RTKW 1 - #EIE2023

RIDE THE KNOWLEDGE WAVE 1 2

#52 - IMPLEMENTATION OF THE OMA VÄYLÄ REHABILITATION PROGRAMME FOR YOUNG PEOPLE WITH ATTENTION DEFICIT AND HYPERACTIVITY DISORDER (ADHD) AND/OR AUTISM SPECTRUM DISORDER (ASD): CORE COMPONENTS FROM THE PERSPECTIVE OF PROFESSIONALS 2

#113 - FIDELITY CONSISTENCY OF PLANNED AND UNPLANNED ADAPTATIONS MADE IN EVIDENCE-BASED PARENTING PROGRAMS 3

#138 - TRANSLATING AND IMPLEMENTING AN EVIDENCE-BASED FRAMEWORK TO DECREASE SUICIDE DEATHS IN THE U.S. MILITARY 4

#184 - BARRIERS AND FACILITATORS FOR REDUCTION OF LOW-VALUE HOME-BASED NURSING CARE. 5

Ride the Knowledge Wave 1

#52- Implementation of the Oma Väylä Rehabilitation Programme for Young People with Attention Deficit and Hyperactivity Disorder (ADHD) and/or Autism Spectrum Disorder (ASD): Core Components From the Perspective of Professionals

Hennariikka Heinijoki[1,2],Maarit Karhula[1,2],Ismo Ukkola[1],Riitta Seppänen-Järvelä[1]

[1]The Social Insurance Institution of Finland, Helsinki, Finland. [2]South-Eastern Finland University of Applied Sciences, Mikkeli, Finland

Research aim

This study applies the Consolidated Framework for Implementation Research (CFIR) and presents the preliminary results of the perceived core components of Oma Väylä ('My Way') rehabilitation from the professionals' perspective. The core components refer to the essential functions, principles, and intervention activities considered necessary to produce desired outcomes.

Setting

Regulated by legislation, the Social Insurance Institution of Finland organizes various rehabilitation interventions, and local service providers, in accordance with service descriptions defining the features of interventions, execute these interventions. The Oma Väylä rehabilitation includes both individual and group sessions as well as working within the client's own network.

Method(s)

The multi-method data sets are collected through electronic surveys and interviews. Multiprofessional teams (n = 98) will answer the questionnaire during January and February 2023. Five focus group interviews was conducted with 26 professionals participating. We used three vignettes to trigger discussion and to reveal the core components of the intervention. A vignette is a brief hypothetical case description presented to participants during an interview. The survey data are analysed using statistical methods, and qualitative thematic analysis is applied in the analysis of interview data. The results from these are integrated according to the mixed methods design.

Key finding(s)

According to the professionals, the perceived core components of the Oma Väylä rehabilitation programme are the empowering and strengths-based approach, individually tailored rehabilitation, continuous evaluation of the client's situation, and reflection in relation to the client's everyday life and functional ability. The survey data will broaden the understanding of core components and complement the interview data. According to the preliminary analysis, there are commonalities between the described core components and the person-centered rehabilitation model.

Discussion

- What are the benefits of using vignette-based interview in defining intervention core components?
- What are the benefits of integrating quantitative and qualitative data to reveal the core components?

Challenges

The recruitment of the participants to answer the electronic survey required continous monitoring and interaction with the professionals. The integration of the qualitative and quantitative data will be in the same time challenging and interesting phase of the research process.

Key highlights

- This study sheds light on the core components of Oma Väylä rehabilitation from the perspective of the professionals and contributes to the understanding of the 'black box' of intervention implementation.
- The results of this research contribute to the evidence-based practices in implementing rehabilitation.

#113- Fidelity consistency of planned and unplanned adaptations made in evidence-based parenting programs

Kristoffer Pettersson[1], Pernilla Liedgren[1], Henna Hasson[2], Fabrizia Giannotta[3], Aaron R. Lyon[4], Ulrica von Thiele Schwarz[1]

[1]Mälardalen University, Västerås, Sweden. [2]Karolinska Institutet, Stockholm, Sweden. [3]Stockholm University, Stockholm, Sweden. [4]University of Washington, Seattle, USA

Research aim

To explore and assess adaptations in a community sample of practitioners who deliver parenting programs. Furthermore, to investigate the extent to which the modifications are planned or unplanned (reactivity) and how that relates to fidelity consistency.

Setting

The study targets group leaders delivering five of Sweden's most widely used evidence-based parenting programs (All Children in Focus, Comet, Connect, Cope, and Triple P). These programs are provided as preventive interventions in local communities, often delivered by teachers and social workers in social services and primary care settings.

Method(s)

The study used a qualitative approach involving focus group and individual interviews to extract examples of adaptations made by group leaders (n = 28). Examples were categorized using the Framework for Reporting Adaptations and Modifications-Enhanced (FRAME). Data was then assessed for fidelity consistency (i.e., if modifications are made in line with core functions of the programs) and reactivity, the degree to which they are planned or unplanned (operationalized as four levels: universal, conditional, situational, and unintentional). Chi-square and logistic regression were used to explore the relationship between consistency and decision-making involved (i.e., planned vs. unplanned).

Key finding(s)

A total of 137 examples of modifications were identified; 78 (57%) were assessed as fidelity consistent and 59 (43 %) as fidelity inconsistent. A logistic regression with fidelity consistency as the dependent variable, and the four levels of reactivity as predictor variables, showed that the model significantly predicted the consistency of modifications (omnibus chi-square = 17.37, df = 3, $p < .001$). Unintentional modifications (i.e., changes made involuntarily or accidentally without any clear reason) showed the most substantial predictive effect.

