

# Can-SOLVE CKD KU/KT Committee

## IMPLEMENTATION TOOLKIT



### Introduction to the Toolkit:

The KT “Implementation Toolkit” developed in 2021 (as part of Can-SOLVE CKD Phase 1) is a companion document to supplement Can-SOLVE CKD KT Project Plans. The Toolkit is a how-to manual; it is a flexible document intended to guide project teams as they plan to do any of the following: scale, spread, or implement their evidence. Use this toolkit to start thinking about what are the key considerations and components to planning for evidence dissemination and implementation.

### Why this Toolkit is important:

As part of project KT Plans (2016-2017), we gathered high-level feedback around your plans for dissemination and implementation. Specifically, we were interested in knowing which stakeholders and end-users (target audiences) will use the evidence to make real-world health and healthcare decisions that would be relevant and meaningful to them.

As a Network, we want to ensure that research teams are also able to increase the quality and timeliness of evidence to healthcare decision makers. Effective dissemination and implementation are critical to achieving this goal. The Implementation Toolkit seeks to address these key considerations by providing actionable guiding steps for implementation planning.

Project teams will use this toolkit to lay the foundation for successful sustainability of their project in their own province/ territory/ region, and/or implementation in other jurisdictions. This toolkit will help project teams identify key steps and considerations when planning for sustainability, dissemination, and implementation.

## Terms we use:

**Knowledge user** – An individual: a) who is likely to be able to use the knowledge generated through research in order to make informed decisions about health policies, programs and/or practices; b) whose level of engagement in the research process may vary in intensity and complexity depending on the nature of the research and their information needs; c) who can be, but is not limited to, a practitioner, policy maker, educator, decision maker, health care administrator, community leader, or an individual in a health charity, patient group, private sector organization or a media outlet.

**Spread and scale** – **Spread** is about replicating an intervention somewhere else and **Scale** is about building infrastructure to support full-scale implementation across an organization, locality, or health system.

**Implementing “evidence”** – this can mean implementing a practice, a program, an intervention, and an innovation. Think of the seven P’s – practices, programs, principles, procedures, products, pills, policies.

**Dissemination** - the intentional, bi-directional, active process of identifying target audiences and tailoring communication strategies to increase awareness and understanding of evidence. It is about motivating the use of evidence in policy, practice, and individual choices.

**Implementation** - the deliberate, iterative process of integrating evidence into policy and practice through adapting evidence to different contexts and facilitating behavior change and decision making based on evidence across individuals, communities, and healthcare systems.

\* Dissemination and implementation are overlapping yet distinct. They overlap because knowledge and awareness of the evidence influence its use. However, dissemination spreads knowledge of evidence, and implementation considers evidence in context and develops strategies to change individual’s behaviors to make the use of evidence easier and routine, and the environment in which they are being implemented.

### Important things to note about implementing evidence:

- ❑ Implementation is highly contextualized. What works in one setting or for one target audience might not work in the same way—or at all—under different circumstances or for another audience.
- ❑ Input from end-users is essential to successful adoption, because they can provide insights about their local context and their buy-in can facilitate implementation.
- ❑ Collaborating with different end-users in developing an implementation strategy promotes application in to local contexts and increases the usefulness of the approach. For example, engaging patients and caregivers requires different approaches than engaging clinicians, hospitals, or health systems.
- ❑ Leverage of champions - consider partnering with organizations and people that can communicate with end-users about the evidence. These key influencers (e.g. knowledge brokers, expert opinion leaders, or other trusted sources) can facilitate implementation because they have high reach at a low cost.
- ❑ Implementation of an intervention may have to occur at multiple levels: a broad level to achieve leadership and infrastructure support for change and an individual level among those who must behave differently to carry out the change.
- ❑ In settings where change is lengthy or complex, consider piloting implementation to get started and to generate buy-in.
- ❑ Adoption hinges on whether a change is supported by the existing financial structures and if there is a business case for adoption. Therefore, communication on these issues is critical.
- ❑ Fostering sustainability is a significant challenge, and many stakeholders need additional resources and other supports to do this effectively.

## STEP 1: VALUE PROPOSITION

A value proposition is a statement or statements that Can-SOLVE CKD projects use to summarize why Kidney Health decision makers (Ministry of Health, Senior Leaders, Managers, Nephrologists) should implement their evidence. This statement convinces them that the product, service, or program will add more value or be a better approach to address a problem.

