

**Adoption/Implementation of *ACT* Tools**  
**Case Example: *HealthPartners*, MN**

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**Abstract**

The *ACT on Alzheimer's*® initiative in Minnesota, which began in 2011, has produced a set of health care provider practice tools and resources to support clinicians and organizations as they work to increase the rate of early detection of Alzheimer's disease and related disorders, and improve follow-up after diagnosis. This case example describes the work of one organization leading that effort—HealthPartners—and, specifically, the efforts of clinical experts and champions who have played a leadership role in developing and implementing these tools. An interview with one leader, Dr. Terry Barclay, in late summer 2015 provides insights into adoption and implementation successes and challenges.

Dr. Barclay is Clinical Director, HealthPartners Neuropsychology/Neurosciences Division, Center for Memory and Aging, and is Adjunct Associate Professor in the Department of Neurology at the University of Minnesota. We thank him for his generosity in sharing his time, insights, and work.

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### **Background**



ACT on Alzheimer's - *ACT on Alzheimer's* (formerly “Prepare MN for Alzheimer's 2020”) is a voluntary, state-wide collaboration launched in June 2011 “seeking to transform the State’s medical and long term care systems and communities to better support individuals with Alzheimer’s disease and their families.” It is described as a *collaboration of medical, academic, community, government, business and nonprofit stakeholders across Minnesota. . . . organized under a unique collaborative structure that is intended to foster collective ownership and accountability for furthering the ACT on Alzheimer's vision. No single organization owns, funds, or controls the initiative. Instead, the vision and goals are furthered through collective contributions of over 400 participants, including over 60 nonprofit, governmental and private sector organizations* (See: [www.actonalz.org](http://www.actonalz.org)).

Goals - ACT on Alzheimer’s set forth five goals in 2011 to address over five years. In 2014 it added the commitment to *fostering a health equity perspective* as the work continued:

- Identify and invest in promising approaches that reduce costs and improve care.
- Increase detection of Alzheimer’s disease and improve ongoing care and support.
- Sustain caregivers by offering them information, resources and in-person support.
- Equip communities to be “dementia capable” to support residents who are touched by Alzheimer’s disease.
- Raise awareness and reduce stigma by engaging communities.

(See: <http://www.actonalz.org/about-the-collaborative>; Accessed September 1, 2015)

### *ACT on Alzheimer's* (®) Provider Practice Tools & Dementia Curriculum

Through the voluntary work of more than 40 individuals involved in the *ACT on Alzheimer's* “Detection and Quality Health Care Leadership Group,” a set of best practice tools and resources, as well as curriculum for educators, were developed and revised in an iterative fashion, utilizing the expertise of clinicians, researchers, and other dementia experts. Tools and resources were developed between September 2011 and June, 2015. The tools and resources are focused on clinicians, care coordinators and others in health or social services organizations as they work to increase the rate of early detection of Alzheimer’s disease and related disorders, and improve follow-up after diagnosis (see: <http://www.actonalz.org/provider-practice-tools> , <http://collectiveactionlab.com/content/meeting-agendas-and-summaries-o> ,

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<http://www.actonalz.org/sites/default/files/documents/ACT-PracticeToolsResources.pdf> ,  
<http://www.actonalz.org/dementia-education>

all Accessed August 1-30, 2015).

These tools include:

- After a Diagnosis (*Rev. 12/01/14*)
- Clinical Provider Practice Tool (*Rev. 02/18/15*) and training videos and webinars
- Care Coordination Practice Tool (*Rev. 02/18/15*) and training videos
- Community Based Service Provider Practice Tool (*Rev. 02/18/15*)
- Dementia Curriculum
- Dementia Trainings for Direct Staff (*Rev. 06/08/15*)
- Electronic Medical Record (EMR) Decision Support Tool, including the EMR Decision Support Tools Template (*Rev. 02/16/15*) and a Guide to Implementation *01/2014*)
- Managing Dementia Across the Continuum Practice Tool (*Rev. 06/10/14*)

A key message of the initiative and these tools/resources is that early detection and diagnosis of Alzheimer's disease is critical for improving the physical and emotional impact of the disease and reducing the financial impacts. The ACT on Alzheimer's website notes that "unfortunately, medical providers do not routinely assess the cognitive health of their patients, leading to delayed Alzheimer's diagnosis and post diagnostic care. Currently, less than 35 percent of people with Alzheimer's disease and related dementias have the diagnosis documented in their medical record" (see <http://www.actonalz.org/importance-of-early-detection>).

To improve the rate of detection and support providers and their organizations to implement methods consistently and with ease, the ACT on Alzheimer's practice tools and resources are available without charge, downloadable from the ACT website. The videos and webinars are easily accessible. In addition, experts are available to provide in-person training of clinicians and other healthcare professionals, at a small cost (see:

<http://www.actonalz.org/sites/default/files/documents/ACT-DementiaTraining.pdf>).

## Evaluation

A private foundation<sup>1</sup> funded a modest process/formative evaluation of this initiative to document progress toward the ACT on Alzheimer's goals and objectives.

