RtKW 2: Co-creating implementation

Co-creation approach to adapting an interprofessional pharmacy service targeting initiation adherence in Switzerland: myCare Start – Implementation Science project

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Promoting evidence-based practices through integration of economic evaluations in implementation processes: case study and framework proposal

Rakhi Vashishtha[1], Woan Shin[2,1], Nick Sevdalis[1], Jumana Hashim[1], Ties Hoomans[3]

Co-Designing Practical Guidance to Bridge Implementation Science and Frontline Practice in Acute Care

Rhyann McKay[1], Gabrielle Zimmermann[1,2], Tracy Wasylak[2], Denise Thomson[1], Stephanie Montesanti[1]

Are Rigor and Pragmatism Mutually Exclusive? Lessons and Reflections from Implementing Health System Reform in the Global South

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RtKW 179

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Research aim
The myCare Start-Implementation Project (myCare Start-I) aims to adapt, to the Swiss setting, the New Medicines Service (NMS), which effectively improved medication adherence in the UK but faced implementation challenges when scaled internationally. myCare Start-I utilised a co-creation approach supplemented by rich contextual information, known theory and empirical evidence.

Setting
The myCare Start intervention will be implemented in Swiss community pharmacies and primary care settings across French and German-speaking regions. It targets community-dwelling patients starting long-term medications for chronic conditions, aiming to improve adherence through interprofessional collaboration between pharmacists and physicians.

Method(s)
Guided by the O'Cathain et al. (2019) framework and the ADAPT Guidance, a systematic co-creation approach was applied. An initial in-depth context analysis identified 63 factors impacting intervention design or implementation of myCare Start in Switzerland. A panel of interprofessional investigators, including primary care physicians, pharmacists and end-user representatives, prioritised these factors, assessing both the importance and the confidence in addressing them in the Swiss context to create priority areas. The co-creation process involved an exploratory qualitative approach, including repeated semi-structured focus groups with stakeholders (patients, physicians, and pharmacists) and consensus-based workshops with interprofessional investigators to iteratively refine the intervention.

Key finding(s)
A total of 12 stakeholder focus groups (n=50) and two investigator consensus workshops (n=15) led to a list of seven selected intervention adaptations. Adaptations were mapped in accordance with the Framework for Reporting Adaptations and Modifications Expanded (FRAME). Adaptations occurred at both individual (e.g., flexible delivery modes, extended follow-up timeline, pharmaceutical device demonstration options, inclusion of support persons) and organisational levels (e.g., physician referrals to myCare Start, standardised

pharmacist feedback to physicians and greater guidance for interventions to assist patients). The co-creation process thus successfully produced a contextually appropriate myCare Start model tailored to the needs of Swiss stakeholders.

Discussion

- Implementation science is still an emerging science in the field of pharmacy practice research in Switzerland. This project provides an example of integrating implementation science from adaptation to rollout, offering insights for future studies. Further, it marks the first time implementation science has been used to introduce the NMS in a new setting.
- Buy-in is required on two fronts. How can researchers and practitioners overcome stakeholder resistance when (1) utilising implementation science methodologies that often require patience and careful consideration of the context and (2) when implementing evidence-based interventions, especially in contexts where interregional differences are evident?

Challenges

Interregional differences were evident in Switzerland regarding existing levels, experiences with and openness to interprofessional collaboration and interprofessional health services between health professionals. Further work will be conducted in regions of Switzerland where collaboration is underdeveloped to ensure all adaptations are acceptable and appropriate implementation strategies are selected.

RtKW 268

Promoting evidence-based practices through integration of economic evaluations in implementation processes: case study and framework proposal

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Research aim
This study explores the integration of economic evaluation into implementation science to promote evidence-based practices (EBPs) in routine care. It aims to map economic evaluation methodologies in analysis, communication, and stakeholder alignment. The ultimate goal is establishing a framework that enhances integration, ensuring effective and sustainable healthcare delivery.

Setting
This study entails a case study of a cardiovascular disease (CVD) screening initiative by the National University Health System in Singapore, focusing on community-based approaches to improve accessibility and uptake. Economic evaluation will inform and compare different implementation strategies, considering direct and indirect costs, patient engagement, and provider needs.

Method(s)
The study follows a two-phase approach:
Phase 1: Literature Review. A review will map current trends, methodologies, and gaps in integrating economic evaluation into implementation science.
Phase 2: Panel Discussions. Stakeholders—including policymakers, managers, practitioners, patients and researchers—will discuss real-world challenges and opportunities, guided by the review findings and the CVD case study. Discussions will employ participatory research principles and quantitative economic evaluation to ensure diverse and meaningful input.
Insights from both phases will be synthesised to refine a rigorous economic evaluation framework.

Key finding(s)
- Incorporating economic evaluations into implementation processes remains uncommon.
- Economic evaluation must consider diverse perspectives and broad costs, including practitioner and patient time.
- Costs vary significantly by context, scale, and healthcare system needs.
- High-quality data is scarce, limiting accuracy and long-term impact assessments, such as cost savings and resource reallocations.
- Methodologies for economic evaluations in implementation processes are fragmented.
- Cross-disciplinary collaboration between implementation scientists and health economists is essential to critical to improve real-world relevance.
- Stakeholder priorities must be integrated at all stages of implementation, with economic evaluation embedded as part of implementation efforts.

