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Implementing care programmes for frail older people: A project management perspective

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ABSTRACT

Objective: To examine the issues that influenced the implementation of programmes designed to identify and support frail older people in the community in the Netherlands.
Methods: Qualitative research methods were used to investigate the perspectives of project leaders, project members and members of the steering committee responsible for the implementation of the programmes. Interviews were conducted in 2009 ($n = 10$) and in 2012 ($n = 13$) and a focus group was organised in 2012 ($n = 5$).
Main Findings: The interviews revealed that the implementation was influenced by the extent and quality of collaboration between organisations, adaptation to existing structures, future funding for the programmes and project leadership. A good relationship between participating organisations and professionals is required for successful implementation. A lack of clear project leadership and structural funding hampers the implementation of complex programmes in primary care settings.
Implications for practice: The findings of this study are useful for organisations and professionals who are planning to implement complex programmes. Identifying barriers concerning institutional collaboration, adaptation to existing structures, leadership and continuation of financial support at an early stage of the implementation process can support practitioners in overcoming them.

1. Introduction

With an ageing population, the number of people who suffer from multiple, chronic diseases and social problems increases as well [1]. Multimorbidity is strongly associated with adverse health outcomes and increased health service use. Improving the integration of services and primary care for older people is necessary for improving their quality of care [2]. Although the discipline of geriatric medicine has advanced on many fronts, older people are still more likely

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than any other group to receive inadequate and fragmented care [1,2]. As a response to the ageing population and related challenges, the Dutch government launched the Dutch National Care for the Elderly Programme to improve care for frail older people living in the community which involves the development and implementation of new care programmes [3]. In three regions in the Netherlands, care programmes were developed and implemented in which practice nurses and general practitioners collaborated with other professionals and organisations to detect health problems and provide community-dwelling frail older people with tailor-made care and support [4,5].

Effective implementation is necessary in order to integrate complex programmes into daily health care practice [6]. Poor implementation could lead to a negative appraisal of the programmes. To develop an effective care programme, a good understanding is needed of the enablers that foster and barriers that hinder successful implementation [7]. In other settings, a lack of manpower, poor collaboration and communication [8] staff-turnover, high workload and concurrent projects [9] are identified as barriers in implementing programmes that involve multidisciplinary collaboration. Furthermore, the implementation of multidisciplinary programmes can be hindered by organisational boundaries [10]. For successful implementation, health care professionals should have the knowledge and skills needed to adopt the programme, and organisational conditions have to make this adoption possible [11,12]. The role of project leaders is crucial to the success of the implementation of programmes [13]. Although many of the factors that inhibit or support successful implementation are related to project-leadership and facilitation [14], little information is available on the experiences of managers, project leaders and project members who fulfil important roles in the implementation of care programmes for older people.

This paper focuses on the implementation process of care programmes for community-dwelling frail older people in the Netherlands. This study investigated which issues were relevant in the implementation of care programmes for frail older people at two phases in the implementation process from the perspective of the stakeholders responsible for the implementation. By using qualitative methods we got insight into the experiences of the managers, project leaders and project members responsible for the implementation of the programmes for community-dwelling frail older people.

1.1. Research setting

This study evaluated the implementation of programmes for frail older people in three regions in the Netherlands. Care programmes were implemented that focus on the identification of frail older people in the community and provide them with the appropriate support and care. The main elements of the programmes in the three regions were similar although they used different instruments to assess frailty and different tools to support and care for older people. Furthermore, the programmes were adapted to existing health care structures in the region. The programmes are described below. More detailed information concerning these programmes can be found elsewhere [4,5].

In each region, primary care practices had a central role in the identification of and support for frail older people. In one region, these people were identified using a 15-item postal screening instrument (the Groningen Frailty Indicator) that included items concerning the physical and psychosocial factors of frailty [15]. In the other regions, general practitioner and practice nurses selected people who, according to their opinion, might be frail. Practice nurses performed home visits and assessed the health status of the frail older people. Together with the general practitioner, the practice nurse analysed the situation and negotiated with the older people to agree on an action plan [16]. If necessary, other professionals were involved in the assessment of the older people and the development and execution of the action plan. In one region, a toolbox was developed around five topics (e.g. meaningful activities, social network and social activities) that supported the practice nurses in providing appropriate care [17].

Each region, independently, organised the implementation of the programmes. In each region, a project leader and project team were appointed. Within the total budget of the project, salary for the work of the project leader and other professionals was available. To develop the programme (including protocols and screening instruments), geriatric nurses, practice nurses and general practitioners were involved in the project teams. In addition, a cross-regional steering committee was set up which comprised directors and managers of the organisations involved in the care programmes.

2. Methods

2.1. Design

This study aims to evaluate the implementation of care programmes for frail older people and is part of a wider responsive evaluation. In this type of evaluation, all possible stakeholder perspectives should be included when evaluating a programme [18,19]. In previous work we evaluated the perspectives of frail older people and the practice nurses involved in the care [20]. Furthermore, we developed a Community of Practice in which all perspectives are brought together to create a dialogue and enhance mutual understanding and learning [21].

We used a qualitative design involving in-depth, semi-structured interviews and a focus group to get insight into the views and experiences of project leaders and project members and members of the steering committee to identify barriers and enablers that influenced the implementation process. The study obtained approval from the Medical Ethics Committee of the Maastricht University Medical Centre, and was executed between 2009 and 2012.

2.2. Participants

Participants were selected by the researchers through purposive sampling [22]. We selected participants who had an active role in the development and implementation of the care programmes for frail older people.