

## Adapting a solution developed elsewhere<sup>1</sup>

### Example 1. Integrated care model with case management for neurodivergent children

#### Performing a feasibility analysis

A feasibility analysis was being conducted by using the THCS Feasibility Analysis Tool to assess the practicality, viability, and sustainability of an integrated care model with case management tailored for neurodivergent children.

#### 1. Assess the quality of the care and/or medical/clinical soundness related to the solution

Is the solution medically/clinically sound?

☒ Yes ☐ No/Partly ☐ Not applicable

Does the solution align with the necessary quality of care in your organisation?

☒ Yes ☐ No/Partly ☐ Not applicable

Do the expected outcomes of the solution match the prioritised goals of the organisation?

☒ Yes ☐ No/Partly ☐ Not applicable

Can the solution be effectively managed within the clinical setting?

☒ Yes ☐ No/Partly ☐ Not applicable

Are the core features and content of the solution and the needed context well defined?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Not applicable

#### 2. Assess whether the solution is applicable to the organisation's work processes and compatible with the available technology

Can the solution be practically implemented within your organisation's workflows and/or processes?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the required technology (devices, tools, and software) available/obtainable?

☒ Yes ☐ No/Partly ☐ Not applicable

Are other material resources needed available/obtainable?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Not applicable

#### 3. Assess the availability of competent and qualified workforce

Is competent and qualified staff available?

☐ Yes ☒ No/Partly ☐ Not applicable

If the staff needs specific training to deliver the solution, can it be organised?

---

<sup>1</sup> The examples were created using ChatGPT and Copilot AI tools.

☒ Yes ☐ No/Partly ☐ Not applicable

If ongoing support and supervision is needed, can it be provided?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Staff recruitment challenges can be addressed through partnerships with training institutions and implementation of structured onboarding and continuous professional development programs.

#### 4. Assess the usability of the solution from professionals and/or patients' perspective

Is the solution easy to use from the patients' perspective?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution easy to use from the professionals' perspective?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution useful from the patients' perspective?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution useful from the professionals' perspective?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Not applicable

#### 5. Assess the risks related to the solution

Is the solution risk-free (including financial, operational, clinical, and legal risks)?

☐ Yes ☒ No/Partly ☐ Not applicable

Does the solution take account of environmental impacts and is it eco-friendly?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution non-discriminatory and enhances equality?

☒ Yes ☐ No/Partly ☐ Not applicable

Can the solution be piloted?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution reversible and/or can it be de-implemented?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Risk mitigation can be achieved through comprehensive training, development of data protection protocols, and securing diverse funding to reduce financial vulnerability.

#### 6. Assess the required funding

Is the cost-benefit ratio of the solution reasonable?

☒ Yes ☐ No/Partly ☐ Not applicable

Is sufficient funding available or are there potential sources of funding?

☐ Yes ☒ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Initial investment challenges can be managed by applying for grants and highlighting long-term financial benefits through improved coordination and reduced emergency care.

7. Based on the above analysis, assess and describe below the long-term sustainability of the solution beyond the initial implementation phase

The long-term sustainability of the solution is likely if continued investment in staff development, stakeholder collaboration, and outcome monitoring is ensured. The model's flexibility and alignment with holistic care priorities further support its adaptability to future policy and population needs.

Conclusions: List here whether/how the “No/Partly” responses can be addressed to implement the solution in your context

- Workforce capacity can be enhanced through local training collaborations and career development opportunities
- Identified risks can be reduced through structured implementation plans, provider engagement, and robust information governance
- External funding options should be explored to cover upfront costs, leveraging the long-term cost-effectiveness of the model

## Adapting and localising

Based on the feasibility analysis, necessary adaptations were being made to ensure successful implementation, though some were not fully addressing all contextual challenges.

Key Adaptations: Care coordination pathways were being modified to integrate with local primary care, mental health services, and educational support systems, though gaps in inter-agency collaboration persisted. Telehealth options were being implemented to increase accessibility, but issues with digital literacy and internet access were emerging. Culturally appropriate training programs for professionals involved in case management were being developed, though retention and engagement levels varied. Peer-support networks for families and caregivers were being introduced, but participation levels fluctuated. The digital case management platform was being adapted to comply with local data protection laws and interoperability standards, though full integration across agencies was taking time. Multilingual and easy-to-read documentation was being implemented to support diverse populations, though ensuring clarity and accuracy remained a challenge.