Theoretical Framework - The theoretical framework for the evaluation drew from literature on community coalition-building and implementation/dissemination of innovations. The assumption was that the *ACT on Alzheimer's* initiative would be implemented within a larger context/environment, which would influence the communities', organizations', and providers' level and rate of adoption and progress around the 5 stated goals—and that community and organizational readiness, delivery system capacity, technical support/training, and the “fit” of the work/tools with the community/organization would impact adoption and implementation (Figure 1).

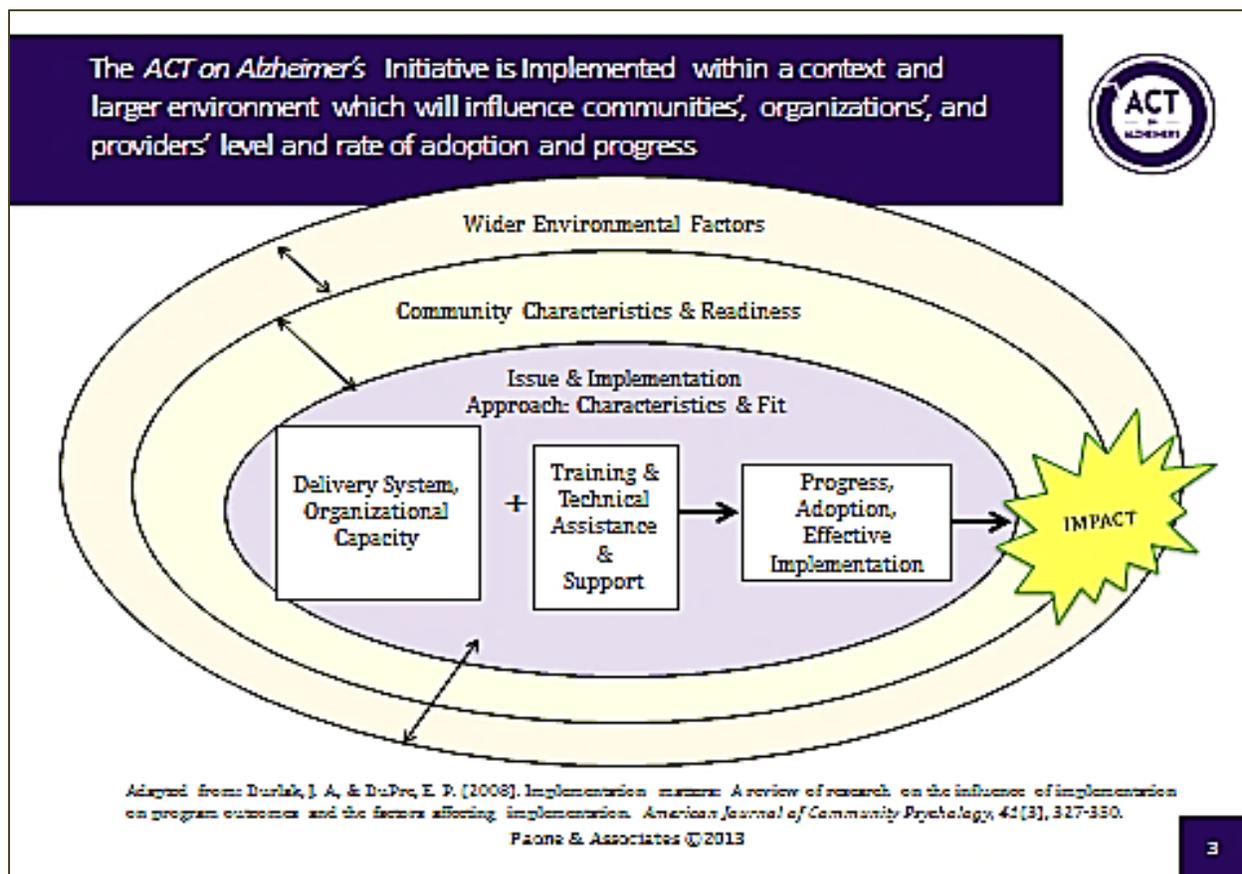


Figure 1. Evaluation Framework for the ACT on Alzheimer's Initiative - Paone, D, 2013; adapted from Durlak & DuPre, 2008

<sup>1</sup> GHR Foundation

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Logic Model for Adoption of Tools/Curriculum – The adoption and implementation of the ACT health care practice tools and resources is considered an important indicator of progress toward the goal of improved detection and quality health care.

We created a logic model in 2013, as part of the formative evaluation for ACT on Alzheimer's. A logic model helps portray initial assumptions and expectations in terms of inputs, outputs, and influences that pertain to the work. This particular logic model focused on the ACT health care provider practice tools and dementia curriculum adoption/implementation. It depicts expected contextual factors, inputs, implementation activities, and short/long-term outputs or outcomes for adoption and implementation of these ACT practice tools and the dementia curriculum (Figure 2).

