# Motives and strategies of CEOs for stimulating sharing and application of knowledge in the care and support for people with intellectual disabilities

Marion Kersten, Elsbeth Taminiau, Mathieu Weggeman and Petri Embregts

(Information about the authors can be found at the end of this article.)

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**Abstract**

**Purpose** – *Within intellectual disability care organizations (IDCOs), it is vital that professionals share and apply knowledge to improve the quality of care for their service users. Given that chief executive officers (CEOs) play a pivotal role in enabling these processes, this paper aims to investigate both the underlying motives and strategies behind CEOs' organizational knowledge leadership and their contribution to improving these knowledge processes.*

**Design/methodology/approach** – *In this exploratory qualitative study, 11 CEOs from IDCOs in the Netherlands who are actively involved in knowledge management within their organizations were interviewed. An inductive thematic analysis was conducted.*

**Findings** – *CEOs' motives for stimulating knowledge processes among professionals in IDCOs arise from the internal (e.g. the CEOs themselves) and external (e.g. policy) contexts. This study also identified four strategies adopted by CEOs to stimulate sharing and application of knowledge: providing organizational conditions for effective knowledge processes; focused attention on talent development; acknowledgment and deployment of knowledge holders; and knowledge-driven participation in collaborative partnerships. These strategies are used in combination and have been shown to reinforce one another.*

**Practical implications** – *An overview of strategies for stimulating knowledge processes is now available.*

**Originality/value** – *The results display the leadership of CEOs in knowledge strategies. Insights into their perceptions and values are provided while elaborating on their motives to take this role.*

**Keywords** *Knowledge management, CEOs, Strategies, Motives, Intellectual disabilities, Qualitative research, Leadership*

**Paper type** *Research paper*

## 1. Introduction

Just as with general health care, the sharing and application of knowledge are vital processes in improving the quality of care in intellectual disability care organizations (IDCOs), which provide care and support to people with intellectual disabilities (Greenhalgh *et al.*, 2004; Grol *et al.*, 2007). However, the specific nature of IDCOs, namely, the fact that they are multidisciplinary and underpinned by different knowledge bases, raises a number of challenges when seeking to improve these knowledge processes (Farrington *et al.*, 2015; Kersten *et al.*, 2018). In light of this, we conducted an exploratory qualitative study among eleven chief executive officers (CEOs) from IDCOs in The Netherlands who are actively involved in knowledge management within their organizations. By presenting the motives and strategies of these CEOs for stimulating the sharing and application of knowledge by

professionals in IDCOs, this paper sheds light upon how organizational knowledge leadership enables the improvement of these knowledge processes.

We will, therefore, start by presenting the context, that is, the key characteristics of this field of care: a heterogeneous client population, a broad range of knowledge holders, the nature of their knowledge and the systems in which this knowledge is processed. Intellectual disability care (IDC) provides mainstream and specialized services to people whose disabilities range from mild to profound (World Health Organization, 2011; Public Health England, 2016; Kroneman *et al.*, 2016). Given that interventions used for the general population are usually not suitable, this means that care and support must be customized to a variety of target groups, such as persons with profound intellectual and multiple disabilities (Vlaskamp *et al.*, 2007) or parents with intellectual disabilities (Hodes *et al.*, 2014).

The lifelong and life-wide character of IDC means that it not only involves multiple professional disciplines but also members of the service user's informal network, for example, in the development, execution and evaluation of the service user's support plans, to which they all contribute their own areas of knowledge (Herps *et al.*, 2013). Knowledge processes in IDC, therefore, include evidence-based knowledge, alongside professional knowledge and the experiential knowledge of service users and their relatives (Embregts, 2017). The types of knowledge stemming from these different sources vary in terms of their properties, and this, in turn, has consequences for their use in knowledge processes (Farrington *et al.*, 2015; Robertson *et al.*, 2015; Zorginstituut Nederland, 2016). A key property in this respect is the nature of knowledge, i.e. whether it is codifiable and "explicit" or noncodifiable and "implicit" or "tacit" (Polanyi, 2009). While explicit knowledge is recorded and takes the form of "know that" knowledge such as facts, policies and protocols, implicit knowledge takes the form of "know how" knowledge, which is present in the minds of certain groups and individuals.

