WtT 2

Results from living labs implementing adherence interventions as evaluated by the Medication Adherence Knowledge, Expertise and Implementation Taskforce (Make-It)

Caroline van de Steeg-van Gompel[1], Marcia Vervloet[2], Liset van Dijk[2], Mirthe Oude Lansink[3]

[1]SIR Institute for Pharmacy Practice and Policy, Leiden, Netherlands
[2]Nivel, Utrecht, Netherlands
[3]Sint Maartenskliniek, Nijmegen, Netherlands

Introduction

Numerous interventions that can promote medication adherence are sparsely implemented in practice. The Medication Adherence Knowledge and Expertise and Implementation Taskforce (Make-It) guides, monitors and evaluates the implementation of tested medication adherence interventions in real-world primary care settings (living labs) to bridge this research-to-practice gap. In 2023, we presented the design of Make-It, the context analysis of the first four living labs, and the implementation strategies they used. Now, we will discuss the operationalisation of the most frequently used implementation strategies, results for implementation outcomes from the first four living labs and the scalability of their implemented medication adherence interventions.

Presentation I

Background: In the first Make-It round with four living labs, we identified eight ERIC strategies used by all living labs: 1) Build a coalition; 2) Inform local opinion leaders; 3)Assess for readiness and identify barriers and facilitators; 4) Work with educational institutions; 5) Develop educational materials; 6) Use an implementation advisor; 7) Centralize technical assistance; 8) Audit and provide feedback. For the present study in the second round, we aimed to gain more insight into the operationalisation of the implementation strategies most frequently used.
Methods: Four new living labs were instructed to incorporate the eight strategies into their projects. During the implementation phase, they were asked in a workshop to write down how they had operationalized these strategies, according to a predefined format. An explanation of each strategy was provided in a workbook.
Results: Living labs operationalized the eight strategies in varying ways. The operationalisations also included actions belonging to other strategies. For example, Build a coalition had overlap with Capture and share local knowledge, Assess for readiness and identify barriers and facilitators, and Promote network weaving.
Discussion: This research illustrates the tension between implementation science and practice. Transferring the definition of strategies and their distinction from other strategies in a limited time proved difficult. Also, experienced implementers are not always aware of what is self-evident to them, but what is very interesting for implementation science. We would like to exchange ideas, experiences and recommendations on this topic with the workshop attendants.

Presentation II

Background: The first four pharmacy-driven living labs implemented consultation-based medication adherence interventions in routine primary care. This study evaluated the implementation outcomes of these living labs.
Methods: This was a mixed-method study. Interviews were held with the project leaders from the living labs after their project ended and were transcribed verbatim. Data were extracted from documentation generated by the living labs and Make-It (e.g. reports, meeting minutes, logbooks). The Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) framework was used to guide data collection, data extraction and analyses.
Results: Reach was successful as three living labs included (more than) their anticipated patients numbers. The fourth lab aimed to include all patients in their refill service, which was not feasible in their project duration. The majority of the pharmacy staff adopted the interventions. A highly motivated project leader and appropriate staff training facilitated adoption. Pharmacy staff and patients appreciated the interventions, strengthening their contact. Fidelity was high in all living labs. Implementation was facilitated by interventions

being compatible, good leadership, intrinsic motivation of staff, and by short-cycle evaluations before scaling up. Patient-reported outcomes improved in all living labs. The interventions were not sustained in three labs due to limited capacity and finances.
Discussion: Implementation of adherence interventions in primary care can be successful, but requires large investment to create support amongst all involved. We would like to discuss leadership as a crucial factor for successful implementation: how to ensure good implementation leadership?

Presentation III

Background: A recent realist review found six domains to be relevant for scalability of medication adherence interventions: (1) complexity; (2) training needed; (3) customisation; (4) drivers of the intervention; (5) technical interventions; and (6) stakeholder involvement. This study aimed to explore the scalability of interventions used by the first four living labs based on these six domains.
Methods: The living labs implemented relatively simple adherence interventions, which were evaluated in an implementation study. Based on that study, one author categorised the outcomes related to scalability in the six domains. Next, another author validated this analysis. Discrepancies were resolved.
Results: For scalability, a balance between feasibility and effectiveness exists: less complex interventions are easier to implement but make less difference to standard care (domain: complexity). In the living labs the focus was on feasibility. Training is usually needed for the initial implementation of the intervention, as well as in the living labs (training). As training can lead to delaying scaling-up, participants sharing positive training experiences are needed. The interventions used in the living labs can be adapted to local settings and needs (customisation), which contributes to scalability. Lack of remuneration for an intervention is a major barrier to scale-up (drivers) and should be included in discussions between relevant stakeholders (stakeholder involvement).
Discussion: Scaling up relatively simple adherence interventions in less advanced settings remains a challenge. We like to discuss the scalability of adherence interventions making use of the results of our study.