Discussion
The proposed framework emphasises stakeholder engagement and participatory principles, ensuring that economic considerations are relevant and actionable. It provides a structured approach to effectively integrate economic considerations into implementation science, leveraging tools like causal pathway analysis and data mapping for practical application. This study highlights the underutilisation of economic evaluation in implementation science despite its potential to enhance EBPs. Future efforts should refine the framework and strengthen data collection to support scalable, sustainable implementation strategies across diverse contexts.

Challenges

Economic evaluations must adapt to the dynamic priorities of stakeholders across implementation phases. Collaborative investment models and comprehensive cost identification are key to enhancing program sustainability and stakeholder engagement. Achieving consensus during panel discussions will be essential to align diverse stakeholder priorities with effective healthcare outcomes.

RtKW 339

Co-Designing Practical Guidance to Bridge Implementation Science and Frontline Practice in Acute Care

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Research aim
This work explores the co-design of an implementation guide for a provincially-scaled programmatic acute care improvement initiative in Alberta, Canada, Acute Care Bundle Improvement (ACBI). The co-design process reconciled tensions between implementation science frameworks and the dynamic realities of healthcare delivery, fostering alignment between theoretical rigour and practical utility.

Setting
ACBI was implemented across Alberta's 14 highest-volume acute care hospitals, coordinated by a province-wide health authority. This multi-year implementation process required ongoing collaboration and negotiation across system levels to maintain alignment with the initiative's core objectives while supporting tailoring to reflect the local context, needs, and priorities at each site.

Method(s)
A descriptive case study approach was used to explore the process of co-designing an implementation guide ("Playbook") for the ACBI program, guided by the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework. Iterative co-design involved multidisciplinary collaboration across system levels (i.e., provincial programs, hospitals, clinical service programs, units) with healthcare providers, operational leaders, and researchers. Co-design activities were planned pragmatically. Examples include strategy mapping, World Cafés, walkthroughs, and prototyping tools. Feedback cycles prioritised practicality and contextual sensitivity while integrating evidence-based practices into a cohesive guide. Key tools emphasised flexibility, responsiveness to operational constraints, and alignment with frontline language and practice.

Key finding(s)
Co-designing the "Playbook" facilitated integration across different system levels, as well as improvement approaches (e.g., implementation science, quality improvement, change management), which are often siloed, enabling alignment of diverse priorities and practices. This approach enhanced relevance and adaptability, resulting in a flexible implementation guide with tools tailored to the language and processes of frontline users. Trade-offs between rigour and pragmatism often required extensively adapting or omitting theory-based tools perceived as impractical by frontline users. Insights into collaborative development processes underscored the value of flexibility in navigating complex adaptive systems.

Discussion
- Implementation science is intended to support sustained, evidence-based system change, yet its application in practice is often challenging. What can implementation science researchers do to enhance the application of implementation science theories, models, and frameworks in ways that align with the operational realities of complex systems?
- How can implementation science learn from and align with related disciplines such as quality improvement and change management to make implementing science more user-friendly and enhance the field as a whole?

Challenges
Challenges included negotiating competing priorities across system levels, adapting to local contexts and constraints (e.g., staff turnover/shortages, workflow preferences, and post-pandemic burnout), and reconciling theory-based tools with practical utility. Iterative co-design helped to mitigate these issues but emphasised the tension between scientific rigour and pragmatism in complex systems.

RtKW 340

Are Rigor and Pragmatism Mutually Exclusive? Lessons and Reflections from Implementing Health System Reform in the Global South

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Research aim
The EIE2025 theme on a tightrope between rigour and pragmatism suggests the two are mutually exclusive. This presentation will challenge this assumption by drawing lessons and epistemological reflections from the author's body of research on implementing health system reform, showing examples of how scientific rigour and pragmatism could be unified.

Setting
This presentation is mostly about the public health sector in the global south, but the orientation towards health policy and systems makes the lessons also relevant to other sectors, including social policy and education.

Method(s)
This presentation covers more than one study: (a) an analysis of the effectiveness of decentralising the public health sector in the Philippines using a qualitative study that examined the perspectives of policymakers; (b) an initiative to estimate health workforce needs for the Philippines and formulate policies to address gaps based on the model of co-creation among stakeholders; (c) a collaboration between researchers in Nepal, Indonesia, and the Philippines to determine organisational capacities for health policy and systems research; and (d) a proposed approach for building a culture of reflexivity based on reflections from global health work in Switzerland and Malaysia.

Key finding(s)
- Philippine experience suggests that decentralisation is a complex journey and not an automatic solution for enhancing service delivery. The role of the central decision-maker remains important to assist local levels to perform their functions well.
- Across three health professions that comprised skilled health workers, the estimated requirements using the benchmark densities were significantly higher than the estimates that considered epidemiological and sociodemographic factors.
- Organisational attributes of well-performing organisations include research expertise, leadership and management, policy translation, and networking.
- We diverge from reflexivity's place in qualitative research and framed it as self-understanding, dialogue with peers, and insights-to-action.

Discussion
Questions are posed based on discussion points: (a) assessing decentralisation was not about whether or not it was effective but "how" it becomes effective for the health system; (b) estimating health workforce requirements depends on a range of approaches that vary in the intensity of data needed and feasibility of policy to meet shortages; (c) the strength of an organisation that performs health systems research includes not only research expertise but also on the capacity to lead, network, and influence policy; (d) to be better researchers, we advocate for reflexivity through dialogues with peers that translate insights into collective action.

Challenges
Taken together, the challenges included
- The dominance of the positivist paradigm in understanding the meaning of rigour and
- The prevailing view of knowledge translation as a linear rather than a complex process.

These were addressed by valuing other epistemological traditions, including qualitative research, and by applying co-creation in doing research.