Rightarrow quan
 - QUAN \Rightarrow qual
 - QUAL $+$ QUAN
- Many data collection approaches
 - QUAL_{dc} \Rightarrow quan_{dc} \Rightarrow QUAL_{dc}
 - QUAN_{dc} $+$ qual_{dc}
- Many data analysis approaches
 - QUAN_{da} \Rightarrow qual_{da}

Palinkas, L.A., Mendon, S.J., Hamilton, A.B. Innovations in Mixed Methods Evaluations. Ann Rev Pub Hlth 40: 423-42 (2019).

- Convergence or triangulation
- Complementarity
- Expansion or explanation
- Development
- Sampling

- Plan carefully to take advantage of mixed methods
 - What is your mixed methods design?
 - What do you want to learn from the mixed methods (convergence, complimentary, etc.)
 - Sequencing of data collection?
 - Sequencing of data analysis?
- Caution: the path of least resistance is parallel data collection and analysis.
- Intentionality is needed to effectively use mixed methods.

*Conducting a Participatory
Intersectional Needs
Assessment for Intervention
and Implementation Planning*

**St. Louis Enhancing
Engagement and
Retention in HIV (STEER)**



Humphries DL, Marotta P, Hu Y, Wang V, Gross G, Rucker D, Jones J, Alam F, Brown T, Spiegelman D, Carter CR. St. Louis enhancing engagement and retention (STEER) in HIV/AIDS care: a participatory intersectional needs assessment for intervention and implementation planning. *Frontiers in Public Health*. 2025 Jun 11;13:1589671.

STEER Team



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Fast-Track St. Louis Steering Committee



Enbal Shachem



Elvin Geng



Donna Spiegelman



Robert Heimer



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Yue Hu

Enhanced personal contact between CHWs and people living with HIV/AIDS (PLWH) has been shown to strengthen retention in care

... However, how best to structure and implement CHW-supported programs in the context of the St. Louis community remains an important question



Two-fold aim

1

Assess barriers to engagement and retention in HIV care in St. Louis using the CFIR

2

Identify and adapt implementation strategies for CHW intervention to support care engagement in hard-to-reach populations

In-depth Interviews or Focus Groups with individuals recruited from five different categories

Interviewees



HRSA Model Program CHWs & Supervisors
 $n = 6$
(Interviews)



Clinical Leaders
 $n = 4$
(Interviews)



Community Leaders
 $n = 5$
(Interviews)



Front Line Lay Health Workers
 $n = 12$
(2 Focus Groups)



People Living with HIV
 $n = 12$

Formats



Focus Groups



1:1 Tele-Interviews



1:1 In-Person Interviews



INITIAL SYNTHESIS INTO RAP SHEETS

- Develop RAP sheet templates for each group
- Overlaps in key areas
- Some unique fields

CONDUCT INTERVIEWS or FOCUS GROUPS

- Record interviews
- Transcribe
- Transcriptions reviewed and corrected

QUALITY CHECKS ON ANALYSIS

- Transcriptions reviewed and corrected
- RAP sheets reviewed by team member who did not participate in the interview
- Initial results for each group presented to planning team for feedback

Moderator:
Interviewee Number (e.g. CLIN1A):
Interview Date and Time:
Note Taker:

1. Peer Navigator Experiences

2. Strengths / Suggestions of Using Community Health Workers in St. Louis

3. Integration of CHWs into the Care Team

4. Challenges of Using CHWs in St. Louis

Moderator:-Debbie-¶
Interviewee-Number-(e.g.-CLIN1A):-CLINLEAD2¶
Interview-Date-and-Time:-5/26/2022-5:00PM¶
Note-Taker:-Greg-¶

1.->Peer-Navigator-Experiences¶

¶
The-respondent-had-no-prior-experience-working-with-a-peer-navigator-nor-was-familiar-with-any-peer-led-interventions.-[9]-¶