A strong value proposition will clearly communicate the benefit of the product, service, or program; will focus on what patients/families/communities' value and want; is compelling and easy to remember. Ideally, the value statement will include the Quintuple Aim of better outcomes, improved patient experience, bending the cost curve, improved provider experience, and advancing health equity.

The following questions are/may be helpful as you think about and write your value proposition:

1. What is the issue and why it is important?
2. What is the solution?
3. What is/are the benefit(s)?
4. What are the numbers?
  - Think about cost, effectiveness, patient safety etc.
  - Should present evidence to back up the benefits and numbers if possible
5. End with the recommendation.

Using patient quotes/testimonials are remarkably effective in the value proposition and humanizes the issue.

Value propositions can be presented in usual paragraph form or with an infographic or both depending on your audience.

### Example 1 of a Value Proposition (illustrative purposes only):

*Have you ever been so itchy, you wanted to scratch your skin off?*

*Pruritus (itch) is a common complaint of people with chronic kidney disease, particularly those on dialysis. There is a clear association between itch and poorer psychosocial and medical outcomes. Asking dialysis patients about their symptoms is important because not all people feel comfortable bringing these concerns to their kidney care team, consequently they suffer in silence.*

*The EMPATHY project of the Can-SOLVE CKD network has evaluated the impact of routinely measuring and reporting patient-reported experience and outcomes, clinical outcomes, and healthcare utilization in hemodialysis units in Alberta and Ontario.*

*Using computer stations in the dialysis unit waiting room, patients filled out a standard symptom assessment scale and printed their results once monthly. This printout initiated a conversation with the kidney care team about their top clinical concern (for instance pruritus). Care algorithms and patient materials were simultaneously developed. Members of the kidney care team were trained to initiate the care algorithm and to follow-up.*

*Patients reported improved symptom management and quality of life on the standard symptom assessment scale. Quantitative assessment showed a 25% improvement in symptoms. The kidney care team felt they had contributed to more holistic patient care. "A small initial investment for computers and printers has made my life better. My itch is managed, and I feel my kidney care team really listens to me now." (AZ, hemodialysis patient)*

*We are recommending the initiation of a computer-based patient reported outcome measure program in Saskatchewan hemodialysis units.*

#### **1. What is the issue, and why is it important?**

- Issue: asking a patient about their dialysis symptoms
- Why it is important: patient reticence to bring up vexing symptoms to kidney care team; poorer outcomes due to inadequate management of symptoms; patients and caregivers "suffer in silence" and patients become more involved in their care.

#### **2. What is the solution?**

Computer based symptom assessment scale with printout once monthly.

### **3. What is/are the benefit(s)?**

- Patients able to start the conversation with their kidney care team
- Standard care algorithms and patient self-help materials developed
- Improved symptom management and quality of life
- Quantitative assessments show improvement in symptom management
- Patient centered care – individualized care plans, everyone on kidney care team empowered to initiate the care algorithms and educate patients and caregivers.

### **4. What are the numbers?**

Small initial investment but better quality of life (*this could be expanded to show more concrete information or data*)

### **5. What are we recommending?**

The initiation of a computer-based patient reported outcome measure program in Saskatchewan hemodialysis units.

### **Example 2 of a Value Proposition (illustrative purposes only):**

*There are few Indigenous focussed educational materials about treatment options for kidney failure.*

*Canadian Indigenous people have a 2 – 4-fold higher incidence of end stage kidney disease than non-Indigenous Canadians do. Lack of culturally appropriate education resources is one of the barriers faced by Indigenous people in order for them to make an informed choice about treatment options. As a result, the most often chosen modality for end-stage kidney disease is in-center hemodialysis.*

*A Can-SOLVE CKD project – Improving Indigenous Patient Knowledge about the Treatment Options for Failing Kidneys - has co-created culturally appropriate educational materials with Indigenous people who have kidney disease. These materials are available in video and paper format. There are 7 videos featuring Indigenous people who have kidney disease that cover: How the kidneys work; How to keep your kidneys healthy; Introduction to treatment options for kidney failure; Kidney Transplant; Peritoneal dialysis; Hemodialysis and Conservative kidney management. The paper format covers the content of the videos. Culturally appropriate lesson plans for the Kidney care team are also available.*

*These co-created educational materials have been reviewed by other Indigenous patients, their families, and communities for validity. Health care professionals who care for Indigenous people with kidney*

disease have also reviewed these materials to determine usefulness in their practice. The response has been overwhelmingly positive.

