

Implementeringsforskning

Ane-Marthe Solheim Skar, PhD/MA (hun/henne)

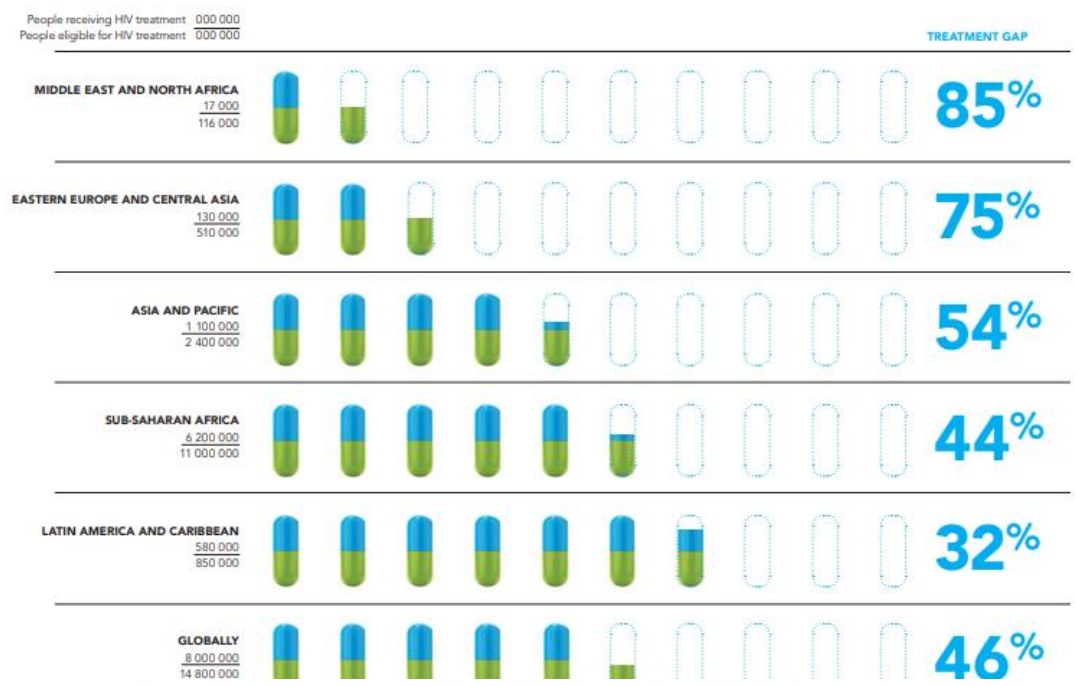
Fagdirektør (fung.), Klynge for global helse, Folkehelseinstituttet (FHI)

Forsker/prosjektleder, Seksjon for implementerings- og behandlingsforskning, Nasjonalt kunnskapssenter om vold og traumatisk stress (NKVTS)

The treatment gap in low- and middle-income countries

Antiretroviral therapy reached 8 million people by the end of 2011, a twenty-fold increase since 2003. In 2011, for the first time, a majority (54%) of people eligible for antiretroviral therapy in low- and middle-income countries were receiving it. This chart shows the gap in 2011 between the number of people receiving antiretroviral therapy and the number of people eligible for treatment.