2.->Strengths/Suggestions-of-Using-Community-Health-Workers-in-St.-Louis.¶

¶
¶

3.->Integration-of-CHWs-into-the-Care-Team¶

¶
Places-where-a-CHW-could-be-most-useful-for-helping-the-patient's-HIV-management:-[420-433]¶
1)->Communication-with-the-health-care-provider¶
2)->Attending-a-medical-appointment-¶
3)->Filling-prescription¶
4)->Taking-HIV-medicine-¶

¶
¶

4.->Challenges-of-Using-CHWs-in-St.-Louis.¶

¶
Silos-in-clinical-practice-limit-the-integration-of-CHWs-into-the-care-team.-¶

¶
"Unfortunately,-for-the-time-in-which-I've-worked-in-HIV,-there-hasn't-been-a-great-inter-departmental-reliance-on-other-people's-specialties,-whether-it-be-professionally-or-working-with-lay-individuals."-[24-25]¶

¶

ANALYSIS MATRIX

- Analysis across the respondents (for each of the five stakeholder groups)
- Summarize key takeaways

INTEGRATED MATRIX

- Analysis of **key takeaways** across the stakeholder groups
- Summarize key results
- Synthesize cross-cutting results

[Link to sample matrix](#)

	Using CHWs in St Louis		
	Strengths	Suggestions	Challenges
CLINLEAD1	<p>call them community health workers and community health advocates. And there is no question their efficacy. And it's a model in St Louis that healthcare systems have embraced, and healthcare organizations have embraced, and nonprofits have embraced. They are right up there with doulas and people respect them, they have power here, you know that it's not this like one off thing, and they have an entire coalition." [85-89]</p> <p>•CHWs know what the structure needs to be to bridge gaps, connect vulnerable population, and improve quality of care.</p> <p>"I don't know I just don't feel the need to say anything but the truth. And the truth is, whether or not community health workers are capable of bridging gaps and connecting the people who are vulnerable and improving quality of care, to me, I mean I could tell you, yes, and the structure, you know it's all dependent on community... I mean the whole point is they know how to create that. They are the ones that know what the structure needs to be and its specifics." [95-99]</p> <p>•Community health advocates get deeper relationships with the</p>	<p>"I mean, they are people who care about their neighbors right. That is the common denominator, with all of this. Most of the people who work with us volunteered with us first. They did it because they wanted to, and they cared about their neighbors, and they could not stand the injustice that they saw happening around them. So that's a really, really, really important concept."</p> <p>"I think the other components are people who have some general confidence and interacting with the public and managing conflict, that's really super basic. People who are well acquainted with and have a system for managing their own trauma. That's where we've had some of the biggest troubles. People want to do the work, but they have not yet healed from their own trauma, and so they get completely overwhelmed and they are interacting with other people's trauma, or they simply regurgitate their trauma under the person, and then that gets really, really complicated." [422-427]</p>	<p>about your HIV, I can only see you about your substance abuse, I can only see you about your mental health concerns, I can only see you about your foot wounds. I can only see you about your housing concerns. I can only see you about your legal concerns...So that silo-ing is the problem." [99-104]</p> <p>oDistrust from racialized trauma in the region: White dominant health professionals and health facilities trying to interact with CHWs that are mostly AAs.