*“It is good to see people who look like me showing how peritoneal dialysis works – I am not so scared now.” (CKD patient nearing dialysis); “I now know what the white doctor was talking about.” (Family member); “These resources will help me teach students in our school.” (Community member); “I often do not have enough time to talk about kidney failure and treatment choices with my patients – these resources will be very useful.” (Family physician).*

*We are sharing these resources with you so that your multidisciplinary kidney care clinic and your Indigenous patients and families have tools to improve their kidney failure treatment decisions.*

**1. What is the issue, and why is it important?**

- Issue: few Indigenous specific educational materials for treatment options for kidney failure.
- Why is it important: Indigenous people unable to make an informed choice. Default modality selection of in-center hemodialysis. Perhaps increased uptake of home-based therapies.

**2. What is the solution?**

- Indigenous specific educational materials about treatment choices
- Lesson plans for the kidney care team specifically targeting Indigenous people.

**3. What is/are the benefit(s)?**

- Indigenous patients, families and communities receive culturally appropriate education about kidney function, kidney health and treatment options.
- Indigenous people and families able to make informed choices.
- Health professionals who care for Indigenous people with kidney disease have culturally appropriate tools to use with defined lesson plans.

**4. What are the numbers?**

There could be potential savings if home-based therapies (cost-efficient therapies) are chosen (*this could be expanded to show more concrete information or data*)

**5. What are we recommending?**

We are sharing these resources with you so that your multidisciplinary kidney care clinic and your Indigenous patients and families have tools to improve their kidney failure treatment decisions.

**Does the Value Proposition apply if a project, or trial, has negative results?** No. However, it is still important to convey these negative results. This reflection can be written to highlight lessons learned and how this may inform future work in the project area. For instance, “if we were to do this research again, we would do the following ...”; “the barriers for this research included ... Mitigation strategies for these barriers could be ...”. This is particularly important for the sustainability of the Can-SOLVE CKD network.



## STEP 1B: PROJECT SUMMARY

This is the background evidence to support the value proposition. Project summaries can be presented in usual paragraph form or with an infographic or both depending on your audience. We recommend the following key elements:

<b>1. Background:</b>	<ul style="list-style-type: none"><li>• Pertinent and brief information related to the project.</li><li>• Include who are the stakeholders and how they were engaged.</li></ul>
<b>2. Current Status:</b>	<ul style="list-style-type: none"><li>• Of the project</li><li>• Could include costs, HR, IT requirements</li></ul>
<b>3. The Evidence</b>	<ul style="list-style-type: none"><li>• To support the project and/or outcomes.</li></ul>
<b>4. What Does This Mean</b>	<ul style="list-style-type: none"><li>• Depends on the audience (ie: For policy and/or decision makers, for directors of kidney health, for program managers, for patients/families, for communities)</li><li>• May be an analysis and consideration of options – what is the impact of the project.</li><li>• What are the risks?</li><li>• What are the benefits? (ie: quadruple aim)</li></ul>
<b>5. Conclusion(s) and/or recommendation(s)</b>	<ul style="list-style-type: none"><li>• Present as bullet points</li></ul>

For Step 1B, information from existing documents such as grant applications, publications, previous ROC face sheet submissions can be repurposed. For Step 1A, some of this information can also be used together with “what does this mean” and “conclusions/ recommendations” from your project summary.

The Can-SOLVE KT/KU committee (KT experts and decision makers) will host a series of workshops for the KT community of practice to collectively review project teams’ value propositions and project summaries. This will give the project teams an opportunity for more in-depth feedback.

For other helpful resources, see end of document.

## STEP 2: ASSESSING THE CONTEXT FOR SUCCESSFUL ADOPTION

A true readiness assessment will need to be done by the project champion(s) in the jurisdiction to which the project team has presented the value proposition and project summary. If the project team can identify the context for successful adoption in one or two pages that would be very helpful to jurisdictional leaders.