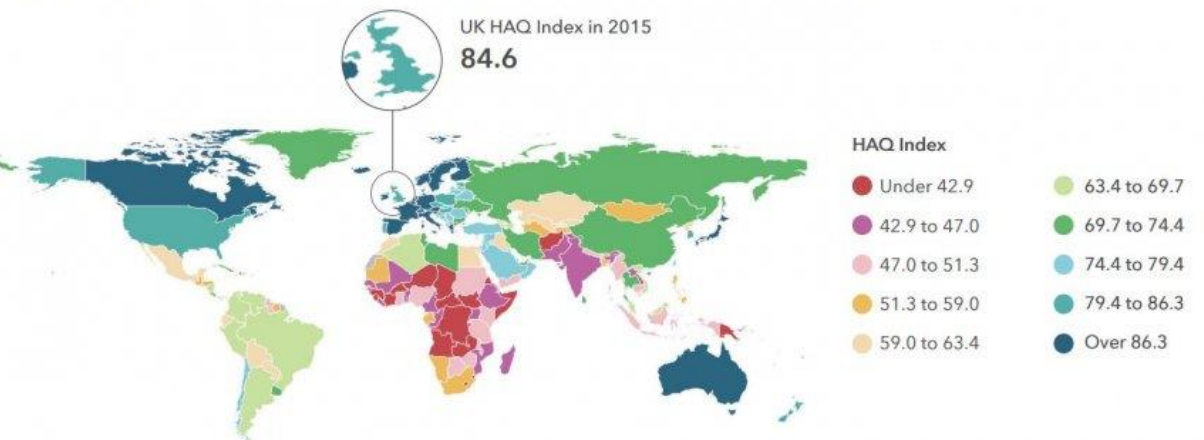
Source: UNAIDS 2012 Global Report



TREATMENT GAP

- 85% of people with severe mental disorders receive no treatment

Mapping personal healthcare access and quality worldwide in 2015



Alonge et al., 2019; Malhotra et al., 2022; Yapa et al., 2018; WHO, 2018;
https://www.unaids.org/en/resources/infographics/20121120_results_treatment_gap
<https://www.lshtm.ac.uk/newsevents/news/2018/healthcare-inequality-between-countries-grows-despite-global-improvements>

- Helsepersonell i USA følger anbefalte praksiser bare 54% av tiden.
- Innen smitteverntiltak:
- Under innsetting av sentrale venekatetre bruker amerikanske sykehus regelmessig anbefalte tiltak for å forhindre kateterrelatert blodstrøminfeksjon - mindre enn 75% av tiden.
- Bruken av påminnelser (eller stopp-ordre) for urinkateter for å forebygge urinveisinfeksjon relatert til kateter - en annen sterkt anbefalt praksis - brukes i mindre enn 1 av 10 amerikanske sykehus.
- Omtrent 40% av helsepersonell overholder anbefalte håndhygienetiltak.

McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348:2635-45. [[PubMed](#)] [[Google Scholar](#)]

Krein SL, Hofer TP, Kowalski CP, et al. Use of central venous catheter-related bloodstream infection prevention practices by US hospitals. *Mayo Clin Proc*. 2007;82:672-8. [[PubMed](#)] [[Google Scholar](#)]

Saint S, Kowalski CP, Kaufman SR, et al. Preventing hospital-acquired urinary tract infection in the United States: a national study. *Clin Infect Dis*. 2008;46:243-50. [[PubMed](#)] [[Google Scholar](#)]

Implementering: Utfordringer og muligheter

Balas & Boren, 2000; Grant, Green, & Mason, 2003; Morris, Wooding, & Grant, 2011



Det tar ofte mer enn et tiår for omtrent halvparten av EBP-ene å nå praksisfeltet

Revisiting time to translation: implementation of evidence-based practices (EBPs) in cancer control

Shahnaz Khan ^{1 2}, David Chambers ³, Gila Neta ³

Affiliations + expand

PMID: 33392908 DOI: [10.1007/s10552-020-01376-z](#)

Abstract

Purpose: Previous studies estimate translation of research evidence into practice takes 17 years. However, this estimate is not specific to cancer control evidence-based practices (EBPs), nor do these studies evaluate variation in the translational process. We examined the translational pathway of cancer control EBPs.

Methods: We selected five cancer control EBPs where data on uptake were readily available. Years from landmark publication to clinical guideline issuance to implementation, defined as 50% uptake, were measured. The translational pathway for each EBP was mapped and an average total time across EBPs was calculated.

Results: Five cancer control EBPs were included: mammography, clinicians' advice to quit smoking, colorectal cancer screening, HPV co-testing, and HPV vaccination. Time from publication to implementation ranged from 13 to 21 years, averaging 15 years. Time from publication to guideline issuance ranged from 3 to 17 years, and from guideline issuance to implementation, - 4 to 12 years. Clinician's advice to quit smoking, HPV co-testing, and HPV vaccination were most rapidly implemented; colorectal cancer screening and mammography were slowest to implement.

Conclusion: The average time to implementation was 15 years for the five EBPs we evaluated, a marginal improvement from prior findings. Although newer EBPs such as HPV vaccination and HPV co-testing were faster to implement than other EBPs, continued efforts in implementation science to speed research to practice are needed.

