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Research Article

Factors Explaining Program Sustainability: A Study of the Implementation of a Social Services Program in Sweden

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Even for successfully implemented programs, there is a great risk that new work practices are not sustained over time. Previous research has yielded a number of factors which influence program sustainability, but little is known about which factors are most important in different contexts or how these factors interact. This study tests a model of sustainability factors in a case where a program for structured needs assessment and documentation was implemented in the Swedish social services. In November 2020, a questionnaire was sent out to local implementing actors in the municipalities. The data include 135 municipal organizations with 1–3 respondents per organization. Descriptive statistics and multiple regression were used in the analysis. The outcome variable was routinization as one of the most central components of sustainability. The findings show that while the program was implemented at 21.5% of sites, it was both implemented *and* routinized at only 13.3% of sites. A key factor for successful routinization was an open project strategy, which entails coordination between the implementation process and other change initiatives, the identification of a long-term planning horizon, and development based on continuous feedback. Additional factors found to contribute to routinization were management commitment, user participation, first-line manager commitment, and available resources. Certain factors were identified as pertinent to the implementing actors themselves, such as effective project leadership and rationally planned projects. These latter factors, however, demonstrated less importance towards routinization. These findings are discussed in relation to the fragmented context of the implementation, whereby the recipient organizations were not single, unified organizations, but rather organizational clusters involving both purchaser and provider organizations. The findings have implications for the planning, management, and evaluation of social program implementation and the ability to sustain novel work practices.

1. Introduction

Evidence suggests that few implementation initiatives are sustained over time [1]. Even if the initial implementation is deemed successful, there is a great risk that the organizational changes will not survive in the long term [2, 3]. Thus, it is common for organizations to recede back into old routines as new practices are forgotten or abandoned. This problem has been described as the "improvement evaporation effect" or "initiative decay" [4].

Despite extensive research on implementation in public organizations, there is a need for further investigation into how new programs can be sustained over time to ensure continued benefits for clients [5–7]. Previous research has identified a plethora of factors affecting program sustainability, but they have not been systematically compared. For example, Bodkin and Hakimi [8] identify 274 facilitators and barriers in a systematic review of health promotion programs. Despite identification, there remains a lack of research as to how these factors interact and intersect, as well as which factors are most important in diverse contexts. To evoke Matland [9], this vast collection of factors does not need more factors but structure. It is reasonable to assume that all factors are not equally important in each case. For example, their significance depends on the characteristics of the object of implementation and varies between

organizational and institutional settings [10, 11]. Therefore, it is imperative to contextualize sustainability research and study which of the previously identified factors best account for program sustainability.

The aim of this study is therefore to evaluate the impact of sustainability factors identified in previous research and to explain how these factors relate to each other. In this paper, we report findings from a cross-sectional survey testing a model of sustainability factors in a case of implementation within the Swedish social services. We also elaborate on how the organizational setting may affect the factors' impact on program sustainability.

The studied program is called IBIC (individens behov i centrum, or roughly translated, the individual's needs in focus) and was developed in 2016 by the National Board of Health and Welfare (NBHW). The stated objective of the program has been to establish a more person-centered and needs-oriented social care, but an overarching goal has also been to promote evidence-based practice through structured documentation, standardized processes, and a common conceptual framework to assess individual needs, resources, goals, and results [12]. The implementation initiative included the NBHW at the national level and 173 out of the 290 Swedish municipalities. Our study focuses on the implementation at the municipal level.

Social services in Sweden are tax-financed and based on a decentralized model whereby oversight is allocated to 290 municipalities. This sector is structured by means of a purchaser-provider split, meaning that public providers, nonprofit organizations, and private companies can be contracted as providers by municipalities. IBIC is intended to permeate both the purchaser and provider organizations. Therefore, its implementation not only involves numerous municipalities, but also a variety of organizations at each implementation site. Consequently, the recipient organizations are not single, unified organizations, but rather clusters in which several organizational units interact. We identify this characteristic as organizational fragmentation and highlight its significance in the concluding discussion.

In the next section, sustainability is defined and related to the concepts of implementation and routinization. Then, an overview of factors shown to affect sustainability in previous research is presented. In the subsequent methods section, the study object and setting, research process, questionnaire, respondents, measures, and analyses are described in detail. Thereafter, the findings are reported, with the main findings summarized in Table 1. In the concluding discussion, we elaborate on the key findings and situate them within the fragmented organizational settings that characterize the context of implementation.

1.1. Defining Sustainability. Sustainability research is itself fragmented. The field is theoretically pluralistic and there is no standard or commonly accepted definition of sustainability [6, 7, 13]. In this study, we use implementation and sustainability as two distinct but related concepts that can be seen as concomitant processes [14]. Implementation is defined as the process of putting an innovation, new method, or program to use within an organizational setting [15, 16]. Sustainability is defined in accordance with Fleiszer et al. [5] as a process whereby "improvements are maintained, new ways of working become routine, surrounding systems are transformed in support and the innovation may even be developed, over a period of time appropriate to a given situation."

