Sustaining program effectiveness after implementation: The case of the self-management of well-being group intervention for older adults

Martine M. Goedendorp\textsuperscript{a,}\textsuperscript{*}, Daphne Kuiper\textsuperscript{a,}\textsuperscript{b}, Sijmen A. Reijneveld\textsuperscript{c}, Robbert Sanderman\textsuperscript{a,}\textsuperscript{d}, Nardi Steverink\textsuperscript{a,}\textsuperscript{e}

\textsuperscript{a}Department of Health Psychology, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands
\textsuperscript{b}Clinical Research Office, UMC staff, University Medical Center Groningen, Groningen, The Netherlands
\textsuperscript{c}Department of Health Sciences, (Community & Occupational Medicine,) University Medical Center Groningen, University of Groningen, Groningen, The Netherlands
\textsuperscript{d}Department of Psychology, Health & Technology, University of Twente, Enschede, The Netherlands
\textsuperscript{e}Department of Sociology, University of Groningen, Groningen, The Netherlands

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Objective: The Self-Management of Well-being (SMW) group intervention for older women was implemented in health and social care. Our aim was to assess whether effects of the SMW intervention were comparable with the original randomized controlled trial (RCT). Furthermore, we investigated threats to effectiveness, such as participant adherence, group reached, and program fidelity.

Methods: In the implementation study (IMP) 287 and RCT 142 women participated. We compared scores on self-management ability and well-being of the IMP and RCT. For adherence, drop-out rates and session attendance were compared. Regarding reach, we compared participants’ baseline characteristics. Professionals completed questions regarding program fidelity.

Results: No significant differences were found on effect outcomes and adherence between IMP and RCT (all $p > 0.135$). Intervention effect sizes were equal (0.47–0.59). IMP participants were significantly less lonely and more likely to be married, but had lower well-being. Most professionals followed the protocol, with only minimal deviations.

Conclusion: The effectiveness of the SMW group intervention was reproduced after implementation, with similar participant adherence, minimal changes in the group reached, and high program fidelity.

Practice implications: The SMW group intervention can be transferred to health and social care without loss of effectiveness. Implementation at a larger scale is warranted.

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1. Introduction

The efficacy of interventions is best demonstrated in randomized clinical trials (RCTs) [1], in which the population is clearly defined, protocols are used, professionals are trained, and both participants and professionals are closely monitored [2]. Once efficacy is demonstrated they can be labeled as empirically supported interventions (ESIs). It is certainly for sure a great challenge to transfer ESIs to health care [3] and social work settings while sustaining program effectiveness [4,5]. Effectiveness might be threatened in several ways. First, there is a fair risk that the practice settings may not attract the same type of participants as the research setting [6]. Second, adherence of participants may be less. Third, program fidelity (also known as integrity), the degree to which the intervention is delivered as intended [7], may be a concern. Several studies showed program fidelity can be a moderator of program effectiveness [8–10], and low program fidelity after implementation can even lead to null results [11]. So, changes in the delineated target population, poor adherence of participants, and lack of program fidelity could reduce the effectiveness of implemented ESIs.

Implementing ESIs in practice settings is often guided by implementation frameworks [12] such as implementation of disease self-management programs [13–16]. Implementation frameworks commonly cover the issue of sustainability, also referred to as continuation [17], maintenance [18], or embedding an ESI at hand [19]. Often financial sustainability is the priority. However, what should matter most is the sustainability of effectiveness [20]. Insight into the sustainability of an ESI's
effectiveness could be gained through comparison of the original study results with the results of the same intervention after implementation in practice settings. To our knowledge, such comparisons are scarce, especially in the field of social and well-being interventions.

The focus of the current study is on evaluating the effectiveness of the Self-Management of Well-being (SMW) group intervention for older women after implementation in health and social care. A previously performed randomized controlled trial (RCT) demonstrated that self-management abilities and well-being in the intervention group improved, while feelings of social loneliness were reduced, in comparison with women in the control group [21,22]. However, so far it is unknown whether the effectiveness of the implemented SMW group intervention is sustained after implementation in practice settings.

The aim of the current study was to investigate whether the effectiveness of the SMW group intervention after implementation was comparable with the original RCT. Furthermore, we investigated potential threats to its effectiveness. Specifically, we compared differences in terms of participant adherence (dropout and session attendance), and in terms of the groups reached by the RCT and after implementation. Additionally, we investigated program fidelity after implementation, specifically whether professionals performed the SMW group intervention according to protocol.