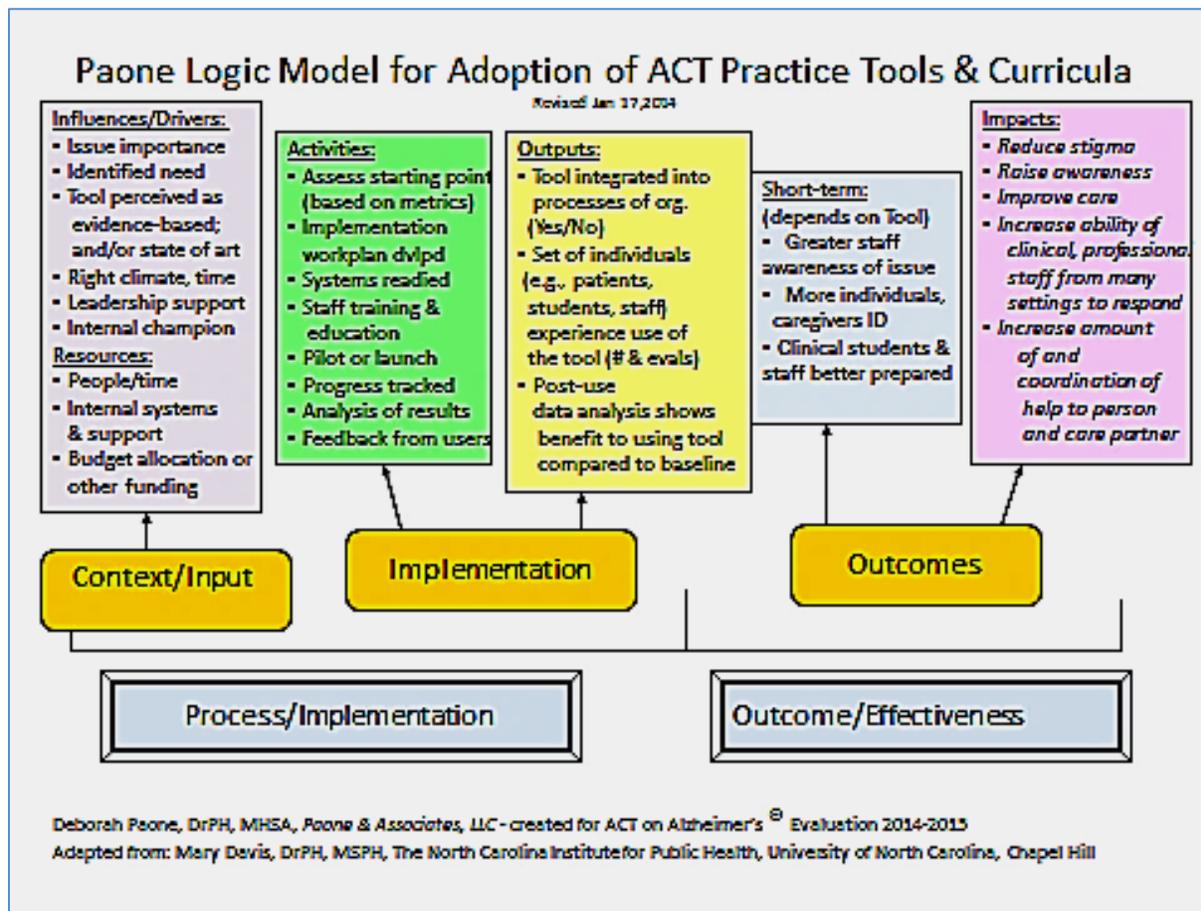


Figure 2. Logic Model for Adoption of ACT Practice Tools and Curricula – Revised January, 2014

As shown in Figure 2, pertaining to *context and the environment* in which the practice tool would be implemented, we hypothesized the following key factors:

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- Issue importance (the issue of detection and care for persons with dementia—perceived importance within the organization or setting)
- Identified need for the tool, new practice, training
- Evidence-based foundation for the tool and/or state-of-the-art nature of the tool
- Right climate and timing for adoption/implementation
- Organizational and clinical leadership support
- Internal champion(s) to drive adoption and promote the value

Regarding the *activities* around implementation, we assumed that there would be a specific work plan and “launch” process developed for promoting effective adoption within the organization or community, teaching others how to use the tool(s), tracking progress, getting feedback, analyzing the pilot test or initial work, and re-adjusting the approach or plan to incorporate learning from the field.

Forecasting the early *outputs* of the implementation, we identified a few possible markers, such as:

- The tool/curriculum/resource is successfully integrated into the processes of the organization (e.g., is written into the electronic record, added to the protocol, part of the required training, incorporated into the educational modules, etc.);
- A set of individuals, such as physicians, students, health care staff, community members, etc. experience use of the tool, curriculum, community action effort to address dementia, and that early response is positive;
- Post-use data analysis shows a benefit to using the tool or resource, as compared to the baseline data collected before use or implementation.

Looking further out, the logic model identified short-term outcomes, such as: greater staff awareness of the issue of dementia and need for detection and follow-up; increase in the number of individuals being diagnosed; evidence that students are better prepared (e.g., through testing). Finally, the long-term impacts that are the key goals of ACT on Alzheimer's included: reducing stigma of the disease, raising awareness, improving care, increasing the ability of clinical and professional staff to respond to needs of patients, and the increase in the coordination of help to the individual with dementia and his/her care partner.