This definition of sustainability combines three main elements recurring in the literature: (1) routinization, (2) program benefits, and (3) continued development or adaptation to dynamic contexts. In this paper, we focus mainly on routinization, which can be seen as the primary or fundamental process of sustainability [17, 18]. Routinization is the process of embedding a program into organizational structures and processes, such that the program becomes a part of the organization's core services [3, 19, 20]. However, the definition does not suggest that all programs are to be routinized, but rather that it is crucial to maintain effective programs that provide benefits, such as improvements for users and organizations [21, 22]. Furthermore, routinized programs should not be static, but continuously adapted to changes in the organizational and institutional environment, and eventually deimplemented when obsolete [7, 23].

1.2. Factors Influencing Sustainability. In the sustainability literature, there is a theoretical tension between a rationalistic, top-down perspective emphasizing fidelity, planning, and control, and a dynamic, bottom-up perspective emphasizing local agency, adaptation, and continuous learning [9, 24]. In their seminal 1998 review, Shediac-Rizkallah and Bone [18] propose a three-level framework of factors influencing sustainability. We use this framework to present an overview of factors recurring in the literature, both from top-down and bottom-up perspectives. The framework includes factors related to (1) the implementation project, (2) the organizational setting, and (3) the broader community and institutional context.

(1) Factors related to the implementation project include the characteristics of the implementation object. For example, complex and resource-intensive programs are less likely to be sustained than simpler programs [22, 25]. Factors at the project level also include process factors such as strategic planning and early planning for sustainability [8, 14], project structure, communication, and use of performance monitoring systems, especially evaluation and feedback [5, 26, 27]. Several researchers emphasize that programs which are modifiable and adaptable to local conditions are more likely to be sustained [3, 6, 28, 29]. Some researchers also claim that sustainability is more likely if the implementation strategy and process is adapted and developed over time based on ongoing evaluations and continuous learning [24, 30, 31].

(2) Factors related to the organizational setting include the characteristics of the recipient organization, such as its absorptive capacity [5, 22], level of education

Table 1: Predictors of routinization (linear regression).

Predictors	Model 1[a]		Model 2[b]		Model 3[c]	
	β [d]	p	β [d]	p	β [d]	p
Implementation strategy and process						
Rationally planned project	**0.481**	**0.000**	0.063	0.518	0.058	0.610
Effective project leaders	**0.367**	**0.000**	0.065	0.404	−0.024	0.792
Open project strategy	**0.637**	**0.000**	**0.551**	**0.000**	**0.373**	**0.003**
Adaptation to local conditions	0.028	0.739	0.098	0.128	0.033	0.601
Evaluation use	**0.253**	**0.002**	0.116	0.068	0.082	0.174
			$\Delta R^2 = 0.390$[e]			
Broad participation						
Care manager participation	**0.255**	**0.003**	**0.177**	**0.042**	−0.057	0.436
First-line manager commitment	**0.402**	**0.001**	**0.331**	**0.006**	0.155	0.110
Provider participation	**0.308**	**0.001**	0.093	0.391	−0.123	0.199
User participation	**0.287**	**0.001**	**0.205**	**0.010**	**0.203**	**0.010**
Provider collaboration	0.087	0.352	−0.120	0.208	−0.065	0.374
			$\Delta R^2 = 0.223$[e]			
Management support						
Informed decision to adopt the program	**0.410**	**0.000**	**0.155**	**0.046**	0.080	0.344
Management commitment	**0.618**	**0.000**	**0.416**	**0.000**	**0.233**	**0.025**
Local politicians' commitment	**0.364**	**0.000**	0.011	0.893	−0.117	0.219
Available resources	**0.468**	**0.000**	**0.210**	**0.007**	**0.198**	**0.024**
			$\Delta R^2 = 0.392$[e]			
Collaboration in the outer context						
Collaboration between social service departments	−0.054	0.539	−0.068	0.454	**−0.200**	**0.005**
Government-led national network	0.030	0.716	−0.011	0.904	0.071	0.333
National web-based forum	−0.008	0.922	−0.041	0.652	−0.034	0.612
Local and regional networks	0.152	0.094	0.171	0.080	0.070	0.331
			$\Delta R^2 = 0.030$[e]		$\Delta R^2 = 0.535$[e]	

[a]Simple model: control only for the two implementation variables ($n = 135$). [b]Thematic model: control for the two implementation variables and the other predictors in the same thematic category ($n = 135$). [c]Full model: control for the two implementation variables and all other predictors in the table ($n = 135$). [d]Standardized beta. [e]ΔR^2 (delta R^2) is the change in R^2 when controlled for the two implementation variables. (R^2 for implementation variables = 0.154). Bold: $p < .05$.

and stability of the workforce [1], and available resources to effectively manage the program [8, 11, 27]. The organizational setting also includes both management and staff commitment to the program. Managers may allocate sufficient resources, establish a shared vision, and build a widespread commitment to the program [8, 32–34]. In addition, staff participation and shared decision-making can create a broad sense of ownership and support for the program [1, 35, 36]. Some researchers emphasize that first-line managers have a central role as they can motivate staff and lead the implementation at ground-level [32, 37].

