RTKW 7 - #EIE2023

Ride the Knowledge Wave 7

#172- DIFFERENCES BETWEEN CLIENT GROUPS IN THE IMPLEMENTATION OF TELEREHABILITATION

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Research aim

The aim of the study is to provide information on the implementation of various practice methods of telerehabilitation with different client groups. This presentation addresses the preliminary results on the barriers and facilitators of the implementation of TR.

Setting

The Social Insurance Institution of Finland (Kela) organised rehabilitation programmes including telerehabilitation (TR) for different client groups (programmes for informal caregivers, adolescents with milder mental health problems and individuals with Type 1 diabetes or Type 2 diabetes). Interdisciplinary group-based rehabilitation programmes combining face-to-face rehabilitation and TR.

Method(s)

This ongoing multifaceted implementation study explores the clients' and the professionals' perceptions of the implementation of TR. The implementation research framework of Wierenga et al. (2012, 2013) is applied in the study to identify the different determinants of the implementation of TR. Quantitative and qualitative data are gathered by online questionnaires at different stages of a rehabilitation programme. Questionnaire data are analysed using descriptive quantitative methods, and qualitative content analysis methods are applied to the analysis of open-ended questions. These data are based on the clients' perceptions in the beginning (n=144) and at the end (n=62) of rehabilitation.

Key finding(s)

The clients' attitudes towards TR were positive. TR seems to be able to meet the clients' needs. A majority of the respondents would like to participate in TR in the future. Different kinds of barriers and facilitators were identified in the study. Participants in the rehabilitation course for informal caregivers were more critical towards the implementation of TR than respondents from the other client groups. Of the informal caregivers, 23% estimated needing technical support and guidance to be able to participate in TR, whereas in other client groups, 7% estimated that they might need technical support.

Discussion

How different characteristics of client groups should be taken into account when designing and implementing TR interventions?
What needs to be considered when modifying face-to-face rehabilitation programmes suitable for telerehabilitation practice?

Challenges

Telerehabilitation practice is still quite new method to carry out rehabilitation programmes for both clients and professionals. Some clients prefer ordinary face-to-face rehabilitation which affected our recruiting process. Also professionals had varying skills to carry out telerehabilitation interventions.

Key highlights

Variation in the characteristics of client groups should be taken into account when designing and implementing TR interventions. It is important to evaluate further the characteristics of TR interventions, such as the methods of individual and interdisciplinary support and the suitability, intensity, and adequacy of methods.

#185- De-implementation is the new black

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Research aim

The overall aim was to examine factors of importance for the de-implementation of established methods when implementing new evidence-based psycho-social interventions. The abandonment of institutionalized practices in favor of new ones is often overlooked when launching new methods and was the main focus in this study.

Setting

The setting was social work and mental health care. The empirical material consisted of the implementation of two psycho-social interventions with strong evidence support: Housing First (HF) and Individual Placement and Support (IPS). They are suggested in Swedish national guidelines and recommended to replace prevocational methods and the staircase-model.

Method(s)

- A scope review scanned 854 published articles on the process of abandoning established methods with low scientific support, whereof 41 articles published between 2014 and 2020 were included.
- A national survey to the 23 Swedish municipalities that had implemented either Housing First or IPS. The purpose was to map the prevalence and organization of HF and IPS and to describe and analyze factors that prevent or enhance implementation.
- Case studies over three years in three municipalities that are implementing HF and IPS with interviews of managers, politicians, service users, and social workers together with analyses of documents.

Key finding(s)

- The realization of HF and IPS requires expanded collaboration with many organizations, which raises the consideration to de-implement broader organizational frameworks and guidelines to enable their implementation.
- There is a lack of practical frameworks and theoretical explanations that could support successful phasing out of unnecessary interventions. This requires developed theories of de-implementation and calls for more research.
- Challenges to de-implement inferior methods emerge due to diverging institutional frames, especially when competing logics are involved. A categorical dividing line between worthy and unworthy clients was found institutionalized in the organization of the social services' work.

Discussion

- Firstly, we want to discuss the need for implementation research to leave the idea that implementation is only about introducing the new. Implementation needs to be expanded with knowledge of how established methods should be phased out. How will such an insight affect theory and methods of implementation?
- Secondly, we have identified how organizational inertia and competing logics are built into institutions' practice and counteract the phasing out of established traditions. That must be challenged and there is a need for a discussion about which mechanisms foster those problems and how to proceed with new research.

Challenges

The outbreak of covid-19 delayed the project and above all made it difficult to get in touch with service users. We have met a great interest in the study from managers and professionals - but at the same time a great uncertainty how to implement measures that support de-implementation.

Key highlights

- De-implementation should be considered the new normal (the new black) and be a part of every implementer's toolbox.
- To support the implementation of new ways of working that better benefit clients we must pay attention to established ways of working. This will require new ways of exercising implementation.

#151- Sumamos Excelencia project: Implementation barriers detected in the Spanish National Health System.

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Research aim

To identify barriers for the implementation of scientific evidence in the NHS units participating in Sumamos Excelencia project. The objective of the Sumamos Excelenca is to implement evidence-based recommendations on the topics: hand hygiene, assessment and management of pain, promotion of breastfeeding, prevention of obesity and management of urinary incontinence.