### Implementation Factors - Literature

The logic model was based on research and practice literature from health care and other fields, where adoption or implementation of a proven innovation or practice improvement has been studied. There is a growing body of research on the art and science of implementation and dissemination—and much of it points to challenges, including the amount of time and effort

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required to successfully implement and embed innovations—even when their value is clearly demonstrated.

Many studies have identified both internal and external factors that support adoption and implementation. External factors (for example, reimbursement and payment parameters, federal or state policies, community characteristics) influence the scope of what organizations can do (Durlak & DuPre, 2008; Klein & Knight, 2005; Meyers, Durlak, & Wandersman, 2012; Miller & Shinn, 2005). At the same time, internal factors (for example organizational culture, staff capability, administrative supports) heavily influence successful implementation of programs (Fixsen, Blasé, Naoom, and Wallace, 2009; Fixsen et al, 2005; Brownson, Colditz & Proctor, 2012; Goodman, 2000; Aarons et al, 2012). In studies of implementation success of evidence-based programs, factors such as program-to-organization fit, mission alignment, presence of a strong organizational champion or leader, strong technical support, and continuity of stable funding, have been shown to be important (Paone, 2015; Kaczorowski et al., 2011; Ory et al., 2010; Aarons et al., 2009; Greenhalgh et al., 2004).

Other studies specifically focusing on physician practice change in primary care offer additional insight into what influences adoption and implementation of practice improvements. For example, a recent study of the implementation of a systematized “Screening, Brief Intervention, Referral to Treatment” (SBIRT) process in six primary care clinics found that key facilitators of implementation were *buy-in from physician* and *clinic leadership*, and *seamless integration* of the process in the *electronic medical record* (Muench, et al., 2015).

Utilizing electronic decision support systems has been shown to be *an effective approach within the primary care setting to foster integrated dementia care*. A study in Germany of a computerized Intervention-Management-System (IMS) to facilitate dementia care management showed additional identification of unmet needs of the person with dementia (PWD) and family caregiver, as well as an increase in specific recommendations for patient management by the general practitioner. The users in this pilot evaluated the system as “very helpful” and wanted to utilize a revised version of the IMS in their practices in the future (Eichler, et al, 2014).

There is also evidence underscoring the difficulty in transforming the approach from diagnosis to end-of-life care in health care and social support systems, as in the United Kingdom. For example, a mixed methods study in the U.K. examined the results of a large-scale effort to educate health care professionals and enhance interdisciplinary collaboration in dementia care from diagnosis to end-of-life. The study found that the intervention/efforts did not greatly alter

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general practice care management, even when incentives, policy pressure, and consumer demand favored the changes (Iliffe et al., 2015).

### Surveys and Interviews of ACT Participants & Leaders on Adoption of Tools

Between February and May, 2014, a survey of 92 individuals who were actively involved in the work of *ACT on Alzheimer's* was conducted as part of the ACT evaluation. These individuals reported on how they were utilizing the tools and resources generated by ACT. The most frequently used resources at that time were: the *Dementia Capable Communities Toolkit*, the "After a Diagnosis" brochure, and the *Care Coordination Tool* (Paone, *Survey of Participants as Early Adopters*, 2014).

Telephone interviews of the ACT Leadership Group chairs were conducted later that year (October-December) as part of the evaluation. Each chair or co-chair member had been involved in the work for 3 or more years. Responses from these leaders about the ACT tools and resources indicated strong support for the development and pilot testing of these tools. It was considered a very important output of the effort. These leaders noted that during the next phase of the ACT on Alzheimer's initiative efforts would need to focus on adoption of these tools—learning effective methods for adopting, implementing, and sustaining dementia practice tools in health care settings, as well as sustaining the work of the ACTION communities (Paone, *Leadership Groups Chairs' Perspectives*, 2015).

With that as background, the next section of this report provides one case example of a health care organization—HealthPartners—that has piloted and implemented the ACT on Alzheimer's practice tools, including the EMR Decision Support Tool, within the organization. This case example highlights the efforts of clinical experts and champions who have played a leadership role in developing and implementing these tools. An interview with one leader, Dr. Terry Barclay, in late summer 2015 provides insights into adoption and implementation successes and challenges. Dr. Barclay is Clinical Director, HealthPartners Neuropsychology/Neurosciences Division, Center for Memory and Aging, and is Adjunct Associate Professor in the Department of Neurology at the University of Minnesota.



## **HealthPartners – Company Overview**

HealthPartners is a Minnesota-based not-for-profit health plan with a mission to *improve the health of members, patients, and the community* ([www.healthpartners.com](http://www.healthpartners.com); Accessed August 2015). The company describes itself as the largest consumer-governed nonprofit health care organization in the nation. It is an integrated health care system that provides health care services and health insurance. HealthPartners serves more than 1.5 million medical and dental health plan members. It includes a multispecialty group practice of more than 1,700 employed physicians and a regional network of more than 148,000 doctors and other care providers in Minnesota, western Wisconsin, South and North Dakota. The network of organizations within the HealthPartners family includes: 50+ primary care clinics, 7 hospitals, 22 urgent care centers, 26 pharmacies, an orthopaedic center, transitional care center, and other clinics and centers in specialty areas, such as neck & back, eating disorders, memory and aging, and others. The organization also has an Institute for Education and Research (See: [www.healthpartners.com/public/about](http://www.healthpartners.com/public/about) ).