(3) Factors in the broader community and institutional context include support from other organizations in the environment. For example, sustainability is more likely if there is collaboration and knowledge exchange with other organizations implementing the same program [31, 38, 39]. Collaboration can enhance access to required resources, expertise, new perspectives, and political support [3, 24, 40]. Sustainability may also be supported by the involvement of government agencies and universities [31], diversity of funding, and involvement of the principle funding body [33, 34]. Moreover, the institutional context includes the legislative and regulatory environment [23], and social norms, trends, and rationalized myths in the surrounding society [22, 41].

2. Materials and Methods

Sustainability factors identified in previous research were tested in a cross-sectional survey. First, we developed a questionnaire and recruited potential participants. Second, the data were processed in three main stages: (a) responses from the same organization were aggregated, (b) principal component analyses (PCA) were performed to identify latent patterns in the data, informing the construction of index variables, and (c) a multiple imputation was carried out to replace missing data. Third, variables were analysed with descriptive statistics and linear regression. All analyses were conducted in SPSS 27.

2.1. Study Object and Setting. The social services in Sweden are organized based on a purchaser-provider split, and it follows that IBIC should be implemented and routinized in both purchaser and provider organizations. IBIC was developed by NBHW with the explicit goal of ensuring that the provision of social care services is based on the needs of each individual [12]. IBIC is described as a needs-oriented, systematic, and structured working model, which can be applied to all adults with needs according to the Social Services Act (SFS 2001:453) or the Act Regulating Support and Service to Persons with Certain Functional Impairments (SFS 1993:387).

IBIC is based on the International Classification of Functioning, Disability, and Health (ICF) [42], and introduces a standardized process and terminology to assess the individual's needs and resources in eleven "areas of life." Individual results and goal fulfilment are to be measured and evaluated systematically. Data should be used to adjust the individual's treatment and services, but also as a basis for quality improvements [12]. Overall, IBIC is a complex program, as it affects the whole process, from needs assessment to follow-up, and involves both purchasers and providers. The challenges of these complexities were reflected in a government report which concluded that the implementation is demanding and time-consuming [43].

NBHW has a government mandate to promote IBIC implementation, and the Swedish Association of Local Authorities and Regions (SALAR) also supports the implementation. When our data collection was carried out, 173/290 municipalities had implemented the program [44], and the implementation process had been ongoing for an average of 3.7 years (SD = 2.17) across the sites.

2.2. Questionnaire. A questionnaire was developed from previous sustainability research and in close dialogue with IBIC experts at NBHW and SALAR. The questions were informed by several instruments recurring in the literature. Sustainability was measured in terms of routinization through questions inspired by the Level of Institutionalization Scales [45], a questionnaire to assess organizational routines [46], and an instrument for measuring the sustainability of changed work practices [19]. Sustainability determinants were derived from the literature review and informed by the Program Sustainability Index [47] and the Program Sustainability Assessment Tool [48].

The questionnaire was then validated by four local implementers representing four municipalities. They performed a pilot test of the questionnaire, and the questions were adjusted based on their feedback. The questionnaire was designed as a web survey and was sent out in November 2020. Three reminders were sent at two-week intervals.

2.3. Respondents. An e-mail with information about the study was sent to the head of administration in all municipal social services. The study was also presented at two national IBIC conferences arranged by NBHW and SALAR. Potential participants were invited to register via an application form with questions about their role in the implementation. The inclusion criteria were that the municipality had implemented the program and that the respondent had a role with high involvement in the implementation. 186 participants signed up and met the inclusion criteria. They represented 125 municipalities, corresponding to 72.3% of those implementing IBIC.

The number of responses received was 155 (response rate 83.3%). The respondents can be described as street-level bureaucrats implementing the program in practice. A majority (72.3%) represented the purchaser organization or the central administration. They were mainly care managers, quality developers, or strategists. A smaller group (27.7%) represented the provider organizations and was mainly first-line managers, quality developers, or strategists (see Table 2).

Table 2: Information on the respondents ($n = 155$).