Identify:

1. Who are the end-users of this project/policy etc.
2. Key enablers for success
3. Barriers (real and perceived) to adoption
4. Suggested mitigation strategies for barriers
5. Potential risks to patients, healthcare providers, health system
6. What needs to be done and what skills will support this

## STEP 3: DETAILED IMPLEMENTATION CONSIDERATIONS

Once a jurisdiction has decided that they would like to implement a particular program/ policy etc., they will need to have an understanding of the following (which the project team should provide):

1. Budget and/or funding model
2. Human resources needed and training required
3. Technology requirements
4. Equipment needed including cost, training and maintenance
5. Supporting services identified – ie. Laboratory, diagnostic imaging
6. Project specific considerations – ie. Engagement of Indigenous communities
7. Standard operating procedures, policy and procedures if applicable.

## STEP 4: EVALUATION OF IMPLEMENTATION STRATEGIES

Evaluation increases opportunities for scale, spread and replication of successful practices. Evaluation should focus on assessing the effectiveness of implementation activities and impact/outcomes in real world application. Short-term outcome should be evaluated to foster continuous improvement. Early evaluation can lead to mid-course corrections to implementation efforts as well as refined strategies for use in the next initiative.

### Notes on Evaluation in Implementation

- ❑ You should have a plan for ongoing evaluation of implementation activities to ensure that those activities are meeting their intended goals. Evaluation increases opportunities for scale and spread and replication of successful practices elsewhere.
- ❑ Evaluation should focus on assessing the effectiveness of implementation activities while they are still occurring, as well as on short-term outcomes, to foster continuous improvement efforts. In addition, understanding barriers and enablers as implementation progresses is important to optimize project uptake and outcomes. Early evaluation can lead to midcourse corrections to implementation efforts as well as refined strategies for use in the next initiative.
- ❑ One of the biggest barriers to evaluation is lack of time and monetary resources for evaluation.
- ❑ Research teams might be able to play a helpful role in supporting evaluation of implementation activities themselves. For example, researchers can help end-users identify the elements of an intervention that are most effective.
- ❑ Deciding on which method(s) you will use for your evaluation depends on **what you are measuring**, the **purpose of the evaluation**, available **resources**, and other factors unique to an organizations' situation and culture.

- ❑ Process or outcome methods may include interviews, focus groups, questionnaires, observation, surveys and analysis of case notes. Whenever possible, it is best to use standardized measurement tools as this will increase the reliability, validity and generalizability of the data.
- ❑ Planning an evaluation requires clearly identifying both processes and outcomes (see logic model below).
- ❑ Processes are the ways in which an intervention or program is being disseminated or implemented, whereas outcomes include both short- and long-term effects of the intervention or program.
- ❑ To assess the ultimate success or failure of any implementation effort, we must identify whether planned activities were conveyed or deployed correctly. This is why clearly defined metrics are critical.
- ❑ **Short-term outcomes** - can measure relatively soon after implementation. These outcomes can include the number and types of people served and changes in their knowledge, attitudes, and behavior (i.e., uptake and use). Other short-term outcomes might include whether the intervention serves appropriate types and numbers of people (reach) and settings (adoption).
- ❑ The RE-AIM framework ([www.re-aim.org/about/what-is-re-aim](http://www.re-aim.org/about/what-is-re-aim)) can be used to develop plans for implementation and evaluation. Changes in knowledge, attitudes, and behavior can be measured for a variety of audiences, such as patients, providers, or payers, and over a variety of time periods such as quarterly, biannually, or annually.
- ❑ Measuring **long-term outcomes** of an implementation activity is not always direct because changes in these outcomes are influenced by multiple factors. Examples: measuring the effects of an intervention on the health of individuals or the broader target population such as fewer medication errors, improved self-reported health, or reductions in mortality. These long-term outcomes represent what people care about, such as survival, function, symptoms, and health-related quality of life. Patient-reported outcomes are a source of this type of information.