</p> <p>"So, here's where I see the biggest disconnects. I see white dominant health professions and health facilities trying to interact with community health workers that reflect the St Louis city population, which is mostly black folks. And so, you have that hierarchy, that's a massive problem because of the all the racialized trauma in this region and segregation." [321-324]</p> <p>•Hierarchy Western European model in the health care system cannot accept the legitimate knowledge from outside the education paradigm</p> <p>"Everything I'm discussing is a relationship-based model, rather than a structural hierarchical model. And that is so hard for healthcare systems. The problem is not the community health worker, the problem is a system of care that is based on white body supremacy in which hierarchy is supreme in that relationship. Because those same systems of care haven't done the work to dismantle white body supremacy and their practices, they cannot hear these voices."</p> <p>•Silos in clinical practice limit the integration of CHWs into the care team.</p> <p>"Unfortunately, for the time in which I've worked in HIV, there hasn't been a great inter-departmental reliance on other people's specialties, whether it be professionally or working with lay individuals." [24-25]</p>
CLINLEAD2	<p>•People relate better to outreach workers that look more like them.</p> <p>"Well, I think it made 'em aware that the [public health agency] was here and we're available, and what we do. And that you know this is mostly in an African American neighborhood, and the fact that you know the gentleman that was going. [CHW] was his name, that attended some of these things, you know was African American, so you know it's nice to see someone that looks like you at an event that's telling you about services that are available to you." [52-56]</p>	<p>•Create a welcoming environment for a diverse clientele, not just a particular race/ethnicity, sexual orientation, etc.</p> <p>"So I've always worked with people of every race, sexual orientation, you know gender, everything...And that's what I think needs to be represented. It's like it's not only for specifically the black patient, or the LGBTQ patients, or you know the trans...you know what I mean? We needed to be a little more diverse and accepting for everybody, that everybody feels comfortable whether they're white, Asian, Black, you know...that doesn't matter. We want a place that's welcoming for everyone, and you don't want to just specifically pick one person to represent something that serves a diverse clientele." [68-74]</p> <p>"Yeah, and you know we do have MSMs to come here, we do have trans patients that come here, you know. And I mean, as far as... I would like to see everybody come to the clinic, not just a particular race, sex, gender, you know that type of thing, that everybody feels welcome coming to one place, and you can serve everybody in one particular place." [83-86]</p>	<p>•The respondent shared concern about CHWs' qualification to give health information and answer patients' medical questions</p> <p>"Well, hmmm. What would the education level of that person be? Would that be somebody that was like an MA, or an LPN, or a nurse, or you know, Because I mean that's the issue... Like I mean if they're out of their element and the patients are asking questions that they can't answer...To me that would be more of a disservice than a service because they're asking about well, what do I do if I miss my meds, are these side effects of my meds, and if they can't answer it, you know that could go either way. I mean they might be able to help with transportation or bus passes, or you know, whatever. But as far as answering side effects or medication questions, you're talking two different levels of expertise." [336-342]</p>
CLINLEAD3	<p>•CHWs may help PLWH eliminate barriers to managing their care.</p> <p>"I mean in the African American community, it's like the rates</p>	<p>"That I don't know, but I think just having one person represent is you've got limited exposure then. You know you're</p>	<p>"Yeah they may not be able to address it, or you know what for me has been a little more problematic is if you have somebody giving advice that they're not qualified to give, and then the patient believes that person and then when an actual clinician tells them something completely different, it was a no go. They were like nope, this is what so and so said, and it was like gospel, and you know that kind of stuff, and it's really difficult for the clinician to... And then you'd need to</p>