## ***HealthPartners Center for Memory & Aging***

The HealthPartners Center for Memory & Aging provides diagnostic services, treatment, counseling, and supportive care to individuals with memory and cognitive disorders. The most common dementia that the Center sees is Alzheimer's disease, although practitioners specialize in atypical and less common forms of dementia as well (e.g., Lewy Body dementia, frontotemporal dementia, etc.). The Center uses an approach that combines care providers and research professionals to allow patients the opportunity to participate in breakthrough clinical trials (<https://www.healthpartners.com/public/care/providers/cdac/>). The team includes specialists from neurology, neuropsychology, geriatric psychiatry, pharmacy, nursing, and several other specialty areas. The Center describes their process for a first and second visit so that the patient, and a family member or friend who accompanies the patient, is prepared (<https://www.healthpartners.com/public/care/providers/cdac/visit>).

### **Implementation Efforts (June 2012-January 2014)**

In January, 2014, a brief description of the implementation efforts within HealthPartners to encourage use of the ACT Electronic Medical Record (EMR) Decision Support Tool noted the following characteristics and methods that contributed to success to date:

- Implementation of the EMR tools was driven by a “bottom-up” approach, starting with a *small group of champions* from neurology with expertise in dementia;
- A pilot within the neurology department allowed for *early feedback from physicians and leaders* to tailor the tool to the HealthPartners system;
- The EMR tool then was *vetted with physician leadership* within primary care and others within the larger healthcare organization to identify additional clinics that could pilot the tool;
- *Internal buy-in required personal conversation* and contact by the clinical champions
- A key component was having a *research approach with outcome measures* built into the implementation plan;
- *Utilization data* from the organization was used to show that patients with unrecognized cognitive impairment were much higher utilizers of costly emergency room and inpatient services.

The process of internal buy-in to launch additional clinic adoption took about 18 months.

Regarding challenges at this stage (January, 2014), the following were noted:

- Difficulty identifying who could help drive implementation (provider champions' time is allocated to clinical and research efforts, not transformation of care delivery across the system);
- Incomplete buy-in from leadership regarding the proposed benefits of cognitive screening and related EMR guidelines for dementia care;
- Competing priorities in the organization – there were previously identified quality care initiatives for other conditions in primary care and elsewhere that had already been vetted and approved;
- Diffusion of responsibility related to carrying out intended goals.

**Update - Implementation Efforts (January 2014 – June 2015)**

The Evaluator conducted an in-person interview with Dr. Terry Barclay (Clinical Director, HealthPartners Neuropsychology, Neurosciences Division, Center for Memory and Aging, and Adjunct Associate Professor in the Department of Neurology at the University of Minnesota) in August, 2015. The interview questions were provided prior (see Appendix). Dr. Barclay briefly demonstrated the decision support tool within the electronic medical record after the interview was completed.

**Q:** ***Briefly describe the implementation activities since January 2014--so about the last 18 months--within HealthPartners.***

**A:** *As you know, HealthPartners is a large organization with many components.*

*Within our organization's culture, we strongly value evidence-based efforts and want to test the results/effect of a proposed process or practice change before widespread adoption. Given that, we knew we would conduct a pilot of the dementia practice tools and specifically the Electronic Medical Record Decision Support Tool first—building this from the ground up.*

*Our pilot first involved inviting clinics and physician champions to be involved. The neurology clinic, several primary care clinics, an internal medicine practice, as well as select ophthalmology and pharmacy practices expressed interest in participating. The pilot began by systematically using the MiniCog, a rapid cognitive screening tool, in all patients 65 and older without a prior diagnosis of cognitive impairment or dementia.,*

*We established outcome measures to evaluate for all patients 18 months after screening to assess whether screening led to more dementia work-ups and whether patients failing the screen were higher utilizers of so-called “bad healthcare visits” (e.g., ER/Urgent care visits, hospitalizations, etc.). We chose 18 months because we wanted to have enough time after screening to see patterns, trends, and other effects that might not show up right away. Even when a physician, nurse practitioner, or other provider completes a dementia screen and finds a patient has a score indicating there is a deficit, it is possible that other medical priorities can happen that can get in the way of follow-up around that dementia/cognition issue. The end of this month marks the 18 month review period, so we are just beginning to evaluate this data.*

*During our pilot program, we also provided onling training for physicians, nurses, and other providers on the screen and the screening process, as well as the spectrum of dementia management.*

*We advertised the availability of these tools internally. We did email blasts, included the information in physician newsletters, and hosted webinars.*

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*We imbedded the Mini-Cog screen into the EMR and wrapped decision support tools, education, and more information into the electronic tools. This made it very easy for clinicians to see the purpose, background, and evidence about the tool and provided “easy button” access to additional resources, if needed.*

*Several clinics, such as those in Stillwater, Como, and Maplewood, began using the Mini-Cog screen. That was done by the rooming nurses. The feedback from the nurses was that it was easy to do/easy to use. Stillwater got on board because it was also an ACT on Alzheimer's community, implementing the Dementia Capability Communities Toolkit and community engagement process. It was actually the community action team members that approached the HealthPartners clinic there. Someone from the community recommended that the HP clinic receive the provider training.*