	Number	Percent
Gender		
Female	138	89.0
Male	15	9.7
Other/missing	2	1.3
Social service area		
Elder care	89	57.4
Social care <65 year	10	6.5
Disability care	38	24.5
All areas above	13	8.4
Other	5	3.2
Purchaser-provider		
Purchaser or central administration	112	72.3
Provider organization	43	27.7
Position		
Head of administration	2	1.3
Middle manager	6	3.9
First-line manager	26	16.8
Care manager	32	20.6
Quality developer, strategist, or equivalent	55	35.5
Group leader, coordinator, or equivalent	19	12.3
Care staff	5	3.2
Other	10	6.5

All participants indicated informed consent before filling out the questionnaire. The Swedish Ethical Review Authority had no ethical objections to the project (Dnr 2020-01734).

2.4. Measures and Analyses. All items are measured on five-point Likert scales (e.g., 1: strongly disagree and 5: strongly agree). The data were processed in three main steps and then analysed with descriptive statistics and multiple linear regression. There is a debate about the use of parametric tests on Likert scale data, but the overall conclusion is that parametric tests are robust and thus can be used with Likert scales [49–51].

First, responses from the same organization were merged into one aggregate score, calculated as the mean of the individual scores. The objective for this was to maintain the organization as the unit of analysis. We separated elder care, social services for people under 65, and support and services for people with disabilities into three different organizational units. The data includes a total of 135 organizations with 1–3 respondents per organization.

Second, we conducted PCA with Varimax rotation according to the following procedures: (1) intercorrelations between items were checked to avoid multicollinearity. One of a pair of items with a very strong correlation ($r > 0.90$) and items with few correlations ($r > 0.30$) were removed [52]. (2) We conducted the Kaiser–Meyer–Olkin measure of sampling adequacy (KMO > 0.50) and Bartlett's Test of Sphericity ($p < 0.05$) [52]. (3) We looked at commonalities and removed items with low values (<0.30). (4) Factors were extracted with Kaiser's criterion for eigenvalue (>1.0). (5) Items with no high factor loading (>0.40) or equal loadings on more than one factor were removed [52]. (6) Reliability was tested with Cronbach's alpha (α) and we regarded $\alpha > 0.70$ to be acceptable [52]. If reliability was low but increased to an acceptable level without a certain item, that item was removed. (7) The extracted factors were interpreted and named based on the common theme of the included items. (8) Finally, index values were calculated as the mean of the included item scores. In accordance with these procedures, we conducted PCA on ten groups of items. This resulted in 15 index variables. Six items could not be included in any index due to low reliability and were analysed separately. However, one factor named "implementation in the provider organizations" was retained despite somewhat low reliability ($\alpha = 0.62$). We judged this variable to have high face validity; it comprises four items that are theoretically connected and capture relevant aspects of implementation in the provider organizations. All variables, included items, and reliability are reported in Table 3.

Third, a multiple imputation with five iterations was carried out using the Markov chain Monte Carlo method [53]. The process included 26 variables, where the proportion of missing values ranged from 2.2% to 32.1%. In total, 14.2% of the values were missing, and 68.6% of all cases had missing values.

After these three initial steps to prepare the data, the variables were analysed with descriptive statistics and linear regression. Multicollinearity was assessed by checking pairwise correlations ($r < 0.80$) and the variance inflation factor (VIF < 5.0) [52]. Normal distribution of residuals was checked visually with histograms and normal probability plots.

Our outcome variable was routinization, which is the primary process of sustainability [14]. However, routinization cannot be achieved without implementation, because there must be some program components to routinize [27]. Therefore, we also measured the level of implementation, both in purchaser and provider organizations. The predictors were arranged in four categories: (1) implementation strategy and process; (2) broad participation; (3)

Table 3: Measures.