Participants identified both **institutional** and **systemic** challenges to integrating CHWs into the health system that will need to be addressed.



The roles of CHWs are not well-understood by care team members and are often undervalued.



The health system lacks the necessary infrastructure to support a sustainable CHW workforce.



Western healthcare's hierarchy creates silos in care delivery that marginalizes roles without formal education.



Structural racism in the healthcare system reinforces regional racialized trauma.

Providing effective training and technical support

Provide enhanced technical support

Reinforce CHW Training and Professional Development

Utilize dynamic and participatory training methods

Systematic Implementation

Develop implementation blueprints with regional specifics

Develop clear role delineations with local nuance

Assure coordinated record keeping

Addressing structural and systemic issues

Prioritize addressing structural barriers and advocacy

Collaborate with and support relevant partner organizations

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- Thanks to:
 - Planning Team Members:
 - Tawnya Brown
 - Darius Rucker
 - Johnnie Jones
 - Greg Gross
 - Chelsey Carter
 - Yue Hu
 - Victor Wang
 - Phil Marotta
 - Participants
 - St. Louis Fast Track Steering Committee
 - Alycia Jenkins, Missouri Department of Health



Intersectional stigma as a barrier to diffusion and adoption of innovations in harm reduction and treatment for opioid use disorders



Research Team

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Overarching objectives

Investigate the impact of intersecting stigmas on attitudes toward adoption and behaviors among providers working in rural FQHCs and rural health centers in Missouri
Understand the extent to which intersectional stigmas are inhibiting the technical capacity building that is needed to foster adoption of evidence-based comprehensive harm reduction strategies

Aim 1) Identify mechanisms through which intersecting drug, HIV, and sexuality-based stigmas influence primary care providers'

1a. Diffusion, acceptance and adoption of OUD and HIV prevention harm reduction practices

1b. Diffusion, acceptance and adoption of buprenorphine, naltrexone and PrEP prescribing using surveys administered to 400 rural providers

Aim 2) Conduct in-depth interviews with key stakeholders to elucidate multi-level intersecting stigmas at the individual-, provider-, clinic-, community and policy-levels, and possible strategies to reduce stigma with (a) providers (n=30), (b) people living with HIV and OUD (n=24), (c) community advocates (n=6) and (d) regional leaders in OUD and HIV infection, (n=6).

Findings from this study will be used to develop a conceptual model to build and eventually test the impact of a stigma reduction intervention on diffusion of innovation and adoption of harm reduction and gold-standard medication treatments for OUD.

Mixed method approach: QUAN + QUAL

Data collection: $QUAN_{dc} \rightarrow QUAL_{dc}$

Data analysis: $QUAN_{da} + QUAL_{da} \rightarrow QUAN_{da}$

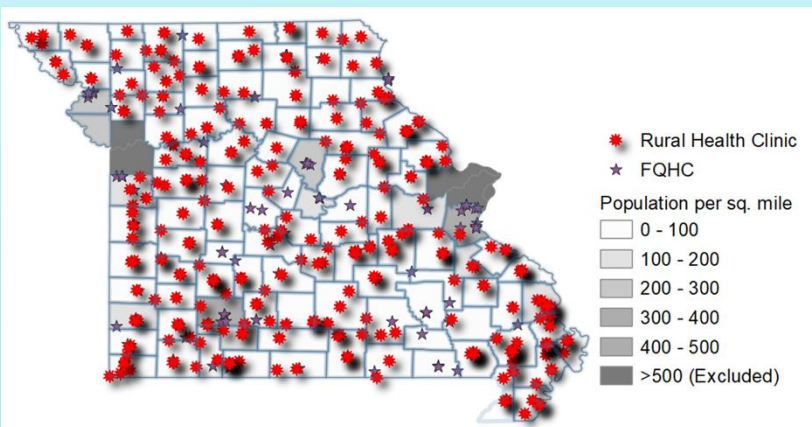
Mixed Method Example: Intersectional stigma as a barrier to diffusion and adoption of innovations in harm reduction

Mixed Methods

Fixed choice surveys

Three stage sampling

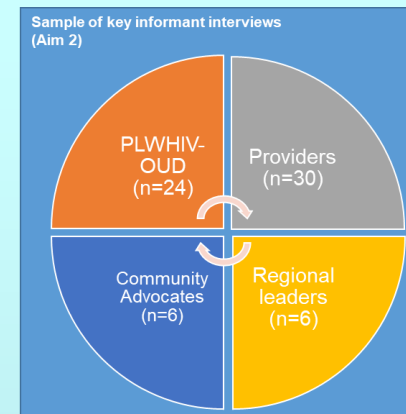
- 1) **112 Counties** with at least 1 provider in counties of <500 per 100,000
- 2) **491 FQHC Facilities**
MRHA, MPCA, MHA
- 3) **400 Providers** that are MD, APRN, PA, DO, working with clients with OUD



Federally Qualified Health Centers/Rural Health Clinics

In-depth interviews

- **PLWHIV-OUD** – experiences of internalized, anticipated and intersectional stigmas, engagement in treatment
- **Providers** – enrich and triangulate measurement of intersectional stigma
- **FQHC/RHC**– norms, values, cultures and social climate, training readiness and efforts
- **Community**, public attitudes toward harm reduction and stigma
- **Policy/Macro** – community advocates and regional leaders will provide deeper insights into impact of recent changes in buprenorphine waiver regulations, syringe exchange, telehealth, peer support, program funding



