



## Facilitating Lewin's change model with collaborative evaluation in promoting evidence based practices of health professionals



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### ABSTRACT

Evidence based practices (EBPs) in clinical settings interact with and adapt to host organizational characteristics. The contextual factors themselves, surrounding health professions' practices, also adapt as practices become sustained. The authors assert the need for better planning models toward these contextual factors, the influence of which undergird a well-documented science to practice gap in literature on EBPs. The mechanism for EBP planners to anticipate contextual effects as programs Unfreeze their host settings, create Movement, and become Refrozen (Lewin, 1951) is present in Lewin's 3-step change model. Planning for contextual change appears equally important as planning for the actual practice outcomes among providers and patients. Two case studies from a Geriatric Education Center network will illustrate the synthesis of Lewin's three steps with collaborative evaluation principles. The use of the model may become an important tool for continuing education evaluators or organizations beginning a journey toward EBP demonstration projects in clinical settings.

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## 1. Introduction

Healthcare providers implement evidence-based practices (EBPs) with patients along a continuum of care in diverse clinical settings (hospitals, long term care). These practices interact with organizational characteristics (Curran, Grimshaw, Hayden, & Campbell, 2011; Luongo, 2007; MacIntosh-Murray, Perrier, & Davis, 2006). Contextual factors (supportive protocols, equipment availability) influence the form and frequency of practices, and can be viewed as facilitators or barriers to both adopting and sustaining those practices (Stange & Glasgow, 2013). Use of EBP repeatedly in one institution can result in institutionalization (Bellg et al., 2004; Thurston & King, 2004; Titler, 2008, chap. 7).

Changes to organizational patterns (workflow, policies) will inevitably occur within the host clinical setting as it adapts to sustained practices.

This article explores the relationship between practices and their systems through the lens of Kurt Lewin's 3-step change model (1951) of *Unfreezing*, *Movement*, and *Refreezing*. Retrofitting this action research model *post hoc* onto observed educational processes and clinical outcomes from two geriatric education projects brings forth the potential for also using the model *a priori* as an implementation guide for programmers, evaluators, and other project stakeholders. Given that the projects' processes and outcomes appear influenced by multiple stakeholder perspectives at the planning, implementation and evaluation phases, the value of incorporating collaborative evaluation principles (O'Sullivan, 2012) with the Lewin framework is also discussed. The Lewin (1951) anchors of altering a traditional clinical path or approach (Unfreezing), refining the emergent provider behaviors (Movement), and reinforcing them through changes in organizational structure (Refreezing) have previously been applied to understanding how health professions' behaviors become accepted and sustained in clinical settings (Holter & Schwartz-Barcott, 1993; Lee, 2006; Walters

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& Eley, 2011). The Lewin model (1951) provides sequential anchors (*Unfreezing*, *Movement*, and *Refreezing*) for discussing inevitable contextual changes with project stakeholders in advance of implementation, beyond the more linear effects typically captured in logic models.

This article illustrates the Lewin model retrofitted to two, 2010–2015 projects of Geriatric Education Centers, or GECs (funded through Department of Health and Human Services, DHHS–Bureau of Health Professions, BHP–Health Resources Services Administration, HRSA) (DHHS–BHP–HRSA/Geriatric Education Centers, 2014) that were able to determine their own planning frameworks for a common EBP (a multifactor falls risk assessment and relevant follow-up procedure, such as a specialized referral and/or patient education, for providers to employ in clinical settings). The EBP projects are new and additional requirements of GECs (primarily located in schools of medicine) who have statutory purposes to develop faculty and professionals to improve the care of older adults. These two exemplars took place in diverse clinical practice settings (*i.e.*, hospital emergency department and falls clinic enrollees) with varying populations, and applying an additional, standardized framework for evaluation *a priori* was deemed premature given the GECs need to strengthen implementation (using formative evaluation to improve educational sessions, monitoring program fidelity, ensuring data access and accuracy in clinical practice sites) during the first years of the project. The authors assert that in hindsight, there is likely value in applying Lewin's model to both evolving and mature EBP demonstrations or other workforce development efforts where newly learned employee behaviors prompt workflow and systems changes.

Despite an increase in the use of EBPs in the last two decades, there are barriers to proven programs translating reliably (in fact and producing similar outcomes) in other clinical settings (AHRQ, 2010; Tuchman & Sarahson, 2011). This incomplete knowledge translation of research findings to practice is one focus of implementation research (Curran et al., 2011) and can occur from weak practice fidelity and a lack of organizational supports, among other reasons (Bell et al., 2004; Grol, Bosch, Hulscher, Eccles, & Wensing, 2007).