## Testing and evaluating

The adapted model was undergoing a structured testing and evaluation phase, though external factors were continuously influencing outcomes. A six-month pilot was being conducted in selected locations to test feasibility and identify operational challenges, but delays and unforeseen obstacles kept arising. Rapid testing sprints were being used to refine processes and service delivery, though making real-time adjustments in complex systems was proving difficult. Service user satisfaction (feedback from children, families, and professionals) was being measured, though response rates were inconsistent. Reduction in fragmented care and wait times was being tracked, but results varied across different service settings. Improvement in developmental and behavioural outcomes was being observed, though attributing progress solely to the intervention remained challenging.

Iterative adaptation: Adjustments were being made based on pilot results and stakeholder feedback, though some necessary changes were proving unfeasible within existing constraints. Areas requiring further modifications were being identified before broader rollout, but continuous adaptation appeared necessary beyond the initial implementation.

## Refining the theory of change

The theory of change was being refined throughout the process based on emerging insights, though some assumptions required ongoing re-evaluation. The original model was intended to enhance coordination and accessibility of care for neurodivergent children through case management, though local variations required fundamental adjustments.

## Example 2. Community-Based Obesity Prevention and Lifestyle Promotion Initiative (COPLPI)

### Performing a feasibility analysis

Feasibility analysis of the Community-Based Obesity Prevention and Lifestyle Promotion Initiative (COPLPI) was performed by using the THCS Feasibility Analysis Tool within an urban setting in a middle-income country.

#### 1. Assess the quality of the care and/or medical/clinical soundness related to the solution

Is the solution medically/clinically sound?

☒ Yes ☐ No/Partly ☐ Not applicable

Does the solution align with the necessary quality of care in your organisation?

☒ Yes ☐ No/Partly ☐ Not applicable

Do the expected outcomes of the solution match the prioritised goals of the organisation?

☒ Yes ☐ No/Partly ☐ Not applicable

Can the solution be effectively managed within the clinical setting?

☐ Yes ☒ No/Partly ☐ Not applicable

Are the core features and content of the solution and the needed context well defined?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Tailoring to diverse urban populations requires training for healthcare providers and additional integration efforts to align with complex care systems.

#### 2. Assess whether the solution is applicable to the organisation's work processes and compatible with the available technology

Can the solution be practically implemented within your organisation's workflows and/or processes?

☐ Yes ☒ No/Partly ☐ Not applicable

Is the required technology (devices, tools, and software) available/obtainable?

☒ Yes ☐ No/Partly ☐ Not applicable

Are other material resources needed available/obtainable?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Workflows must be adapted to urban complexity. Disparities in digital access require inclusive planning and support tools for low-income users.

#### 3. Assess the availability of competent and qualified workforce

Is competent and qualified staff available?

☒ Yes ☐ No/Partly ☐ Not applicable

If the staff needs specific training to deliver the solution, can it be organised?

☒ Yes ☐ No/Partly ☐ Not applicable

If ongoing support and supervision is needed, can it be provided?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Not applicable

#### 4. Assess the usability of the solution from professionals and/or patients' perspective

Is the solution easy to use from the patients' perspective?

☐ Yes ☒ No/Partly ☐ Not applicable

Is the solution easy to use from the professionals' perspective?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution useful from the patients' perspective?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution useful from the professionals' perspective?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Digital engagement may exclude some populations. Strategies like mobile-friendly design and multilingual content will support accessibility.

#### 5. Assess the risks related to the solution

Is the solution risk-free (including financial, operational, clinical, and legal risks)?

☐ Yes ☒ No/Partly ☐ Not applicable

Does the solution take account of environmental impacts and is it eco-friendly?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution non-discriminatory and enhances equality?

☒ Yes ☐ No/Partly ☐ Not applicable

Can the solution be piloted?

☒ Yes ☐ No/Partly ☐ Not applicable

Is the solution reversible and/or can it be de-implemented?

☒ Yes ☐ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Risk mitigation in urban settings should focus on data security and operational efficiency. Transparent communication will address stakeholder concerns.

#### 6. Assess the required funding

Is the cost-benefit ratio of the solution reasonable?

☐ Yes ☒ No/Partly ☐ Not applicable

Is sufficient funding available or are there potential sources of funding?