Variable names	Included items and reliability	Types
Routinization	Seven items ($\alpha = 0.83$). Respondents were asked to rate the degree to which the IBIC program was embedded into organizational structures and processes (e.g., IBIC is integrated into written procedures, new work practices have replaced old routines, it is clear who is accountable for IBIC after implementation, new employees receive introductory training in IBIC)	Outcome
Implementation in the purchaser organization	Four items ($\alpha = 0.75$). Respondents were asked how often key program activities were carried out by care managers (e.g., the ICF assessment tool was used to document the individual's resources, needs, and goals, and individual goal fulfilment was documented in a structured way)	Control
Implementation in the provider organizations	Four items ($\alpha = 0.62$). Respondents were asked how often key program activities were carried out by providers (e.g., individual goals were formulated together with the client, and the "areas of life" were used in the ongoing documentation)	Control
Implementation strategy and process		
Rationally planned project	Four items ($\alpha = 0.87$). Respondents were asked to rate to what degree the implementation was characterized by clear planning, measurable goals, clear responsibilities, and assessment of resource requirements	Predictor
Effective project leaders	Three items ($\alpha = 0.72$). Respondents were asked to what degree project leaders had a clear mission and mandate, time and resources, and in-depth knowledge about IBIC	Predictor
Open project strategy	Three items ($\alpha = 0.74$). Respondents were asked to what degree the implementation process was coordinated with other change initiatives in the organization, if there was an early long-term planning agenda for IBIC after the implementation phase, and if there were continuous follow-ups during the implementation	Predictor
Adaptation to local conditions	Two items ($\alpha = 0.76$). Respondents were asked if the IBIC program was modified to match local needs and local resources	Predictor
Evaluation use	Four items ($\alpha = 0.92$). First respondents were asked if the IBIC implementation was evaluated. If "yes" respondents were asked to what degree evaluation findings were used as input to modify the IBIC program, adjust the implementation strategy, motivate staff, and make long-term plans (nonevaluation was coded as 1 on the five-point scale 1–5).	Predictor
Broad participation		
First-line manager commitment	Three items ($\alpha = 0.80$). Respondents were asked to what degree first-line managers were knowledgeable about IBIC, motivated their staff, and had a passive attitude towards IBIC	Predictor
Provider collaboration	Two items ($\alpha = 0.72$). Respondents were asked to what degree the implementation was characterized by close cooperation between purchaser-providers and between providers	Predictor
Provider participation	Two items ($\alpha = 0.79$). Respondents were asked to what degree the experiences of first-line managers and care staff were included in the implementation process	Predictor
Care manager participation	Single item. Respondents were asked to what degree the experiences of care managers were included in the implementation process	Predictor

Table 3: Continued.

Variable names	Included items and reliability	Types
User participation	Single item. Respondents were asked to what degree the experiences of users (clients) were included in the implementation process	Predictor
Management support		
An informed decision to adopt the program	Two items ($\alpha = 0.84$). Respondents were asked to what degree the decision to adopt IBIC was based on a proper analysis of local needs and knowledge about IBIC	Predictor
Management commitment	Four items ($\alpha = 0.90$). Respondents were asked to what degree senior managers were knowledgeable about IBIC, made IBIC a priority, clarified why it was needed, and requested reports on the implementation	Predictor
Local politicians' commitment	Four items ($\alpha = 0.91$). Respondents were asked to what degree local politicians were knowledgeable about IBIC, made IBIC a priority, clarified why it was needed, and requested reports on the implementation	Predictor
Available resources	Four items ($\alpha = 0.92$). Respondents were asked to rate if there were sufficient resources for an effective implementation (time, information and feedback, mandate, and implementation skills)	Predictor
Collaboration in the outer context		
Collaboration between social services departments	Single item. Respondents were asked to what degree the implementation was characterized by close cooperation between different parts of the municipality's social services (e.g., elder care and disability care)	Predictor
Government-led national network	Single item. Respondents were asked to what degree local implementation agents were active in a national IBIC network organized by the National Board of Health and Welfare (NBHW)	Predictor
National web-based forum	Single item. Respondents were asked to what degree local implementation agents were active in a national web-based IBIC network organized by the Swedish Association of Local Authorities and Regions (SALAR)	Predictor
Local/regional networks	Single item. Respondents were asked to what degree local implementation agents were active in a local/regional IBIC networks with nearby municipalities	Predictor

management support; and (4) collaboration in the outer context. The first category applies to the project level in Shediac-Rizkallah and Bones' [18] three-level framework. The second and third categories belong to the organizational level, and the fourth category applies to the community level. However, we omitted factors pertaining to the implementation object, funding, and institutional context, since all study participants implemented the same program and were part of the same institutional context. Therefore, these factors did not vary between cases.

Three regression models were tested: a simple model, a full model, and a "thematic" model. The simple model assessed the predictors as single variables. The full model included all predictors. In the thematic model we divided the predictors into the four categories mentioned above. Regression analyses were performed on each category to determine the predictors' relative contribution to the model when controlled for the other variables in the same category. In addition, in all regression models, we adjusted for the level of implementation using two implementation variables. Thereby we could determine the predictors' effect on routinization when the variance explained by implementation was accounted for (see Figure 1).

3. Results

In Table 4, descriptive statistics are reported. The results show that IBIC was implemented in the purchaser organization at 78 sites (57.8%) and in the provider organizations at 38 sites (28.1%) (score 4-5). The program was implemented in both the purchaser and provider organizations at 29 sites (21.5%) (score 4-5 on both implementation variables). Overall, the program can be regarded as fully implemented routinized at 18 sites (13.3%) (score 4-5 on both implementation variables and routinization). Thus, after having been implemented for almost four years, the program still showed a low level of sustainability.

There is a fairly strong correlation between implementation and routinization; together the two implementation variables explain 15.4% of the variance in routinization ($R^2 = 0.154$, $p < 0.001$). However, our ambition is to explain routinization as the primary process of sustainability, and therefore the regression models adjusting for the level of implementation.