Implementering: Utfordringer og muligheter

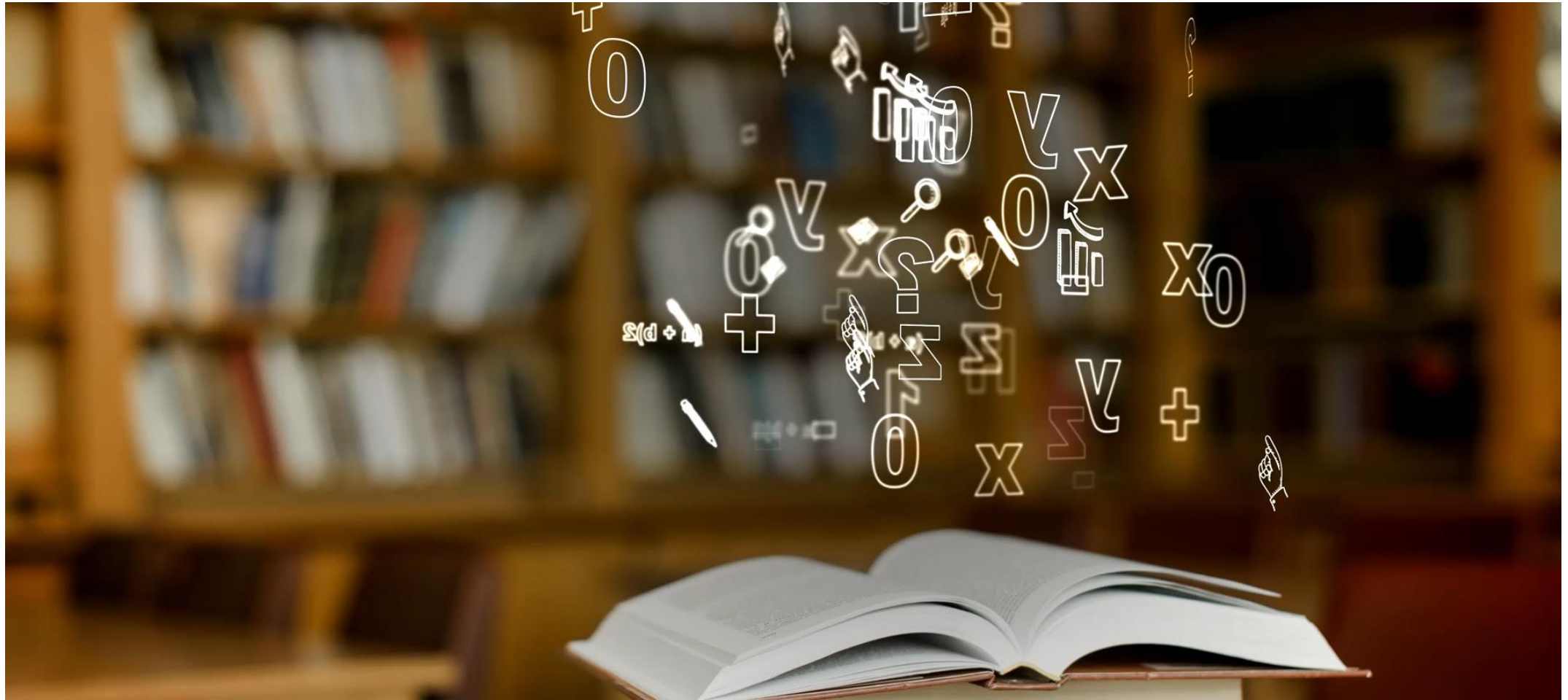
Balas & Boren, 2000; Grant, Green, & Mason, 2003; Morris, Wooding, & Grant, 2011



Det tar ofte mer enn et tiår for omtrent halvparten av EBP-ene å nå praksisfeltet



EBP må IMPLEMENTERES



Hva er implementering?