Discussion

- The study supports the notion that adaptations should be carefully considered (i.e., proactive) rather than haphazardly or intuitive (i.e., reactive). This, however, can be hard to achieve in routine practice. So how can implementation science provide guidance for managing adaptations in practice settings?
- This study uses an unconventional method to explore the relationship between levels of planning involved in making adaptation decisions and fidelity consistency. As research

on adaptation advances, there is a need to find ways to further operationalize and study this relationship. How might this be achieved?

Challenges

Adaptations can be a sensitive topic, which in this study meant that group leaders were hesitant to describe their experiences openly. To handle this issue, the interviewer used several clinical psychology tactics to normalize reactions and create a secure interview setting.

Key highlights

Adaptations made in routine practice can result from qualitative distinct decision-making processes. Although recognized as important, different ways of making adaptations remain underexplored scientifically.
Implementation science needs to guide the management of adaptations, not only during the planning of implementation projects but also to support adaptation decisions in routine practice.

#138- Translating and Implementing an Evidence-Based Framework to Decrease Suicide Deaths in the U.S. Military

Kyle Hawkey, Daniel Perkins - Penn State University, State College, USA

Research aim

Zero Suicide (ZS) is an public health approach to suicide prevention; an evidence-based framework, policies, interventions, and practices. From an implementation perspective, ZS in a military context presents several complex challenges. This presentation will describe the evidence-based framework, its adaptation, challenges encountered, successes, lessons learned, and results.

Setting

The sectors served are any healthcare sectors.

Method(s)

Both qualitative and quantitative data analyses were conducted on an ongoing basis from 2015 - 2019. This included data on training, implementation and program fidelity, adherence to protocols/policies, dosage of interventions, quality delivery, and participant responsiveness. In order to further examine the suicide attempt and death data, a non-experimental, longitudinal cohort study of the 5 pilot bases and 7 control bases was conducted. Generalized estimating equations (GEE) were utilized with base assignment (pilot vs. control), time point, and the interaction of the base assignment and time point as variables in the model; base population was included as an offset.

Key finding(s)

Activities completed as part of the implementation of Zero Suicide fell into the seven key elements of the Zero Suicide Framework: Lead, Train, Identify, Engage, Treat, Transition, Improve. Intensive qualitative reviews were undertaken to form the foundation for the project's implementation and evaluation. Results revealed that although adherence to screening was mediocre, suicide deaths and significantly decreased over time and were significantly lower than suicide deaths at matched comparison bases. Over the four-year implementation of ZSSA, suicide attempts slightly increased at both the intervention and comparison bases; however, the rate of increase was lower at the pilot sites.

Discussion

- How do we successfully adapt evidence-based frameworks to be used in other settings?
- How do we assure and measure implementation success?

Challenges

We occurred many challenges. Implementation challenged (e.g., buy in) were huge. We will discuss the use of implementation teams, marketing, and other efforts to overcome this.

Key highlights

This was the first study to undertake the dissemination and implementation (D&I) of ZSSA across an entire military healthcare system. The findings suggest that a healthcare system wide suicide prevention framework may work in the military context. This knoweledge can be used in a variety of other settings.

#184- Barriers and facilitators for reduction of low-value home-based nursing care.

Milou Cremers[1], Erwin Ista[1], Benjamin Wendt[2], Getty Huisman-deWaal[2]

[1]Erasmus MC, Rotterdam, Netherlands. [2]Radboud MC, Nijmegen, Netherlands

Research aim

Low-value nursing care can induce harm in clients and waste resources. For successful de-implementation of low-value, insights in barriers and facilitators (influencing factors) are needed. Therefore, we explored influencing factors for reducing low-value home-based nursing care.

Setting

The population of the study included healthcare professionals (e.g. nurse assistants, registered nurses, and managers) from 27 different teams of seven home-based nursing care organisations in the Netherlands.

Method(s)

We conducted a qualitative, exploratory study using focus group interviews and individual interviews. A semi-structured interview guide was used based on the Tailored Implementation in Chronic Diseases-checklist (TICD), including the following factors guidelines, individual health professionals, professional interactions, patients, organizational, social, political, legal, incentives and resources factors. These factors were used as the codebook in the analysis of the interviews. The data collection took place from March to June 2022 and all interviews were audio-recorded and transcribed verbatim. A directed content analysis was used. The data was approached deductively and insights on determinants for low value care were clustered.

Key finding(s)

The majority of the 55 healthcare professionals who participated were registered nurses and nurse assistants. We found that the influencing factors for reduction of low value care were related to the domain individual health professional factors, such as daily routine or lack of self-reflection on the provided care. Another relevant domain was patient factors, because patients feel, that they are entitled to receive care or demand care and patients are more outspoken in the care they would like to receive. A third relevant domain was professional interactions. An example is that general practitioners often prescribe low-value care.

Discussion

- To what extent is it possible to develop a tailored de-implementation strategy from registered nurses and nurse assistants' perspective?
- How should be dealt with the missing knowledge from other stakeholders'?

This study contributes to creating a new normal with the shift from intramural setting to the homecare environment. In order to tackle shortages of healthcare professionals low value nursing care should be reduced and in this study the influencing factors are explored.

Challenges

Data was collected data from perspective of healthcare professionals only. To develop a de-implementation strategy, it is important to also include other stakeholders as well, we tried to include clients but were only able to interview two clients, due to reluctance for including patients by the healthcare professionals.

Key highlights

- This research provides insights in barriers and facilitators of the use of low-value nursing care in homecare setting. Which provides input for the development of a tailored de-implementation strategy.
- Healthcare professionals expect a resistance in reducing low-value nursing care among clients who already receive this care for a long time.