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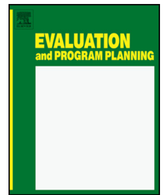

Stimulating program implementation via a Community of Practice: A responsive evaluation of care programs for frail older people in the Netherlands

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ABSTRACT

Evaluation is often used as a vehicle to improve program implementation. To evaluate the implementation of programs that provide care for frail older people a Community of Practice (CoP) was developed in the Netherlands. The purpose of this paper is to describe and reflect on the role of a CoP in the implementation of these programs. Using a responsive evaluation approach this study was based on interviews with participating stakeholders and transcripts of the CoP meetings with 13 professionals, project managers and patient representatives. Findings showed that CoP members had unanticipated concerns regarding the pro-active approach of the programs and older people not being open to receiving care. The heterogenic composition was appreciated and fostered learning. A social infrastructure was created for active learning inside and outside the CoP. We conclude that a CoP is a useful strategy as part of an evaluation aimed at improving program implementation. Lessons learned include the importance of creating ownership among CoP members by sharing responsibilities and paying attention to the heterogenic group composition and professional language spoken to involve all members.
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1. Introduction

Health care is faced with the challenge of meeting the needs of an aging population, which increasingly suffers from multiple related and unrelated health conditions (Bergman et al., 2013) and prefers to live independently for as long as possible (Janssen, Regenmortel, & Abma, 2012). Although there is a growing awareness of the importance of community based care and early detection of disabilities among frail older people, optimal instruments to identify problems have not yet been found, therefore problems can remain undetected (Hamaker et al., 2012).

In response to these developments the Dutch government in 2008 launched the Dutch National Care for the Elderly program to improve care for frail older people in the Netherlands. Within this program, research and implementation projects were funded to develop and implement an integrated approach to detect and prevent disabilities in community-dwelling older people and to provide frail older people with tailor-made care and support (ZonMw, 2008). This policy required professionals to redesign care for an aging population and adopt new care programs.

In general it is recognized that the implementation of programs is complex, especially if it requires collaboration between disciplines and between various stakeholders (Grol & Grimshaw, 2003). The likelihood of people supporting the implementation of new innovations will be enhanced if attention is paid to learning and the creation of an understanding about the change (Lick, 2006). Improvements in practice and knowledge sharing are often limited by professional behavior and organizational boundaries (Kislov, Walshe, & Harvey, 2012). The PARIHS framework (Promoting Action on Research Implementation in Health Services) indicates that successful implementation of programs depends upon the nature and type of evidence, the context and the degree of facilitation. Evidence entails scientific

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research, clinical experience and patient preference. Context related factors impacting implementation include organizational culture, leadership styles, and methods to evaluate and monitor services. Facilitation should be tailored to the readiness of professionals to adopt an intervention and can comprise support or coaching (Kitson, Harvey, & McCormack, 1998; Kitson et al., 2008). Facilitating interactive, small group meetings is found to be an effective method of changing professional behavior (Davis et al., 1999).

A novel strategy in supporting implementation, which includes blending types of knowledge and takes into account the context by involving relevant stakeholders, is a Community of Practice (CoP). Wenger describes CoPs as 'groups of people who share a passion for something that they know how to do, and who interact regularly in order to learn how to do it better' (Wenger, 1999). CoPs are based on the principles of situated learning, which highlights that learning takes place in a social context in relationships between people (Abma, 2007).

Defining elements of CoPs are domain, community and practice (Wenger, McDermott, & Snyder, 2002). The domain refers to the area of knowledge that brings the community together. Within a CoP, this knowledge can be explored and developed. The community reflects the group of people who have an interest in the area of knowledge. It defines who participates in the group. Successful learning in CoPs is established by becoming part of the community. The practice describes the process of accumulating knowledge through interaction (Lave & Wenger, 1991). Even though professionals in health care often organize multidisciplinary meetings to discuss patients or exchange knowledge, a CoP can take the learning process one step further. Members of a CoP can solve problems together, coach each other and develop tools and frameworks. Through interaction they build a shared body of knowledge and community (Wenger, 1999).