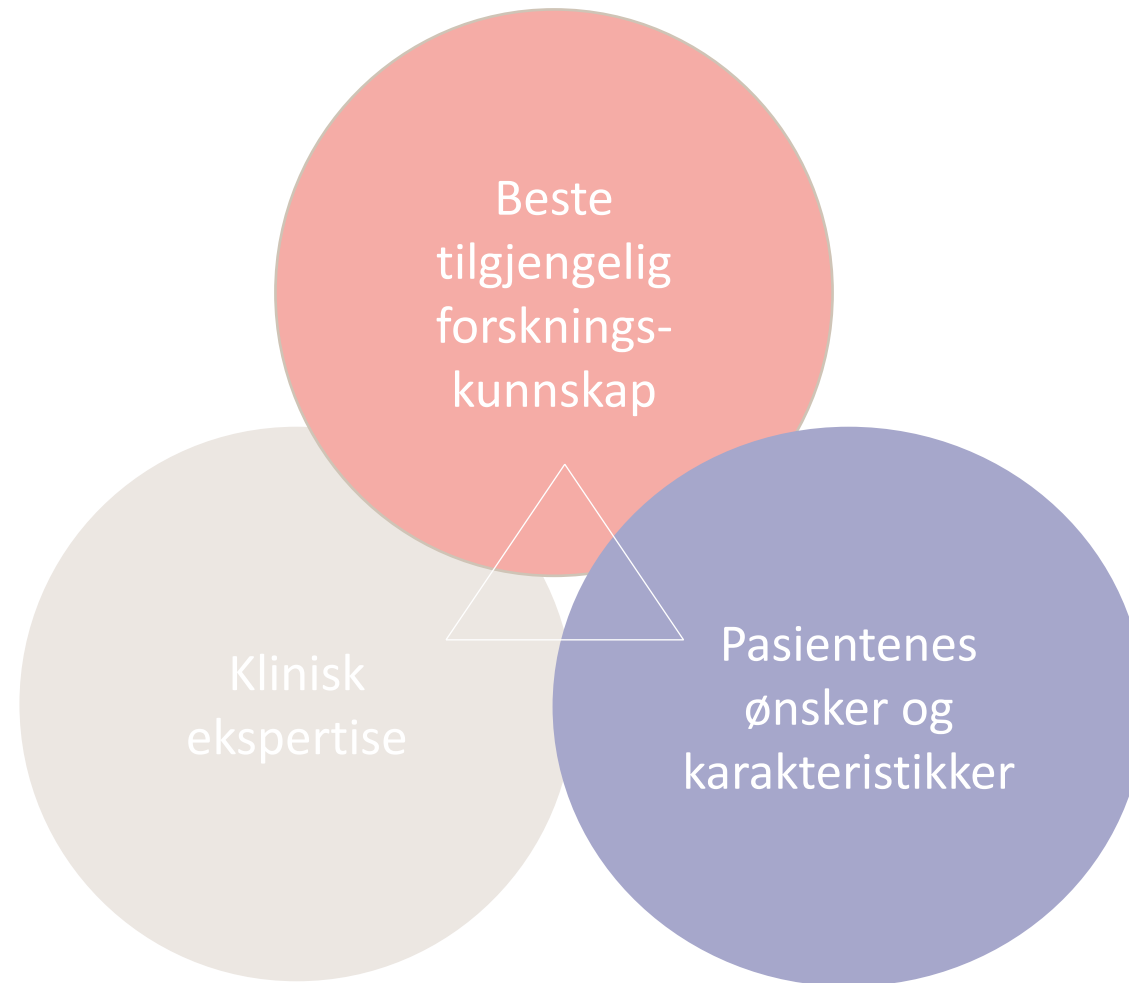


Lomas, 1993

“Implementering er et sett av spesifikke aktiviteter designet for å sette en aktivitet eller et program med kjente dimensjoner ut i praksis .”

Fixsen et al (2005)