*Providers began expressing more interest in the tools as they were/are seeing a lot of geriatric patients. They did not previously have tools or resources at their fingertips regarding memory screening and dementia diagnosis. More providers referred their patients to the Center for Memory and Aging for follow-up evaluation and care.*

### **Q: Can you briefly describe the process to me?**

*A: The process that we are using is to have the Mini-Cog screen completed on an annual basis for patients age 65+ who do not already have a diagnosis of cognitive impairment or dementia. If the patient does well on the screen and there are no other related concerns, then there is no flag. If the patient does not pass the screen, the nurse hands the results to the physician/primary care provider and she/he (PCP) decides what the next steps will be. The screening results are documented in the medical record. Sometimes the next step is a referral to our Memory Center/Neurology. We are seeing that this is generating more referrals to us. Ideally, there would be more care management and follow-up resources devoted to the patient and family. The reality is that is going to require additional resources and practice change. Dementia does not (currently) qualify patients for expanded care management. We will be looking at the 18-month data soon to see if there is a case for more routine provision of such services to this patient population.*

### **Q: What practice tools were/were not implemented? How far did this implementation go throughout your HP network of providers/clinics?**

*A: We have worked to implement the entire ACT on Alzheimer's provider practice tool set—which includes workflows for screening, dementia work-up diagnosis and management of the disease from early to late stage, the “After the Diagnosis” tool for patients and families, and the EMR Decision Support Tool. The only tool we have not implemented yet is the Care Coordination tool—as we are waiting for the results of the pilot study to guide that effort.*

**Q: What are the successes so far?**

A: *The incorporation of the decision support tools into the EMR within HP, including the resources there about screening and dementia management. The biggest value is being experienced by the providers who have been involved in the pilot—they are seeing the value in the contribution to their primary care practice and management of their patients. We are seeing an increase in the detection of dementia. The full data analysis will tell us more, of course.*

*Another major success has been getting the attention of the HealthPartners senior leadership. There are so many competing priorities in healthcare and it is very hard to get the attention of the executive leaders in such a large organization. Holding the Health Care Summit (earlier this year) was a turning point. We were able to get some senior leaders to the Summit where we presented information on a retrospective data analysis we did—looking at the previous 18 months of health care utilization of patients/health plan members who were failed the MiniCog screen. The look-back showed us that those who failed the screen had higher health care utilization over the preceding 18 months as compared to those who passed the screen. In addition, these patients/members had higher rates of no-shows (missed appointments), more calls to their physicians, more visits to the Emergency Room and to the hospital. So that really got some attention.*

*Immediately after the Health Care Summit, emails were sent to key staff members by some of the leaders who attended that meeting. This created an opening and an invitation for me to go to one of their Executive Committee meetings to present the case for better dementia care throughout the system. They gave me a full hour to present on dementia and dementia detection, diagnosis, management, and follow-up. After that hour, they agreed to include brain health and dementia as possible priorities in the Annual Plan for 2016. That is a key marker and milestone. This gets dementia on the radar screen. Areas of focus on the Annual Plan will have resources and implementation support with defined priorities and measures for success.*

**Q: What were some of the barriers?**

A: *One of the challenges has been the small cadre of “champions” who have pushed this work forward. The champions within the Center for Memory and Aging include myself (neuropsychologist), a behavioral neurologist, and a senior neuroscience researcher. It is challenging to lead broad changes in the organization because we are all seeing patients, conducting research, and maintaining the clinical aspects of the Center. There are many competing priorities. We don't have a dedicated person who can do some of the leg-work or keep this on the radar screen—do outreach with HP clinics, etc. All of these activities take extra time and effort.*

*As mentioned, an exceptionally challenging aspect of this work is how to get the attention of executive leadership. It is also challenging to deal with the reality of an*

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*overburdened system—that is, how can we bring yet another “opportunity” to primary care clinicians and expect them to respond favorably or with enthusiasm? There is just very little capacity to do anything new. The clinic and related systems are near maximum capacity. Our approach has been to make slow progress from the bottom up. We seek out isolated pockets of providers within clinics or other settings who want to know a better way to address the issues they are seeing within their own patient population. This takes a lot of time and the building of a sustainable model happens slowly.*

**Q: *Implementation science research typically identifies the following as key factors in implementation success. Can you comment on each of these briefly with regard to this implementation experience within HP?***

**FACTOR: Internal Champion(s)** - *Yes, this is a critical element. As mentioned, there are only 3 lead champions in our organization. One person couldn't have done it alone. But in a system this size, three people is still too few. All 3 of us were involved in creating the tools as part of the ACT Leadership Group on Detection and Quality Health Care. So being part of that effort helped move us forward as well.*

**FACTOR: Visible Leadership Support**- *This is another critical factor. But getting leadership attention took over a year and a half. Really, it took other health care systems and organizations showing up to the Summit and endorsing the concept, the tools and the work--to help our own internal leadership realize that there was something here worth paying attention to. The Health Summit helped make that happen. The five HP leaders who attended helped open a lot of doors for us.*