## Logic Model for Evaluating Implementation

### PROCESS METRICS:

Monitoring the use of dissemination and implementation activities/ tools to measure progress toward goals of implementation plans

#### Example activities or tools

- Brochures or other materials describing the evidence, provided to decision makers
- Seminars offered to decision makers to present the evidence
- CME activities
- Emails sent via a listserv

#### Attributes of activities or tools to measure to monitor progress toward goals

- Duration and frequency of use by target audience Acceptability and appropriateness across different target audiences
- Fidelity to core components of an original intervention
- Consistency across implementation settings
- Interactions between activities or tools and the broader setting, including unanticipated influences and changes

### SHORT-TERM OUTCOME:

Measuring early effects of dissemination and implementation activities

- Reach - types and #'s of people the intervention serves (e.g. # of providers who receive training or # of patients who receive information about the evidence)
- Adoption - types and #'s of organizations that initiate an intervention or evidence-based practice (e.g. # of clinics that implement an intervention)
- Outcomes relevant to patients, clinicians, or caregivers
  - Changes in knowledge or attitudes
    - Awareness and acceptability of the evidence,
    - How well individuals understand the info,
    - Degree to which patients incorporate the evidence into decision-making
  - Changes in behavior (screening completion or the # of recommended procedures conducted)
- Other potential short-term outcomes
  - Changes in medical coverage
  - Reorganization of programs and resources in response to new evidence (e.g. altering procedures or hiring new staff)
  - Changes to clinical practice guidelines
- Sustainability. The extent to which activities or use of evidence become routine

### LONG TERM OUTCOMES:

Measuring the desired effects of an intervention or program

Health outcomes (e.g., self-reported health, or mortality)

- Patient-reported outcomes, such as health-related quality of life or functional status
- Health risk appraisal tools that assess perceived and actual risk to morbidity and mortality
- Changes in service utilization, such as hospitalization
- Reductions in health care expenditures
- Reduction in practice variation or disparities

## RESOURCES/TEMPLATES/SUPPLEMENTAL DATA

**Template for writing a Briefing Note** (developed by Health Evidence) – A briefing note informs decision-makers about an issue - succinctly describing it, providing background information and describing key considerations, options to address the issue and recommended actions

[https://www.healthevidence.org/documents/practice-tools/HETools\\_BriefingNote\\_Sept2021.docx](https://www.healthevidence.org/documents/practice-tools/HETools_BriefingNote_Sept2021.docx)

**Quadruple AIM** - [www.privishealth.com/what-is-the-quadruple-aim-and-what-role-does-it-play-in-healthcare](http://www.privishealth.com/what-is-the-quadruple-aim-and-what-role-does-it-play-in-healthcare)

**Quintuple Aim** - <https://jamanetwork.com/journals/jama/article-abstract/2788483>

**The RE-AIM Framework** - <https://re-aim.org/learn/what-is-re-aim/>

**The RE-AIM Planning Tool** - <https://re-aim.org/wp-content/uploads/2021/10/planning-tool.pdf>

**Planning and Evaluation Questions using the RE-AIM Framework** - [https://www.re-aim.org/wp-content/uploads/2018/02/Planning-and-Evaluation-Questions-for-Initiatives-Intended-to-Produce-Public-Health-Impact-\\_Final.pdf](https://www.re-aim.org/wp-content/uploads/2018/02/Planning-and-Evaluation-Questions-for-Initiatives-Intended-to-Produce-Public-Health-Impact-_Final.pdf)

**Alberta Health Services: Knowledge Translation Strategies for Different Target Audiences** - <http://bit.ly/KTforDiffTargetAudiences>

**Alberta Health Services: Quick Reference: Implementing Evidence-Based Practices in Healthcare** - <http://bit.ly/ImplEvidenceHC>

**PCORI Implementation Toolkit** - <https://www.pcori.org/sites/default/files/PCORI-DI-Toolkit-February-2015.pdf>

Examples of **Infographics, Executive Summaries**, etc.: contact Selina Allu ([soallu@ucalgary.ca](mailto:soallu@ucalgary.ca))

Readiness Assessment tools:

**READINESS THINKING TOOL**® (Wandersman Center) –

<https://www.wandersmancenter.org/uploads/1/2/8/5/128593635/12.9.pdf>

**Checklist to Assess Organizational Readiness (CARI) for Evidence-Informed Practice (EIP)**

**Implementation (M Barwick)** – This is an assessment tool (tailored to the Ontario context) is intended to address the level of readiness for implementing evidence informed practices within behavioural health service provider organizations [https://melaniebarwick.com/wp-content/uploads/2019/01/CARI-Checklist\\_for\\_Assessing\\_Readiness\\_for\\_Implementation-BARWICK.pdf](https://melaniebarwick.com/wp-content/uploads/2019/01/CARI-Checklist_for_Assessing_Readiness_for_Implementation-BARWICK.pdf)