Kunnskapsbasert praksis



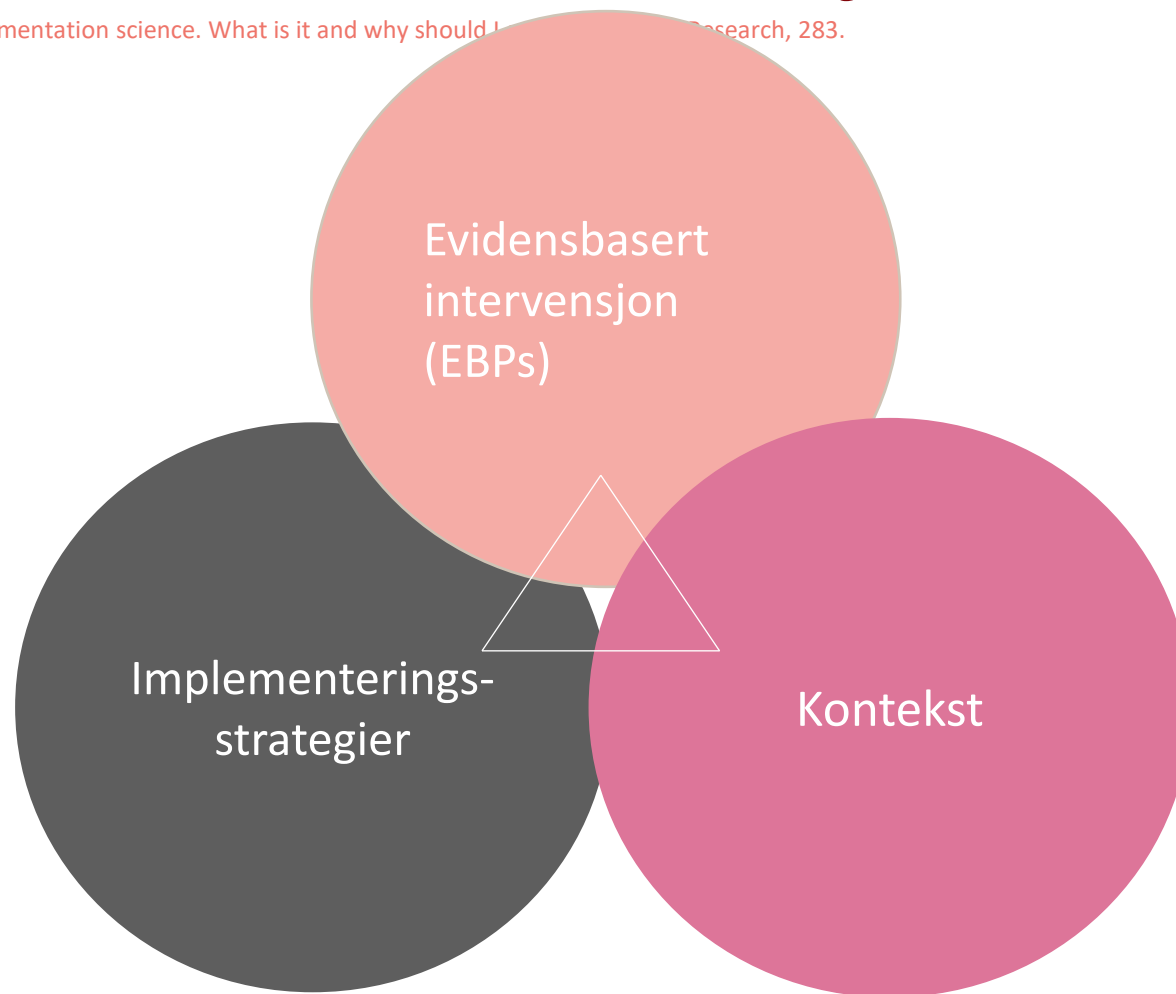
Implementering av håndvaskrutiner

- Historien om Semmelweis peker bla. på viktigheten av “buy in”, tillitsfull ledelse og holdninger som viktige faktorer for å lykkes med implementering!