**FACTOR: Perceived Value of the Program/Practice** – *Regarding making the value argument, we present our retrospective study and show them evidence from the field and from our own system. Once individual providers implement the ACT practice tools, they experience them as “high value.” This is something that the clinicians have to want to adopt and see the value in. In our system, clinic administrators are not the only decision-makers. Physician providers play a key role in adoption of practice change as well.*

**FACTOR: Program/Practice -to-organization "Good Fit"**- *We have been able to align this effort with the triple aim of the organization. That's a core value. We make the case that improved detection and management of dementia improves outcomes for patients, enhances patient experience, and may help to better manage healthcare costs. We will be looking to our own data to understand if there is a fiscal argument that this work is not only the right thing to do but can save money as well.*

**FACTOR: Potential financial incentives/funding**- *The fiscal argument may provide an estimate of cost savings. This is how this effort would be funded. We see people with all types of health insurance, but a large percentage do have HealthPartners insurance. So the money-saving potential is large.*

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**FACTOR: Robust Technical support/training resources-** *That's a factor that we really get and have dedicated a great deal of time and effort to developing. We now have training videos, slides, tools that are available through ACT on Alzheimer's, online resources, etc. Internally, we provide free technical support to our providers through the Specialty Center for Memory & Aging. Now that the tools are also embedded in the EMR, the decision support is right there for clinicians to access whenever needed.*

**FACTOR: Culture/Climate** – *We have a strong culture and climate that supports applied research and practice. It's in our DNA. HealthPartners is known as an innovator and is involved in a lot of practice-research efforts. However, given the size of this organization, it is not necessarily very nimble. It is challenging to implement new innovations system-wide. Also, there are a tremendous number of competing priorities. There is only so much that providers and the system can absorb/do. Therefore the capacity of the climate is also challenge.*

*I have observed that those who are coming to the training are providers and clinical/care decision-makers. They are under a lot of pressure on many fronts. Despite those challenges, they are interested in these tools. We are working to support them as they work within their settings to begin to address dementia.*

*Another opportunity at the organizational level is the Patient Advisory Group –we have a group of patients and caregivers who are served by the Center for Memory & Aging. We have patient stories and obtain their feedback and qualitative information about the effect and impact of our practice approach. They value the work, the research component, and what we are trying to do to infuse this more broadly across the organization.*

**Q: *Considering this organization's implementation experience what would you say were the top lessons learned regarding implementation of ACT practice tools?***

**A:** *I have learned that practice change is much slower than I anticipated or expected. Once you figure out the goal standard—that is just the first step. You can't start with expecting you will be able to implement the entire standard at once. You have to start with something small and something that is most aligned with where people are and are going. The initial goals have to be small and very manageable. Then you celebrate that and show how it was able to be accomplished. For example, just raise the number of people being screened using the Mini-Cog. Getting more providers comfortable with the screening tool is a success. Then you can go to the next step.*

*Clinician buy-in is extremely important. You need clinicians to talk/demonstrate the importance of the work to other clinicians. You have to have some capacity for training, follow-up, and support. This requires a lot of ongoing monitoring and attention. It is not just about developing the tools. The technical and consultative support is absolutely needed.*

*It is also important to have the tools all set up and ready-to-use before you start a pilot project. The tools need to be tested, scripted, and streamlined. A “one-click” experience is always preferred. Those things are important if you are implementing something in busy clinic settings. We learned through trial and error. It is better to test everything first on a small scale--and then roll out slowly after testing has occurred.*

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*Finally, getting the executive level leaders on board as soon as possible is another valuable lesson.*

### **Q: What are baseline "readiness" characteristics or criteria?**

*A: When I go into a clinic and interact with the providers and nurses there, I help them see first off that they are serving a large geriatric population already. When you talk with them, you hear many times that 40-50% or more of their patients are over 65. That is the first point—recognizing that they are already dealing with patients with dementia.*

*From there providers need to realize and recognize the high base rates of this disease. Alzheimer's is not a needle in a haystack. There will be a high proportion of patients affected. That is important to them, because otherwise they see this as a lot of effort for low yield.*

*Then, it moves to talking with providers about the benefits of detection—that goes beyond any treatment. That is, addressing the misdirected reasoning that some providers may have: "if there is no treatment, why detect?" We can show them the evidence of better patient and caregiver experiences if diagnosis happens early. We can talk about all the missed opportunities for the patient if the diagnosis does not happen. There is some real harm that can happen regarding patient self-direction, patient/caregiver quality of life, etc. if nobody ever formally recognizes they are experiencing a chronic brain disease.*

*Another readiness factor is the stability in the rest of the provider workflow. If the clinic or providers are going through a lot of staffing changes, workflow redesign, or other process changes, then it is not a good time to intervene with a new concept. They can't take on anything new at that particular point.*

*At the end of the day, a big motivation for providers is doing what is right. If the discussion focuses more on "show me the money, the data, that says there will be cost savings," then the provider may not be as ready to accept changes in their practice. Cost savings is very important, of course, but in terms of achieving behavior change, the motivation also has to be that these new initiatives are better for the patient.*