Survey Measures

Identity-based Stigma

- *Opening Minds Stigma Scale for Health Care Providers*
- *HIV/AIDS Stigma Scale for Health Care Providers*
- *Sexual Minorities Scale*

Diffusion of innovation

- *Perceived Characteristics of Innovating Scale*
- *Acceptability of Intervention Measure*

Behaviors –Prescribing practices, Intentions

Intervention stigmas


- Naloxone-Related Risk Compensation Beliefs Scale (Winograd R. UMSL)
- Harm reduction attitudes scale
- Opioid overdose Knowledge Scale

Based on existing research in other contexts

- Attitudes toward syringe exchange, safer drug use/sex kits, counseling and health education, fentanyl test strips, low threshold buprenorphine
- PrEP attitudes
 - *"Providing PrEP would encourage my patients to have more sex, providing PrEP would encourage my patients to engage in more risk behaviors etc."*

- Recordings were transcribed and analyzed using rapid qualitative methods to identify patterns in narratives provided by key stakeholders.
- Each transcript was summarized on the appropriate rapid analysis template. Templates included barriers and facilitators for adoption of harm reduction and diffusion of innovation within multiple levels of the social environment, intersecting stigmas and adoption of harm reduction practices

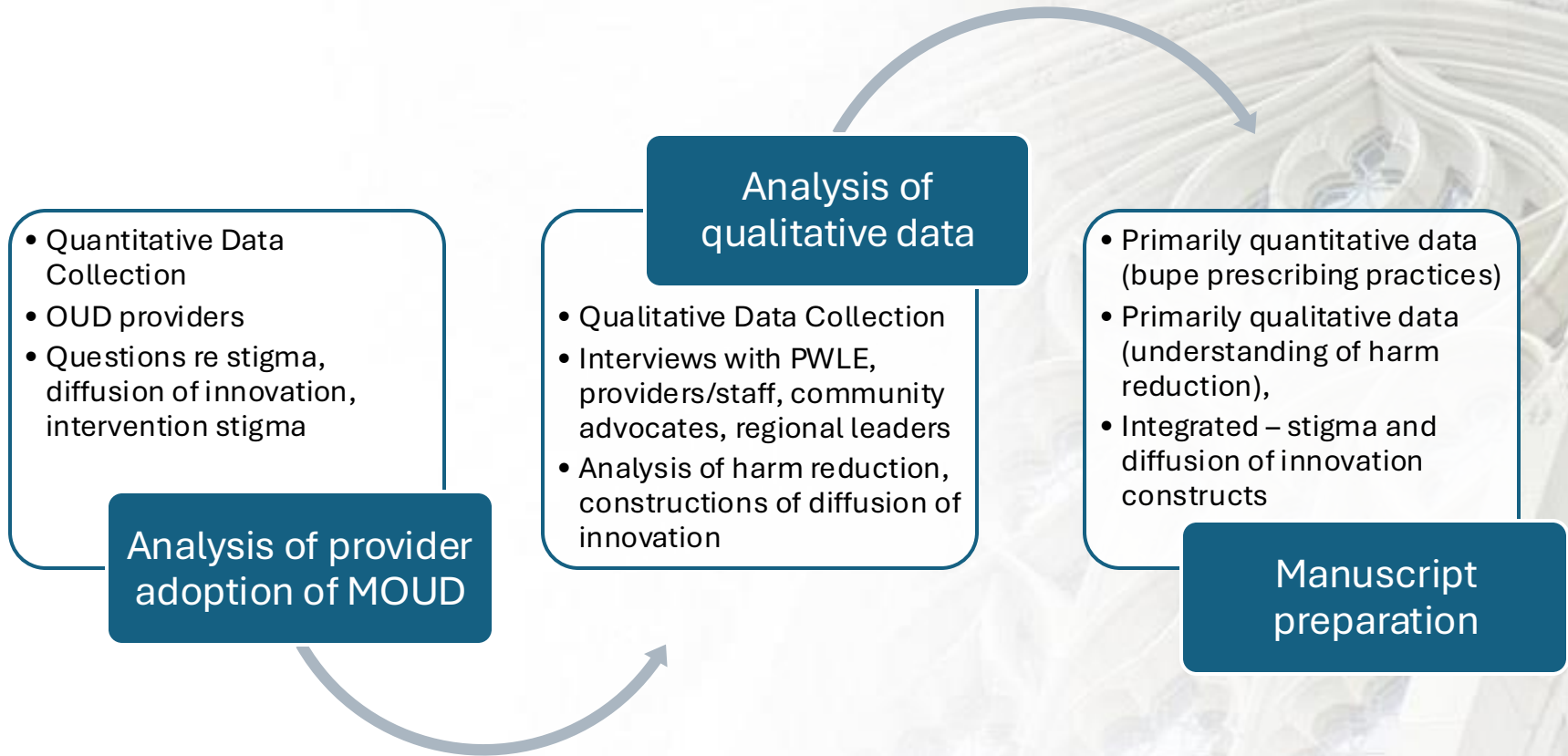
Interviewees



People with lived experience of OUD	Bupe. Providers & Clinic Staff	Community Advocates	Regional Leaders
n = 17	n = 17	n = 5	n = 5

- Qualitative team meetings discussed completion of rapid templates and identification of themes and sub-themes within template construct areas for each interview group.
- Analysis of cross-cutting construct themes also occurred across interview groups.

PWLE	PROV	CMAD	RGLD
<p>Risk Reduction</p> <ul style="list-style-type: none"> Keep those using safer and alive so that they may be able to “change their mind” or “get help” later Encouraging lifestyle adjustments to prevent physical or mental harm while tapering off use <p>Approaching abstinence</p> <ul style="list-style-type: none"> Approaching as close to abstinence as one reasonably can (disagreement over whether MOUD qualifies) <p>More than SUD treatment</p> <ul style="list-style-type: none"> Reclamation of humanity (“quality of life”/“living a normal life” while reducing use) Normalization of addictions (“everyone has vices”) Harm reduction can exist outside of treatment 	<p>Risk Reduction</p> <ul style="list-style-type: none"> Keep clients alive by gradually diminishing use and preventing overdose Proactive, educational interventions can preserve