The regression models are reported in Table 1. Model 1 is a simple model that shows significant correlations between routinization and most single predictors except *adaptation to local conditions, provider collaboration*, and the four predictors related to *collaboration in the outer context*.

The column labelled "Model 2" shows the four "thematic" models, where all predictors in the same thematic category are included. Thus, we can determine the predictors' relative contribution to the model when controlled for the other predictors in the same category. The first category *implementation strategy and process* explains 39.0% of the variance in routinization ($\Delta R^2 = 0.390$, $p < 0.001$), but *open project strategy* is the only predictor with a significant contribution to the model ($\beta = 0.551$, $p = 0.000$). Notably, *rationally planned project* ($\beta = 0.063$, $p = 0.518$) and *effective project leaders* ($\beta = 0.065$, $p = 0.404$) do not contribute any predictive value to the model. The second category *broad participation* explains 22.3% of the variance in routinization ($\Delta R^2 = 0.223$, $p < 0.001$) and three predictors make significant contributions to the model: *first-line manager commitment* ($\beta = 0.331$, $p = 0.006$), *user participation* ($\beta = 0.205$, $p = 0.010$), and *care manager participation* ($\beta = 0.177$, $p = 0.042$). The third category *management support* explains 39.2% of the variance in routinization ($\Delta R^2 = 0.392$, $p < 0.001$) and three predictors make significant contributions to the model: *management commitment* ($\beta = 0.416$, $p = 0.000$), *available resources* ($\beta = 0.210$, $p = 0.007$), and *informed decision to adopt the program* ($\beta = 0.155$, $p = 0.046$). Finally, the fourth category *collaboration in the outer context* does not seem to have any effect on routinization ($\Delta R^2 = 0.030$, $p > 0.05$). In summary, according to the four thematic models, open project strategy, management commitment, and first-line manager commitment were the most important predictors of routinization ($\beta > 0.30$).

Model 3 is a full model where all predictors are included to determine the overall contribution of each predictor. Together the predictors explain 53.5% of the variance in routinization ($\Delta R^2 = 0.535$, $p < 0.001$). In particular, four predictors make a positive contribution to the model: *open project strategy* ($\beta = 0.373$, $p = 0.003$), *management commitment* ($\beta = 0.233$, $p = 0.025$), *user participation* ($\beta = 0.203$, $p = 0.010$), and *available resources* ($\beta = 0.198$, $p = 0.024$). Notably, *collaboration between social services departments* seems to have a negative effect on routinization ($\beta = -0.200$, $p = 0.005$).

Overall, the regression models indicate that the most important factors were open project strategy, management commitment, user participation, first-line manager commitment, and available resources. In the next section, we discuss those factors and reflect on how the fragmented organizational setting may affect the factors' impact on sustainability.

4. Discussion

This paper focuses on routinization as the primary process of sustainability. However, we do not evaluate the program outcome and cannot draw conclusions about the potential benefits of IBIC. That said, the findings indicate that routinization was positively related to factors pertaining to implementation strategy and process, broad participation, and management support, but not with variables pertaining to collaboration in the outer context. Our findings provide empirical support to a dynamic, bottom-up approach to sustainability, but in combination with strong management support.

4.1. Implementation Strategy and Process. The findings suggest that an open project strategy—where the implementation was coordinated with other change initiatives, had a long planning horizon, and was developed over time based on continuous feedback—was the most important factor for routinization. By far, it had the strongest

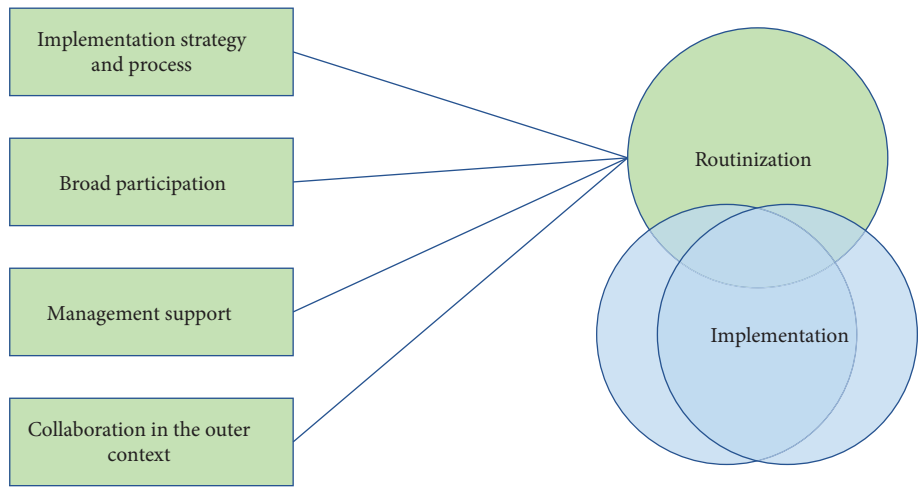

Figure 1: The tested model. Four predictor categories, routinization as the outcome variable, and two implementation variables as controls.