We assert that this quality gap (Shojania, McDonald, Wachter, Owens, & Markkowitz, 2004) is exacerbated by the lack of a unified and comprehensive framework for the planning and evaluation of EBP projects. For example, the Theory of Planned Behavior (TPB) (Ajzen, 2002) has been used in clinical projects that seek to improve the uptake of provider behaviors. However, the focus of TPB is limited to the linear progression of attitudinal improvement toward practices, intention to change behavior, and then behavioral changes without the benefit of couching these effects directly in terms of contextual influences and systems changes. The Translating Research Into Practice (TRIP) Model (Titler et al., 2009) focuses on attitudes and intentions situated within social systems and communication processes (need for advocates and senior level buy-in for practice adoption and sustainability). In fact, various models discuss aspects of facilitators and barriers, both at the individual provider and systems levels that are germane to EBP projects (Shojania et al., 2004). For example, the Donabedian model (Donabedian, 1966, 1988) focuses on both structure (organizational context) and process (provider to patient interactions).

There are clear strengths in some of these models, in terms of recognizing that context matters. However, the notion of planners anticipating disruptions to the normal flow of provider actions (potentially halting the new practices) in a system is perhaps most articulated in Lewin's 1951 model. As will be shown, it may behoove planners of EBP projects to think *a priori* of resistance to change that can occur around new procedures. In doing so, they can engage stakeholders early and identify champions in advance to increase the likelihood of EBP uptake and sustainability.

The important role of stakeholders and working collaboratively with them in implementation research has been asserted (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). Knowledge translation has greater viability when institutional stakeholders associated with the targeted practice settings are involved in the evaluation planning (Légaré et al., 2013; O'Sullivan, 2012; Stange & Glasgow, 2013; Tuchman & Sarahson, 2011). The Lewin model (1951) provides sequential anchors (*Unfreezing*, *Movement*, and *Refreezing*) for discussing inevitable contextual (systemic) changes in a somewhat linear fashion (*Unfreezing* is necessary for *Movement*, so forth) with project stakeholders prior to, during, and post implementation.

Hence, this article seeks to fill a conceptual void. There is simply a strong need for early planning of contextual change if EBPs are to be adopted and sustained in clinical settings. Further, we synthesize Lewin's 3-step change approach with collaborative evaluation principles such as stakeholder participation at multiple project phases, evaluator connections with programming staff, and adaptation of practice to organizational context. Our assertion is this combined framework may lend support to the applied practice aspects of implementation science and be of interest to quality improvement (QI) personnel, continuing education evaluators, health services researchers, and other organizational planners embarking on collaborative EBP projects.

## 2. Improving evidence based practice through geriatric education

In healthcare settings, evidence based practice (EBP) has been stated as the “judicious use of current best evidence in conjunction with clinical expertise and patient values to guide healthcare decisions” (Titler, 2008, chap. 7, pp. 1–113). While there is no single definition of EBP in the health professions (Jennings & Loan, 2001; Thurston & King, 2004), it has been summarized that the best evidence comes from a combination of clinical expertise, patient preferences, and outcomes observations (McKibbin, 1998).

Eighteen of 45 Geriatric Education Centers (GECs) (2010–2015) proposed to train multiple disciplines (nurses, social workers) on the use of a falls risk assessment (of their choosing) with referrals (vision, nutrition) or other follow-up (patient education, falls clinic) that served as an intervention phase. GECs have multiple program tracks (continuing education, faculty development) to improve the health professions' workforce (DHHS–BHP–HRSA/Geriatric Education Centers, 2014). Falls risk identification (through assessment) and referral or patient education (intervention) was one area of five, HRSA-approved possibilities from which GECs could choose to train providers (nursing, social work, so forth) on how to implement assessment and intervention-related EBPs. Essentially a workforce development model, the focus in each of the five areas for the 2010–2015 funding is on provider changes (in their clinical settings) rather than patient outcomes. Other areas were delirium, depression, diabetes, and palliative care. In choosing an area, all funded GECs developed educational sessions to equip providers in implementing research-based practices in clinical settings (one of a few goals of translational science in health services research) (Curran et al., 2011; Zerhouni, 2005).

Several EBPs exist within the realm of falls prevention and include performing assessments to identify risk factors (dementia, medication interactions) and behavioral interventions (strength training) with patients shown to be at risk for falling (Chang & Ganz, 2007; Tinetti et al., 1994). GECs targeting falls prevention collaborated for peer learning and information sharing to hone in on a common EBP within falls. In support, they received technical assistance on planning evaluation outcomes from the National Training and Coordination Collaborative (NTACC), a contract of DHHS–BHP–HRSA to assist GECs in improving data reporting and influencing the range of their local evaluation practices (logic

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