CoPs are gaining in popularity in health care, but research that gives insights into the working and role of these CoPs within implementation processes are limited (Li et al., 2009). The need remains to understand the role of CoPs in health care practice and especially in the care of frail older people where many different professionals and organizations are involved in care innovation (Ranmuthugala et al., 2011). This study examines whether and how a CoP as part of a responsive evaluation can support the implementation of complex programs for frail older people. Two research questions addressed in this paper are: (1) How was a CoP set up and which implementation issues were discussed? (2) How have CoP members learned from each other and how has this improved the implementation?

2. Care programs for frail older people

To be prepared for an aging population the Health Council of the Netherlands (2008) emphasized that frail older people in the community should be identified and their physical, psychological and social functioning assessed to prevent a decline in their daily functioning. For this study we focused on three Dutch regions, in which care programs were implemented aimed at early detection and integrated care for community-dwelling frail older people. In these regions practice nurses (PNs), in cooperation with general practitioners (GPs), screened or selected older people. Home-visits were performed to further assess the health status of older people. Depending on the problems detected, professionals and organizations could be called in for further assessment (e.g. geriatrician, occupational therapist). Based on these assessments, the PN developed a care plan with the older person and GP. The PN could provide care or if needed refer to other professionals. The PN remained the case-manager during the whole process and evaluated the care (Daniels et al., 2011; Stijnen, Duimel-Peeters, Jansen, & Vrijhoef, 2013).

Simultaneously, additional interventions were developed. In one region, an intervention was developed in a hospital setting, in which a geriatric team assessed older patients that entered the outpatient clinic with psychogeriatric problems. A geriatric nurse practitioner was appointed as contact person between the GP and geriatric team and discussed the findings of the geriatric team with the GP. In another region, older patients who were admitted to hospital were screened for frailty with the use of a screening instrument integrated into the standard digital nursing assessment. If older people were identified as frail, a comprehensive geriatric assessment was performed and evaluated by the nurse and the geriatrician. Based on this assessment, the geriatrician provided formal clinical advice and recommendations for the hospital ward.

Each of the interventions was complex due to interacting components, the number of stakeholders involved and the difficulty of behaviors and competences required by those delivering and implementing the intervention (Craig et al., 2008). Professionals had to adopt a new, proactive attitude and holistic approach and take on new roles, such as the PNs who became case-managers. Furthermore, some of the interventions were interrelated and targeted the same population, which made the implementation of individual interventions more complicated.

3. Responsive evaluation

This study aimed to evaluate and foster the development of a CoP as part of a wider responsive evaluation. The aim of the overall responsive evaluation was to evaluate the care programs for frail older people from multiple stakeholder perspectives. Responsive evaluation as an approach was first introduced by Stake (1975) who pleaded for the involvement of as many stakeholders' perspectives as possible when evaluating a program or intervention. Guba and Lincoln (1989) developed responsive evaluation into an interactive approach in which stakeholder issues formed the input for a dialog aimed at enhancing the mutual understanding of the value of a practice. In interactive responsive evaluation, stakeholders become active and equal partners with an evaluator creating conditions for dialog (Abma, 2005).

Notions of joint knowledge production and mutual learning underlying responsive evaluation are in line with ideas on CoPs. Both value experiential knowledge in addition to handbook knowledge, both emphasize situated learning-in-action located in a particular context leading to local versus universal knowledge and both stress learning via social interaction. A CoP can contribute to the learning process of community members (Abma, 2007; Greene, 2001) and support the responsive implementation and evaluation of programs (Abma, 2000).

3.1. Participants

The CoP was set up at the start of the implementation of care programs for frail older people in 2009 and continued until 2012. Participants in the CoP in our study were selected based on their involvement in the implementation and execution of programs for older people in the participating regions. The researcher (first author) introduced herself to the project managers in face-to-face meetings and selected participants via snowball sampling (Noy, 2008). Participants should have a passion for the care of older people and be involved in the implementation of the programs, either at a strategic level or at a professional level. The researcher interviewed 12 stakeholders prior to the start of the CoP to find out if stakeholders met the inclusion criteria and were willing to participate in the CoP. Two of 12 respondents could not participate in the CoP, owing to busy schedules, and asked other professionals in their organization to represent them (one respondent asked two

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