Table 4: Descriptive statistics.

Variable	Agree[a]	Mean (SD)[b]
Outcome variables		
Routinization	49 (36.3)	3.12 (0.93)
Implementation in purchaser organization	78 (57.8)	3.54 (1.08)
Implementation in provider organizations	38 (28.1)	2.68 (1.14)
Implementation strategy and process		
Rationally planned project	64 (47.4)	3.28 (0.96)
Effective project leaders	82 (60.7)	3.66 (0.92)
Open project strategy	47 (34.8)	2.91 (0.98)
Adaptation to local conditions	42 (31.1)	2.75 (1.16)
Evaluation use	14 (10.4)	1.52 (1.01)
Broad participation		
Care manager participation	115 (85.2)	4.20 (0.76)
First-line manager commitment	46 (34.1)	3.07 (1.00)
Provider participation	55 (40.7)	3.03 (1.08)
User participation	11 (8.1)	1.96 (0.94)
Provider collaboration	45 (33.3)	2.91 (1.06)
Management support		
Informed decision to adopt the program	40 (29.6)	2.72 (1.17)
Management commitment	45 (33.3)	2.91 (1.05)
Local politician' commitment	20 (14.8)	2.26 (1.08)
Available resources	67 (49.6)	3.40 (0.84)
Collaboration in the outer context		
Collaboration between social services departments	54 (40.0)	3.00 (1.31)
Government-led national network	67 (49.6)	3.29 (1.51)
National web-based forum	70 (51.9)	3.37 (1.44)
Local and regional networks	80 (59.3)	3.64 (1.46)

[a]Number (percent) of sites scoring 4-5 on a five-point scale of 1–5 ($n = 135$). [b]Mean (standard deviation) on a five-point scale of 1–5 ($n = 135$).

explanatory value of the variables pertaining to implementation strategy and process. Other project-related factors, such as effective project leaders and rationally planned project, did not contribute with any additional explanatory value. These findings are an important contribution to the sustainability research. A strong project leader can certainly be important by pushing for implementation, but our findings suggest that a project leader plays less of a role in the routinization process (cf. [34, 54]).

A relevant question is thus how an *open project strategy* should be understood. The concept can be interpreted as three aspects of "openness" (cf. [55, 56]). First, the implementation work is open in the sense that it is coordinated with other change initiatives in the organization. Thus, it is not narrowly limited to the specific implementation task, but takes on a broader perspective on the organizational setting (cf. [57, 58]). Second, a focus on long-term planning implies an openness towards the future after the initial

implementation. The implementation is not solely focused on operational efficiency and delivery of short-term goals, but also includes an early planning for sustaining new work practices (cf. [8, 14, 33]). Third, the implementation work is open to adaptation through ongoing follow-ups and feedback. Thus, it is not tied to premade plans, but can be continuously modified and developed [23, 24, 59].

We suggest that an open project strategy might be especially important in fragmented organizational settings. One reason for this is that fragmentation implies that the number of involved actors, possible relationships, and the level of complexity increases, which in turn may decrease the ability to plan and control the process. This motivates an open and adaptive strategy that enables the implementing actors to adjust and modify project activities and handle unforeseen events [56, 60].

We found no connection, however, between routinization and adaptation to local conditions. Unlike open project strategy, this variable is not about adaptations of the implementation strategy and process, but about adapting the program itself to meet local needs and resources. In this respect, our findings seem to deviate from previous research showing that programs that are adapted to local conditions are more likely to be sustained [6, 28, 29, 61]. One possible interpretation is that the adaptations made to IBIC were inadequate. Several researchers emphasize that new programs often need to be adapted to fit the mission, culture, and operating procedures of the organization [3, 22], but these adaptations should not be ad hoc, but rather guided by systematic evaluations and feedback that provide reliable information about the program [8, 23, 62]. However, our study shows that few sites (10.4%) used evaluation findings to inform program adaptations (see Table 4). Therefore, implementing actors lacked systematic knowledge about the outcome and organizational fit of IBIC, which in turn created a weak foundation for well-informed adaptations of the program.

4.2. Broad Participation. The findings suggest that user participation and first-line manager commitment had a significant effect on routinization. Previous research shows that sustainability is more likely if relevant actors are involved in the implementation process, as it may provide valuable input and create a sense of ownership and commitment to the program [30, 31, 35]. The fact that user participation seemed to have such a strong impact on routinization is an interesting finding. This means that the social service users were involved in the implementation work and that their experiences were used as inputs to the process. Previous studies often highlight participation from managers, staff, and community actors, but our findings suggest that user participation can also be an important feature. Participation may make users more positive towards the program, and sustainability is more likely if changes are perceived as positive by users [1, 3]. User participation creates legitimacy for the program [22] and is likely to increase the motivation and commitment of both managers and staff.