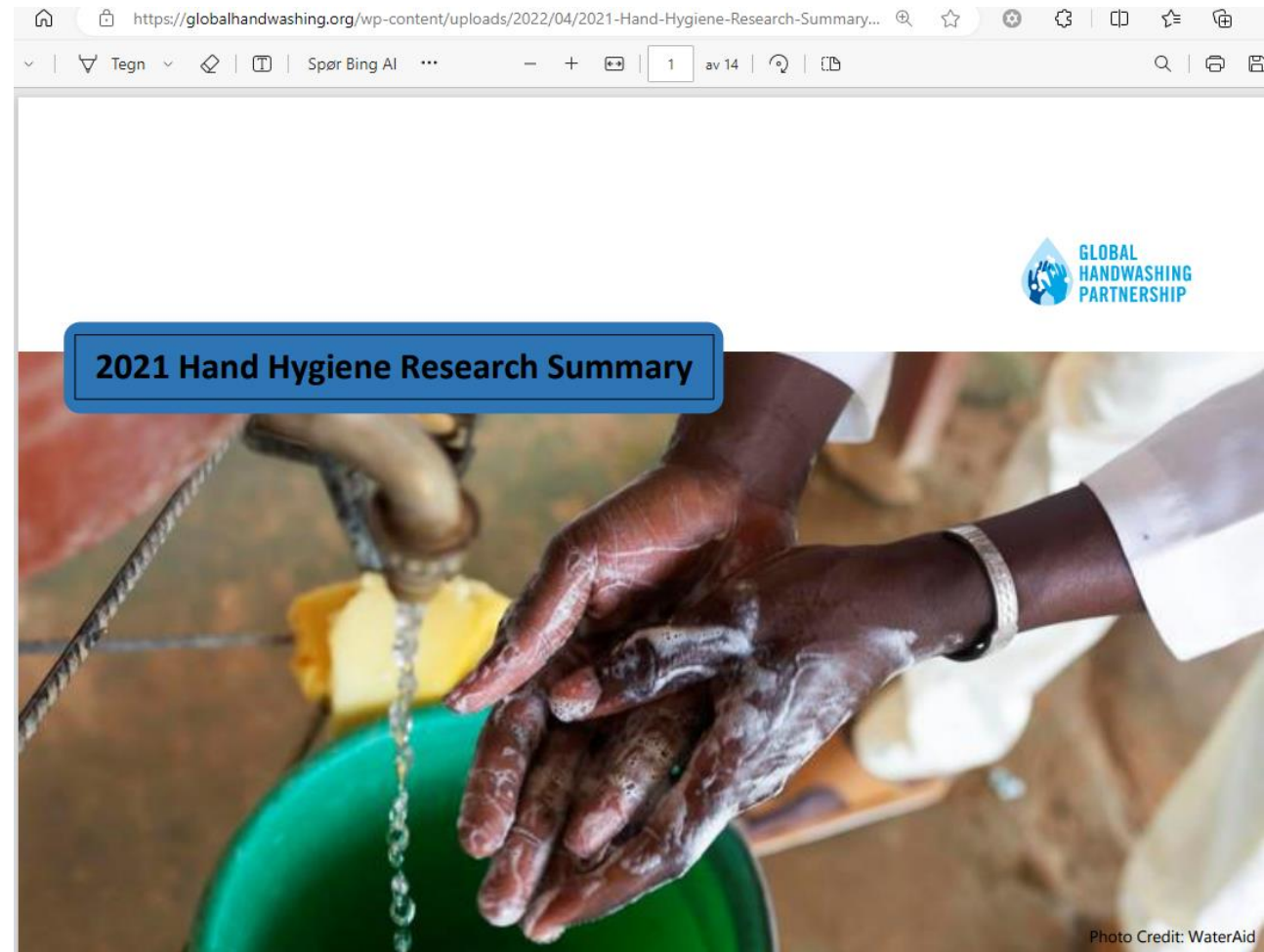


Vellykkede helseintervensjoner

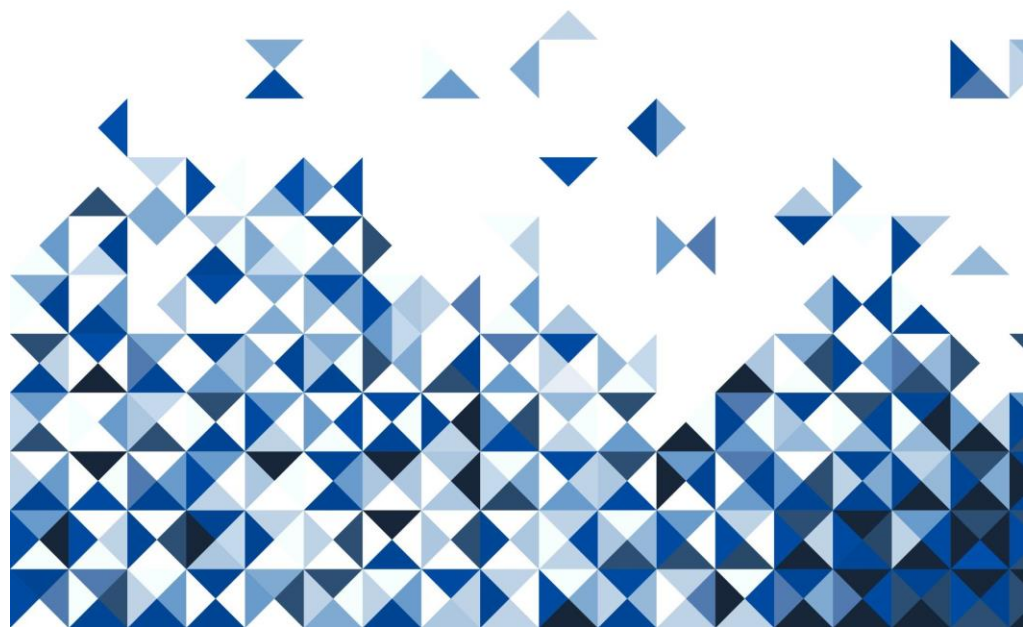
Bauer, M. S., & Kirchner, J.A. (2020). Implementation science. What is it and why should I care? *Medical Research*, 283.



“While access and supplies are necessary to ensure hand hygiene behavior, **access alone is not enough** to change hand hygiene behavior. **Behavior change** efforts must address a range of **behavioral determinants, enabling factors, individual motives, and barriers** which may differ based on the **setting**.



Hva må til?



- Starte å gjøre noe nytt
- Slutte å gjøre noe (deimplementering)
- Begge deler

The intervention/method/guideline etc. is THE THING

- Effectiveness research looks at whether THE THING works;
- Implementation research looks at how best to help people (e.g., employers and workers)/(work)places DO THE THING;
- Implementation strategies are the stuff researchers do to try to help people/(work) places DO THE THING as designed/intended (i.e., with fidelity), such as provide training, technical assistance, and/or incentives;
- Main implementation outcomes are HOW MUCH and HOW WELL they DO THE THING.