physical, mental, and financial health <p>Approaching Abstinence</p> <ul style="list-style-type: none"> Is a model used for “individuals that are not quite to that point of wanting to make change (receive treatment) or are ambivalent” <p>More than SUD treatment</p> <ul style="list-style-type: none"> Similar to how healthcare operates with other risks (diet and exercise, sunscreen, seatbelts, etc.) <p>Accepting people without judgment</p> <ul style="list-style-type: none"> Behaviors, strategies, models, goals, and attitudes matter: evidence-based practices and reduction of bias and stigma through language adjustments Empower and preserve autonomy and quality of life of clients <p>Practicality</p> <ul style="list-style-type: none"> Has a practical effect that can prevent clients from taking “two steps forward and one step back” Can conserve resources, such as reducing unnecessary ER visits 	<p>Risk Reduction</p> <ul style="list-style-type: none"> Keeping oneself and the community safer while preserving autonomy <p>Accepting people without judgement</p> <ul style="list-style-type: none"> Accepting people “where they are” Avoidance of punitive language or approaches Rapport and empathy can make a strong impact on use Inclusivity is a cornerstone <p>Strengthening coping skills</p> <ul style="list-style-type: none"> Enhancing protective factors 	<p>Risk Reduction</p> <ul style="list-style-type: none"> For those using substances and their communities Risk minimization to self or others <p>Whatever people with SUD consider most appropriate for meeting their own needs</p>



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Thank you to the research team, participants, and organizational partners



- **Qualitative and mixed methods** are essential tools in implementation science (IS), offering deep, context-sensitive insights that inform **design, implementation** and **evaluation**.
- **Qualitative methods** help us understand individual perspectives, mechanisms of change, and the contextual nuances that influence implementation success or failure.
- **Rapid qualitative approaches** can produce **timely, actionable feedback** for real-world settings, but require careful design and rigor.
- **Mixed methods** strengthen IS by **triangulating evidence**, explaining outcomes, and enriching understanding across multiple levels and data types.
- Effective use of these methods depends on clear purpose, intentional design, and **strong collaboration** across teams.
- **Seek mentors** and **continue learning**—rigorous application is critical to maximizing impact.