2. Methods

2.1. Design and sample

The current study was part of a larger implementation study (IMP) [23]. During that study, 48 professionals from 18 different health (home health care and retirement homes) and social care organizations were trained to deliver the SMW group intervention to their clients. Between November 2010 and November 2013, thirty-nine SMW group interventions were delivered to 287 participants by 32 trained professionals. For the RCT [21], 142 women were recruited in 2004 and were randomly assigned to either the intervention condition (IRCT, n = 63 in six groups) or the control condition (CRCT, n = 79). The medical ethical review committee of the University Medical Center Groningen evaluated and approved both studies and indicated they were not subject to the Medical Research Involving Human Subjects Act.

2.2. Procedure

We performed the RCT and the IMP separately. Mirroring the order in which they were conducted, we describe the procedure of the RCT first and that of the IMP second. For the RCT, potential participants were recruited through advertisements in local newspapers in two regions of the Netherlands. The advertisements asked community-dwelling women aged 55 and older who were living alone to contact the researchers by phone if they would like to “give their life more luster or gleam”. After the first telephone contact, women received a letter containing a flyer with more information about the intervention, the study and four self-diagnostic questions, and an informed consent form. The four self-diagnostic questions asked whether a woman: 1) missed having people around them; 2) would like to have more friends; 2) was engaged in only a few leisure activities; or 4) had trouble initiating activities. Women were told by covering text that when one or more of these questions were answered with “yes”, the intervention would probably be helpful [21]. Being single was an inclusion criterion. Women who signed and returned the informed consent were asked to complete the baseline assessment (T0). Subsequently, they were randomly allocated to the intervention or control group. For women assigned to the intervention, the second assessment (T1) was post-intervention, six weeks after T0. Participation of the control group involved only completion of the questionnaires at T0 and T1.

For the IMP, health and social care organizations recruited participants in various active and passive ways, including personal persuasion, open informational workshops, flyers in public places, and advertisements in local newspapers. Phrasing used in these recruitment methods was similar to that used in the RCT. After a woman signed up individually, she received an intake with a professional who checked for contraindications for participation. Contraindications included illiteracy, deep mourning, severe depression, severe divorce issues, severe physical impairments, unresolved trauma, or inability to function in a group. Contrary to the RCT, being single was not an inclusion criterion. Women who participated completed the T0 in two parts. One questionnaire was completed at the start of the first intervention session and included questions assessing demographic variables, self-management ability and well-being. A second questionnaire was completed at home after the first session and included questions assessing general health and loneliness. T1 was completed at the end of the final intervention session, six weeks after T0. The flow of participants in both studies is illustrated in Fig. 1. Finally, to evaluate program fidelity, the 32 trained professionals who carried out the SMW group interventions were asked to complete a questionnaire to assess whether they performed the intervention according to protocol. This occurred at the conclusion of the IMP in 2014.

2.3. Intervention

In both studies the SMW group intervention was similar. The intervention is based on SMW theory. SMW theory specifies six core self-management abilities assumed to be important for managing one’s physical and social resources in such a way that physical and social well-being are achieved and maintained, and that losses in physical and social resources are managed optimally [24,25]. The SMW group intervention consisted of six one-week interval group sessions of 2½ hours with about ten participants. During the sessions the six self-management abilities identified by SMW theory [24,25] were addressed. These abilities include: 1) taking initiatives; 2) being self-efficacious; 3) investing; 4) having a positive outlook; 5) ensuring multi-functionality in resources; and 6) ensuring variety in resources. Additionally, participants were taught to apply these abilities to the five dimensions of well-being, as also specified in SMW theory. These dimensions of well-being are derived from five basic human physical and social needs, and include needs for comfort and stimulation (physical needs), as well as needs for affection, behavioral confirmation, and status (social needs). All participants received a workbook with summaries of the sessions and homework exercises. Homework exercises were designed to let participants list their resources on the five domains of well-being as well as list changes in resources they preferred to make. Homework exercises were also designed to help participants practice applying the six self-management abilities to the five domains of well-being. For example, a homework exercise involved keeping a diary of positive daily events to practice the self-management ability “having a positive outlook”. More details about the SMW group intervention can be found elsewhere [21].

2.4. Training of professionals

In the IMP the SMW group intervention was carried out by two trained professionals, referred to as ‘teachers’. The professionals had to be female, employed in a formal health or social organization, and have experience or interest with group
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