Curran, 2020



Classifying the strategies used in implementation science and practice

Classes of implementation strategies	Examples of implementation strategies
1. Dissemination	Develop customized information for the target groups
2. Implementation process	Engage key partners Evaluate the process and outcome
3. Integration strategies	Provide supervision Allocate responsibilities
4. Capacity building strategies	Training Materials to support the implementation process
5. Scale-up strategies	Train-the-trainer Developing of infrastructure



Kunnskap

Implementerings-
forskning

Praksis

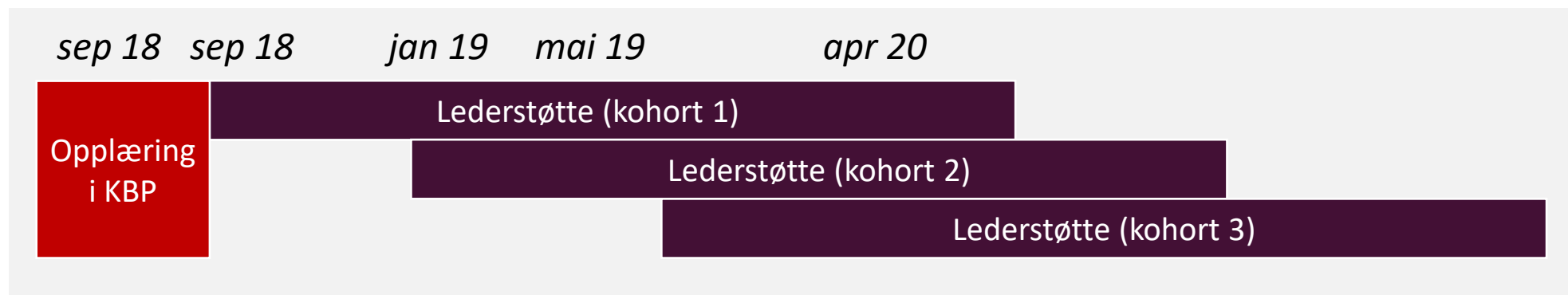
Implementeringsforskning

Kan fokusere hovedsakelig på intervensjonen, på implementeringen, eller begge!

- (1) teste effekten av en intervensjon på relevante resultater mens du observerer og samler informasjon om implementering
- (2) dobbel testing av kliniske resultater og implementeringsintervensjoner/strategier
- (3) teste en implementeringsstrategi mens man observerer og samler informasjon om den kliniske intervensjonens innvirkning på relevante utfall.