Qualitative methods:

- Leslie Curry:

https://www.youtube.com/watch?v=wbdN_sLWI88&list=PLqHnHG5X2PXCcCMYn3_EzugAF7GKN2poQ

Rapid Qualitative Methods:

- Alison Hamilton; 2014:

<https://www.betterevaluation.org/tools-resources/qualitative-methods-rapid-turn-around-health-services-research>

- <https://the-sra.org.uk/SRA/Blog/Anintroductiontorapidqualitativeevaluation.aspx>

- Ashley Hagaman:

<https://www.youtube.com/watch?v=rIzVJRIRIRQ>



1. Qualitative Research in Implementation Science working group, National Cancer Institute. Qualitative Methods in Implementation Science. White paper. <https://cancercontrol.cancer.gov/sites/default/files/2020-09/nci-dccps-implementation-science-whitepaper.pdf>
2. Vindrola-Padros, Cecilia, and Ginger A. Johnson. "Rapid techniques in qualitative research: A critical review of the literature." *Qualitative Health Research* 30.10 (2020): 1596-1604.
3. Johnson, Ginger A., and Cecilia Vindrola-Padros. "Rapid qualitative research methods during complex health emergencies: a systematic review of the literature." *Social Science & Medicine* 189 (2017): 63-75.
4. Finley, Erin P., et al. "Periodic reflections: a method of guided discussions for documenting implementation phenomena." *BMC medical research methodology* 18.1 (2018): 1-15.
5. Keith RE, Crosson JC, O'Malley AS, Crompton D, Taylor EF. Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation. *Implement Sci.* 2017 Feb 10;12(1):15. doi: 10.1186/s13012-017-0550-7. PMID: 28187747; PMCID: PMC5303301.
6. Mthembu J, Hamilton AB, Milburn NG, Sinclair D, Mkhabela S, Mashego M, Manengela T, Wyatt GE. "It Had a Lot of Cultural Stuff in It": HIV-Serodiscordant African American Couples' Experiences of a Culturally Congruent Sexual Health Intervention. *Ethn Dis.* 2020 Apr 23;30(2):269-276. doi: 10.18865/ed.30.2.269. PMID: 32346272; PMCID: PMC7186048.
7. Palinkas, L.A., Mendon, S.J., Hamilton, A.B. Innovations in Mixed Methods Evaluations. *Ann Rev Pub Hlth* 40: 423-42 (2019).
8. McMullen, C. K., Ash, J. S., Sittig, D. F., Bunce, A., Guappone, K., Dykstra, R., Carpenter, J., Richardson, J., & Wright, A. (2011). Rapid assessment of clinical information systems in the healthcare setting: an efficient method for time-pressed evaluation. *Methods of information in medicine*, 50(4), 299–307. <https://doi.org/10.3414/ME10-01-0042>
9. Gale RC, Wu J, Erhardt T, Bounthavong M, Reardon CM, Damschroder LJ, Midboe AM. Comparison of rapid vs in-depth qualitative analytic methods from a process evaluation of academic detailing in the Veterans Health Administration. *Implement Sci.* 2019;14(1):11. PMCID: PMC6359833
10. Hamilton AB, Finley EP. Qualitative methods in implementation research: An introduction. *Psychiatry Res.* 2019;280:112516. PMCID: PMC7023962
11. Nevedal AL, Reardon CM, Opra Widerquist MA, Jackson GL, Cutrona SL, White BS, Damschroder LJ. Rapid versus traditional qualitative analysis using the Consolidated Framework for Implementation Research (CFIR). *Implement Sci.* 2021;16(1):67. PMCID: PMC8252308



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