In a fragmented organizational setting with numerous provider organizations, first-line managers may hold key positions. As operations managers at the providers, they can potentially link top management strategies with staff experiences and perspectives. They can drive implementation and routinization forward and build commitment among their staff, but they can also work against changes they do not support [37]. Aarons et al. [32] show that first-line managers with a so-called transformational leadership style, which involves inspiring and motivating staff, predicted program sustainability. Passive-avoidant leadership predicted nonsustainability.

4.3. Management Support. Management commitment and available resources were found to be two of the most important factors for routinization, but the factor labelled informed decision to adopt the program also had some explanatory value. This is in line with previous research, which shows that management commitment, ownership, and support are crucial for routinization and sustainability [5, 8, 33].

However, in a fragmented organizational setting it can be more demanding to create a shared sense of ownership and commitment to the program [30]. IBIC was, for example, received differently by purchaser and provider organizations. The providers were not as involved and committed to the IBIC program as the purchasers, and both implementation and routinization were less successful on the provider side. This may indicate a need for strong management support, where managers can coordinate the implementation, establish a shared vision, and build widespread commitment to the program [8, 32, 34]. Managers also have a responsibility to ensure that decisions to adopt new programs are based on actual and perceived needs, so that employees, users, and other stakeholders consider the implementation as meaningful [22, 39].

4.4. Collaboration in the Outer Context. The findings show that no variables connected to collaboration in the outer context were related to successful routinization. Active participation in national or local/regional IBIC networks had no predictive value, and collaboration between social service departments in the municipality even seemed to have a negative effect on routinization.

This is contradictory to previous studies indicating that collaborations and learning networks can facilitate sustainability [31, 38, 40]. A possible explanation for the divergent findings in this study is that collaboration and networks do not support sustainability *per se*. Networks need to be organized effectively because it is difficult to transfer the individual learning that takes place in networks back to the participants' home organizations. However, this transfer of knowledge from networks often tends to be ad hoc and relies on personal commitment [22, 63, 64]. Nevertheless, all collaborations and networks require resources, increase complexity, and take time and focus from other activities. Therefore, if collaborations and networks do not affect the implementation in the home organizations, they can become a cost without added value.

4.5. Limitations. The study has some limitations. First, all data concerns the implementation of IBIC in the Swedish social services and statistical generalizations beyond this case is not possible. However, we believe that the findings are transferable to similar cases, but this transfer must be done with an understanding that both program attributes and context may affect sustainability. Second, the study is based on self-reported data. Literature reviews indicate that self-reports tend to overestimate sustainability [1]. Nevertheless, deeply involved actors have unique insights that are important for understanding sustainability. Third, the study is relatively small ($n = 135$) and had low representation from provider organizations (27.7%). However, the response rate was high (83.3%) and represented a large proportion of the municipalities implementing IBIC (72.3%). Fourth, for some variables, there were several missing values, especially on local politicians' commitment (32.1%), user participation (27.7%), and first-line manager commitment (27.0%). These gaps were handled with multiple imputations, which van Ginkel et al. [65] argue is to be preferred over listwise and pairwise deletion. However, the findings regarding these variables should be interpreted with caution. Lastly, the data as a whole was not suitable for PCA. Therefore, PCAs were made on subgroups of items related to the same theme. The constructed index variables, however, had good face validity and reliability.

5. Conclusions

The findings suggest that five factors—open project strategy, management commitment, user participation, first-line manager commitment, and available resources—were key factors for routinization as the primary process of sustainability. We argue that these factors may be especially important in fragmented organizational settings, where the recipient organizations are not single, unified organizations, but are rather organizational clusters. Fragmentation results from organizational complexity and makes planning and control less predictable. Thus, in a fragmented setting, program sustainment is more likely if the implementation is guided by an open project strategy, where the implementing actors can adjust and modify project activities and handle unforeseen events based on continuous feedback and learning, long-term planning, and coordination with other change initiatives. Fragmentation also makes it harder to create a shared sense of ownership and commitment to the program. Thus, in a fragmented setting, sustainability may be promoted by broad participation throughout the process, including both first-line managers and users. These findings constitute empirical support for a dynamic, bottom-up approach. However, our findings also suggest that this bottom-up approach should be combined with strong management support, whereby managers allocate sufficient resources, coordinate the fragmented implementation processes, establish a shared vision, and foster a widespread commitment to the program.

The findings have practical implications for both local and national actors in planning, managing, and evaluating program implementation. Municipalities should consider adopting open project strategies, broad participation, and management support in their future implementation. Government agencies should design national programs that support these factors to increase the likelihood of sustaining new work practices.

Data Availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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