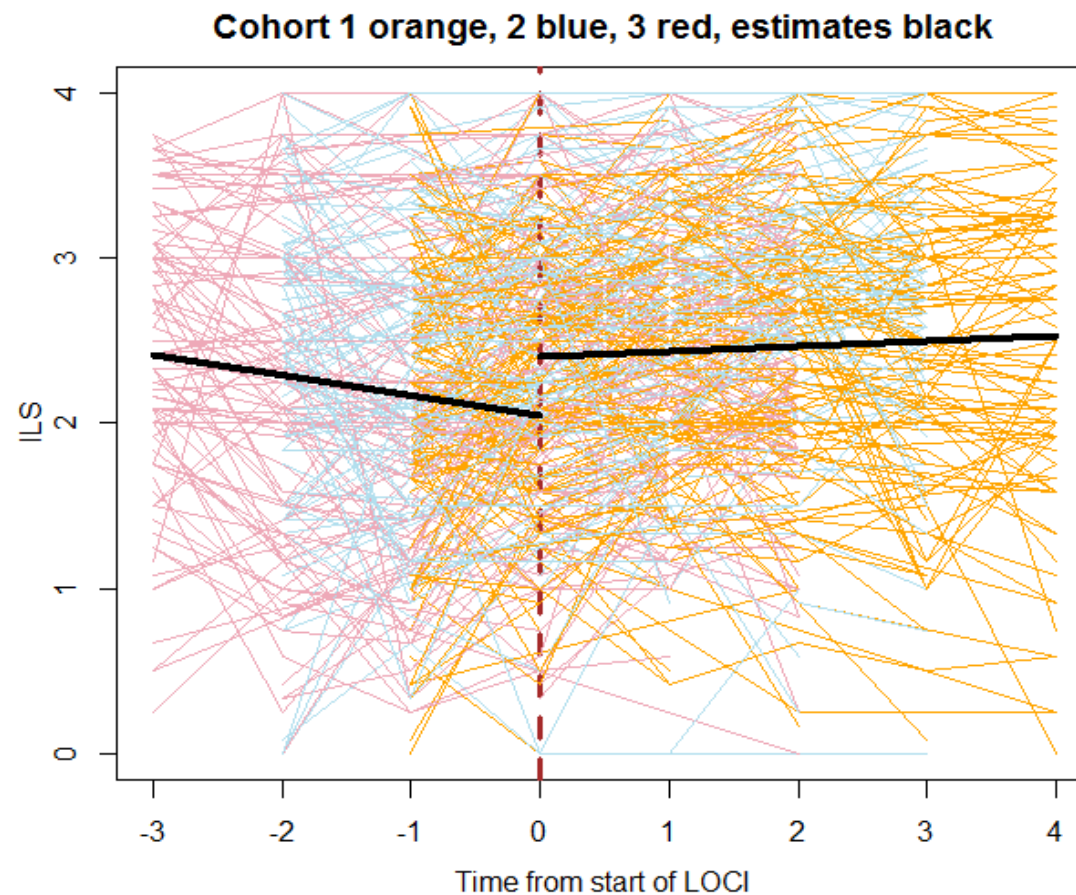
Eksempel på en implementeringsstudie

- Klyngerandomisert design
- 43 enheter deltok (DPS, BUP)
- Undersøkte effekten av lederstøtte på terapeuters opplevelse av implementeringsledelse



Implementeringsledelse

Nedgang i opplevd lederstøtte over tid – økte etter ledere fikk opplæring i implementeringsledelse og holdt seg stabilt over tid



Achieving change in primary care--causes of the evidence to practice gap: systematic reviews of reviews

Rosa Lau ¹, Fiona Stevenson ², Bie Nio Ong ³, Krysia Dziedzic ³, Shaun Treweek ⁴, Sandra Eldridge ⁵, Hazel Everitt ⁶, Anne Kennedy ⁷, Nadeem Qureshi ⁸, Anne Rogers ⁷, Richard Peacock ⁹, Elizabeth Murray ²

Affiliations + expand

PMID: 27001107 PMID: PMC4802575 DOI: 10.1186/s13012-016-0396-4

[Free PMC article](#)

Abstract

Background: This study is to identify, summarise and synthesise literature on the causes of the evidence to practice gap for complex interventions in primary care.

Design: This study is a systematic review of reviews.

Methods: MEDLINE, EMBASE, CINAHL, Cochrane Library and PsychINFO were searched, from inception to December 2013. Eligible reviews addressed causes of the evidence to practice gap in primary care in developed countries. Data from included reviews were extracted and synthesised using guidelines for meta-synthesis.

Results: Seventy reviews fulfilled the inclusion criteria and encompassed a wide range of topics, e.g. guideline implementation, integration of new roles, technology implementation, public health and preventative medicine. None of the included papers used the term "cause" or stated an intention to investigate causes at all. A descriptive approach was often used, and the included papers expressed "causes" in terms of "barriers and facilitators" to implementation. We developed a four-level framework covering external context, organisation, professionals and intervention. External contextual factors included policies, incentivisation structures, dominant paradigms, stakeholders' buy-in, infrastructure and advances in technology. Organisation-related factors included culture, available resources, integration with existing processes, relationships, skill mix and staff involvement. At the level of individual professionals, professional role, underlying philosophy of care and competencies were important. Characteristics of the intervention that impacted on implementation included evidence of benefit, ease of use and adaptability to local circumstances. We postulate that the "fit" between the intervention and the context is critical in determining the success of implementation.

Conclusions: This comprehensive review of reviews summarises current knowledge on the barriers and facilitators to implementation of diverse complex interventions in primary care. To maximise the uptake of complex interventions in primary care, health care professionals and commissioning organisations should consider the range of contextual factors, remaining aware of the dynamic nature of context. Future studies should place an emphasis on describing context and articulating the relationships between the factors identified here.



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Dissemination and implementation science for infection prevention: A primer

[Heather M. Gilmartin, PhD, NP, CIC, FAPIC](#)   • [Amanda J. Hessels, PhD, MPH, RN, CIC, CPHQ, FAPIC](#)

Published: March 05, 2019 • DOI: <https://doi.org/10.1016/j.ajic.2019.01.023> •



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1 Articles

Dissemination and implementation science (D&I) is a rapidly growing area of investigation. Although many evidence-based guidelines for infection prevention are available, not all are systematically implemented into clinical practice. This evidence-to-practice gap has been linked to poor health outcomes. D&I science bridges the gap between research and everyday practice by providing a knowledge base about how health information, interventions, and new clinical practices and policies are translated for use in specific settings. D&I science can expedite and sustain the successful integration of evidence into practice to improve care delivery, population health, and health outcomes. This article offers an introductory overview of D&I and addresses issues such as variation in terminology, finding and appraising evidence, theories and models, implementation strategies, and the future of D&I. Examples from the infection prevention literature are presented throughout.

Takk for meg!

Ane-Marthe Solheim Skar

E-mail: a.m.s.skar@nkvts.no / Ane-MartheSolheim.Skar@fhi.no

Tlf.: +47 97 66 15 91



@AneMartheSSkar