Setting

Units providing direct care to patients in the Spanish National Health System. Includes primary care centers, hospitals´ units and nursing homes.

Method(s)

Sumamos Excelencia is a quasi-experimental multicentre before-and-after study, based on continuous quality improvement cycle model. Last 15 months: 3 months for registration, training, baseline audit, barriers assessment and strategies design; 12 months for implementation, with audits at 3-6-12 months, local implementation teams and remote external facilitation. For the barriers assessment we adapted the questionnaire developed by TICD project. The resulting questionnaire has 52 barriers, 7 domains: evidence-related factors, professional-related factors, patient-related factors, professional interactions, incentives and resources, capacity for change, and social, political and legal factors. This work presents the descriptive analysis of the baseline barriers assessment. Project is ongoing.

Key finding(s)

The project involves 112 units, 84 from hospital and 28 from primary care. 100% implement hand hygiene recommendations, 52.6% pain , 29.3% breastfeeding, 12.1% incontinence and 6% obesity. The most frecuent barriers are patient-related, 41.59%, incentives and resources, 35.51%, and individual characteristics of the professionals, 35.03%. The most selected barrier in hospital is difficulty of changing routines; in primary care is related to patients' beliefs, knowledge and skills. According to the implementation cycle, most frequent barriers are: in breastfeeding,

interprofessional relations; in obesity, the capacity for change; in pain, incentives and resources, and in incontinence, patient-related factors.

Discussion

Depending on the setting and the cycle, the barriers found are different. This variability reinforces the idea that, when implementing recommendations, it is essential to take into account the context where they are implemented by carrying out a good context analysis and adapting the strategies to overcome barriers to the implementation cycle and setting.
Would be interesting to discuss about the possible strategies to address this barriers and about which is the best approach to facilitate the implementation in several units with different barriers from the point of view of a remote external facilitator.

Challenges

The biggest challenge has been how to facilitate implementation remotely in many different units, implementing recommendations on various topics and in several Spanish regions. Webinars have been organised and contact has been maintained with the units via phone and email. This is intended to be improved in the next editions.

Key highlights

This project will clarify the barriers to implementation in the NHS and will make possible to find solutions to address them. In addition, it aims to demonstrate how using implementation science in evidence-based implementation projects improves NHS outcomes, and, with its innovative methodology, will add knowledge to this science.

#232- Improving organized colorectal cancer (CRC) screening programs in Switzerland: An implementation science study

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Research aim

Since 2016, half of Switzerland's 26 cantons have established an organized CRC screening program, offering stool test or colonoscopy-based CRC screening systematically to 50–69-year-olds. We aimed to understand how Swiss CRC screening programs are implemented, focusing on factors influencing and opportunities for strengthening implementation.

Setting

This study was conducted within the context of the decentralized Swiss health care system, where organized CRC screening programs are initiated by cantonal health authorities. When setting up and running CRC screening programs, these authorities typically collaborate with health insurances, health care providers and intermediary organizations (e.g., swiss cancer screening).

Method(s)

This study used a mixed methods multiple case study design. We interviewed implementation leaders for 11 established/planned CRC screening programs (n=10) to explore key characteristics of program implementation. We then examined the implementation of four programs in detail, based on additional interviews (n=19), involving implementers operating at the program, cantonal and federal level. In parallel, we conducted a systematic integrative literature review to synthesize current best knowledge about implementation determinants and strategies reported for organized CRC screening programs across Europe. The Consolidated Framework for Implementation Research 2.0 and ERIC compilation of implementation strategies guided data analysis.

Key finding(s)

We provide the first overview of key characteristics and challenges characterizing CRC program implementation in the highly decentralized Swiss health care system. The design of CRC screening programs varies across cantons due to the need to align service provision with available implementation infrastructure. Limited availability of intermediary mechanisms for sharing and utilizing previous implementation experience, impedes processes of collaborative cross-cantonal program learning and development. The complexity of CRC screening program operations in combination with inadequate legislative and funding structures represent important barriers that implementers must navigate. Our findings can inform current and future CRC screening program planning and implementation.

Discussion

Implementation practice question: Within the context of a decentralized health care system, it is important to build capacity for knowledge exchange and shared learning to avoid different entities continuing to “re-invent the wheel”. What could this capacity look like and how can it be built and enhanced over time?
Implementation research question: Using the updated version of the Consolidated Framework for Implementation Research (CFIR 2.0) for coding qualitative data created multiple challenges for our research team. We will share our experience and invite the audience to discuss: Have you encountered similar challenges, and how did you navigate these?

Challenges

In comparison with its original version, the CFIR 2.0 requires a new approach to coding qualitative data. We developed a coding manual including examples of coding excerpts, taken from a broad range of CRC screening studies. The draft of this manual was discussed and piloted on a sample of studies.

Key highlights

Implementers of existing/future organized CRC screening programs can use our study findings to reflect on current/planned implementation practice and consider if and how to change this practice. We will invite EIE2023 attendees to a wider knowledge exchange about using the CFIR 2.0 for coding qualitative data.