### **Q: What were some successful strategies?**

*A: Strategies included starting with known dementia champions. You have to have the internal drive and those who are passionate about this issue to move things forward.*

*Then, looking ahead toward facilitating dissemination and practice change, the next successful strategy is to identify those clinic providers who are already recognizing dementia in their practices. This may involve looking at the data and finding those who are already making a lot of referrals to Neurology or the Memory Center; those who have a prescribing pattern that indicates they are treating individuals with memory disorders/dementia; those with higher than expected dementia-related diagnoses in their patient group. We are able to do this kind of analysis using the EMR data and data analytics. Starting with those provider champions is easier, as they already are identifying acting to address dementia in their patients. They are already seeing it.*

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*Another strategy is to reach out and slowly involve providers who respond favorably to dementia training sessions.*

*As I said before, it is very important to have the tools well-developed and to start with simple, do-able goals.*

**Q: *What evidence of effectiveness can you offer as a result of the implementation?***

**A:** *Demonstrating effectiveness is an ongoing process. The data analysis will tell us more. We do, anecdotally, see an increase in referrals to Neurology and the Center for Memory and Aging. Ultimately, we hope to see a reduction in unnecessary healthcare utilization and an increase in referrals for patients and family members to receive community support.*

*We are also currently conducting a randomized control trial looking at the outcomes of two interventions for patients and family members after a dementia diagnosis. One arm is telephonic care consultation. The other arm is in-person visits of an MSW from the Alzheimer's Association over a 4 month period. We want to compare the results related to health care utilization, completion of Advance Directives, and other measures. This is the kind of research that will inform our own work and how to appropriately and effectively follow-up after diagnosis. We know patients and families have a lot of questions and needs after diagnosis and those needs must be addressed.*

**Q: *What advice would you give to others seeking to implement these practice tools?***

**A:** *I would advise other health care organizations to talk to colleagues who have successfully done similar work in their systems. Learn about successful models/approaches regarding changes in clinical practice within a managed care environment, especially around EMR decision support tools and caregiver support. Start small, identify internal dementia champions to drive the work, and garner executive leadership support as early as possible.*

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### **Discussion**

Based on the insights of an internal champion, key factors that promoted adoption and implementation and the success measures to date within HealthPartners are:

- Tools embedded in the EMR - The implementation of nearly the entire set of *ACT on Alzheimer's* provider practice tools within HealthPartners EMR; incorporating these tools within HealthPartner's electronic medical record as a set of clinical decision support tools available system-wide promoted visibility and use.
- Data analysis- The results from a retrospective review of HealthPartner member data for those recently screened and diagnosed with Alzheimer's disease showed significantly higher utilization of the ER and other medical care services resulting in higher total costs of care compared to HP members matched based on specific criteria but who did not have the disease. This aligned with the "data/research culture" of the organization.
- Prospective pilot study - Launch of a prospective (real-time) pilot study collecting and analyzing HealthPartner member data to determine cost of care and care outcomes for individuals just diagnosed. Again, this study will lend credibility and provide evidence of the value of making practice changes.
- Clinic engagement by more than 7 primary care clinics within HealthPartners to implement early detection and follow-up methods consistently within their practices. This demonstrates early buy-in.
- Senior Leadership Attention - A key success factor noted was getting the attention of senior leadership within HealthPartners, which was done through presenting the results from the retrospective data review and through engaging senior leaders to attend a 1-day Health Care Summit, organized by *ACT on Alzheimer's* held in February, 2015 (see: <http://www.actonalz.org/sites/default/files/documents/ACT%20Health%20Leadership%20Summit.pdf> ).

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**Appendix**

**Key Informant Question Set – In-Person or Telephone Interview Protocol**

- 1) Describe the implementation activities since January 2014--so about the last 18 months--within your organization (briefly/summary version).
- 2) What practice tools were/were not implemented? How far did this implementation go throughout your network of providers/clinics?
- 3) What were the successes?
- 4) What were the barriers?
- 5) Implementation science research typically identifies the following as key factors in implementation success. Can you comment on each of these briefly with regard to this implementation experience within the organization?
  - a. Internal Champion(s)
  - b. Visible Leadership Support
  - c. Perceived Value of the Program/Practice
  - d. Program/Practice -to-organization "Good Fit"
  - e. Potential financial incentives/funding
  - f. Robust Technical support/training resources
  - g. Culture/Climate
- 6) Considering this organization's implementation experience what would you say where the top lessons learned regarding implementation of ACT practice tools?
- 7) What are baseline "readiness" characteristics or criteria?
- 8) What were successful strategies?
- 9) What evidence of effectiveness can you offer as a result of the implementation?
- 10) What advice would you give to others seeking to implement these practice tools?

**About the Author**

Deborah Paone, DrPH, MHSA, is principal and owner of *Paone & Associates, LLC*, a company she founded in 2002. Dr. Paone conducted a study of implementation factors associated with effective implementation among organizations that sustained an evidence-based program from 4 to 10 years; she was the principal consultant for a five-year implementation study for the State of Minnesota; and she has served as Executive Director of a community-based aging and caregiver services organization where she guided implementation of several evidence-based programs.

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