Mixed-method case studies were conducted in 9 sites, Germany, Greece, Italy, Poland, Portugal, (Spain) Catalonia, Sweden and (United Kingdom) Scotland and Northern Ireland, mapping the structures, processes, and outcomes of policies and practices at the institutional, regional, and local level.

Phase I
Desk Review
Evaluating economic, political, and cultural context;
Checklist of complex interventions.

Phase II
Key Informant Interviews
Assessing development and implementation strategies.
Participants included: Primary care and hospital pharmacists, hospital geriatricians, primary care and hospital managers, health system administrators.

Phase III
Focus Groups
Validating interim report findings with focus group of primary care pharmacists, hospital and primary care geriatricians, hospital manager and health system administrator.

To learn more about Project SIMPATHY and polypharmacy and adherence in the elderly across Europe contact:
Alpana Mair,
Deputy Chief Pharmaceutical Officer for Scotland
alpana.mair@scotland.gsi.gov.uk

To learn more about Project SIMPATHY in Catalonia, please contact:
Carles Codina, Head of Pharmacy
Department, Hospital Clinic Barcelona
ccodina@clinic.cat


Innovative ideas in development

This leaflet is part of the SIMPATHY project (663082), which has received funding from the European Union's Health Programme (2014-2020).
The **Government sponsored model** was lead by the Department of Health and targeted at primary care physicians. It utilised a vertical approach to implementation with the primary focus on patient safety, individual physician prescribing, and had a goal of implementation throughout the entire healthcare system.

The **Institutional network sponsored model** (Hospital, long-term care, nursing home) was lead by geriatrician health professionals and supported by department heads and hospital administrators. It employed a horizontal implementation strategy with a global patient-centred focus, including polypharmacy management. It was driven by a small multidisciplinary team with the goal of creating a scalable programme. Key facilitators included a “culture of geriatrics” supporting the use of multidisciplinary teams and an institutional culture of innovation.

The **Catalan Health Plan** provided an underlying strategic vision with less specific recommendations about medicines management in hospitals.

The contract between the government payer and the hospital did not establish explicit objectives regarding polypharmacy, allowing for the development of a strong local vision of medicines management.

The vision and strategy were understood and adopted by a group of professionals integrated as a multidisciplinary team.

Polypharmacy was integrated as a specific component of a broader patient-centred service model with a focus on global health outcomes. Adherence remained a less developed component.

The objectives of the contract were transferred to primary care physicians. There was no specific contractual role for nurses.

Theoretically the objectives mirrored the comprehensive patient-centred vision outlined in the Health Plan although, in practical terms, polypharmacy focused on a narrower subset of quality and safety indicators, and to a lesser extent on adherence.

These two examples illustrate how the challenge of polypharmacy can be addressed in different healthcare settings utilising different resources. Both programmes face challenges in effectively changing current practices to facilitate the full implementation and subsequent scale up.