☐ Yes ☒ No/Partly ☐ Not applicable

If No/Partly, can adaptations be made by keeping the original core elements and/or can other barriers be resolved? How?

Urban implementation demands higher investment. Diverse funding sources including municipal support and private partnerships should be explored.

7. Based on the above analysis, assess and describe below the long-term sustainability of the solution beyond the initial implementation phase

Long-term sustainability depends on embedding the initiative into institutions like schools and workplaces, utilizing digital tools, and building partnerships. Ongoing adaptability and engagement with transient populations will be key to maintaining momentum and impact.

Conclusions: List here whether/how the “No/Partly” responses can be addressed to implement the solution in your context

- Strengthen digital inclusivity through targeted tools for underserved population
- Secure diverse funding streams to accommodate higher urban operational costs
- Streamline workflows and improve communication across complex urban systems
- Emphasize piloting, data security, and provider engagement to mitigate risks

## Adapting and localising the solution

After performing a feasibility analysis, it was clear that COPLPI requires adaptations to suit our urban context. The minimally viable solution designed incorporates the core elements of the original initiative while addressing the unique characteristics of an urban environment.

Core elements from the original solution:

- Stakeholder collaboration across sectors (healthcare providers, educators, policymakers, and community leaders).
- Multi-sectoral approach to address obesity prevention at individual, community, and systemic levels.
- Phased process including stakeholder engagement, awareness-building, intervention implementation, monitoring, and sustainability planning.

Contextual elements for our urban setting:

- Digital Engagement Tools: Replace rural face-to-face methods with digital platforms for community engagement (e.g., social media campaigns, virtual workshops, and mobile apps).
- Tailored Outreach for Diversity: Customise program content to address cultural dietary practices and socioeconomic variations in urban populations.
- Scalable Interventions: Design interventions (e.g., subsidized gym memberships, urban walking programs, and school meal plans) that accommodate high population density and heavy demands on healthcare systems.
- Collaboration with City Planners: Partner with urban planning authorities to integrate green spaces and pedestrian zones into the initiative.
- Data Privacy Measures: Implement robust data protection strategies to address privacy concerns in digital tools used for program participation and tracking.

Design of the minimally viable solution:

Phase 1: Stakeholder Engagement and Goal Alignment In our urban context, stakeholders include local NGOs, corporate partners, schools, and municipal governments. A digital town hall meeting will initiate

dialogue and align stakeholders' goals.

Phase 2: Awareness and Capacity Building Community education will occur through both virtual workshops and strategically placed public awareness campaigns (e.g., posters in public transport). Healthcare professionals in urban clinics will receive training on culturally relevant obesity prevention practices.

Phase 3: Implementation of Interventions Key interventions include:

- Subsidized gym memberships in collaboration with local fitness chains.
- Public walking programs promoted via urban parks.
- Healthy meal planning initiatives in schools, involving local catering businesses. Policy advocacy will focus on lobbying for subsidies on fresh produce in urban grocery stores and integrating physical activity zones in city planning.

Phase 4: Monitoring and Feedback Loops Data collected through fitness tracking tools and participant feedback will inform iterative refinements to interventions. An advisory board of community representatives and urban health experts will oversee the monitoring process.

Phase 5: Sustainability Planning Partnerships with corporate sponsors and schools will secure long-term funding and program continuity. Documented success stories will showcase the program's adaptability and encourage scaling to other urban areas.

## Testing and Evaluating

The minimally viable solution was tested through rapid implementation sprints in pilot neighbourhoods. Key outcome metrics include:

- Participation rates in interventions.
- Changes in nutritional knowledge and physical activity levels.
- Short-term reductions in BMI and obesity prevalence within the pilot areas.

Each sprint included stakeholder feedback sessions to identify areas for improvement. Adjustments were made iteratively until stakeholders agreed that the solution is optimally adapted for the urban setting.

## Refining the theory of change

The original theory of change posits that sustainable reductions in obesity require a multi-sectoral approach addressing individual, community, and systemic levels. For our urban context, the refined theory of change emphasizes:

- The role of digital tools in engaging diverse urban populations.
- Urban infrastructure as a facilitator for healthier lifestyles.
- The importance of collaboration between public, private, and civil society actors in a dense and complex setting.

The iterative refinement process ensures that the adapted solution continues to achieve its intended outcomes while aligning with the dynamic needs of our urban community.