Evidence-based knowledge has an explicit character (e.g. an evidence-based guideline), but this holds to a far lesser extent for professional and experiential knowledge (e.g. practice-based methods). Explicit knowledge is relatively easy to exchange within and between organizations but is only available to a limited extent in IDC (Farrington *et al.*, 2015). Professional and experiential knowledge mainly take the form of implicit or tacit knowledge, such as individual experiences in caring for and supporting the service user, present or past. Situated in a specific context and limited to particular individuals and groups, this knowledge is harder to articulate and exchange (Farrington *et al.*, 2015). Moreover, the multidisciplinary character of IDC poses additional challenges, such as difficulties in bringing together professionals from different disciplines at the same time and place (Smulders *et al.*, 2013) and the fragmentation of knowledge that is distributed across a large number of locations and sources (Nicolini *et al.*, 2008).

Duryan *et al.* (2012, 2014) show that IDCOs can be perceived as complex systems. In the aforementioned description of knowledge holders, a system at the microlevel in which knowledge is processed can already be identified. This microlevel system includes the multidisciplinary team and the network of the service user. At the macrolevel, the IDCO is part of a larger health-care system consisting of the national government, the health-care authority, health insurers, patients and other providers (World Health Organization, 2011; Public Health England, 2016; Kroneman *et al.*, 2016). In-between these levels, at the meso or organizational level (the IDCO), the system involves several subsystems, including location, professional groups, communities of practice and collaborative partnerships of IDCOs. Characteristics of the mesosystem, such as properties associated with the various knowledge sources and the organizational context in which knowledge is shared and applied, are also key factors in stimulating successful quality improvement (Kaplan *et al.*, 2010) and innovation (Greenhalgh *et al.*, 2004). However, insight into the impact of the organizational context on knowledge processes within long-term care organizations is

limited (Cammer *et al.*, 2013; Kersten *et al.*, 2018). In their systematic review, Kersten *et al.* (2018) identify three main clusters of organizational factors that enable or disable the stimulation of knowledge processes in IDC:

1. factors related to the tools and processes used to implement a method;
2. factors related to people working in IDCOs (professionals, management); and
3. material and immaterial factors related to the organizational context, such as office arrangements and team size.

Overall analyses suggest that management has a key role to play by exerting its influence to guide and shape these factors.

In general health care, top management (CEOs) fulfills a particularly crucial role in enhancing innovations and quality improvement that involve knowledge processing. This can take the form of support at the highest level of management, personal commitment and employee motivation (Greenhalgh *et al.*, 2004; Kaplan *et al.*, 2010; Karamitri *et al.*, 2017). Effective leadership, which expresses itself through behavior such as advocating change and articulating a vision, requires underlying skills, values, personality traits and roles – all aspects which have not been the focus of a great deal of research (Yukl, 2012). An exploratory study by Larson *et al.* (2012) did establish patterns of motivation and attitudes among CEOs in a broad spectrum of high-performing organizations, including the need to drive continuous evolution and strong focus on learning. Nieboer and Strating (2012) found a significant correlation between commitment to quality improvement among CEOs of Dutch long-term care organizations and transformational leadership: the ability to change the status quo and existing rule structures by establishing "new orders" and ways of doing things (Avolio and Gardner, 2005).

In an exploratory study, Lakshman (2009) found preliminary empirical evidence for the pivotal role that senior-level executive leaders across a broad spectrum of organizations play in knowledge management, which, in turn, enhances organizational performance. Given that the perceptions of these CEOs on knowledge sharing appear to be instrumental in this process, Lakshman recommends further investigation into the role of leaders in information and knowledge management, including their perceptions. With regard to improving organizational performance in general, the "framework for leading the transformation to performance," developed by Latham (2013a, 2013b), points toward the interaction of forces and facilitators, approaches, behaviors, culture and the characteristics of individual leaders. To the best of our knowledge, the first study dedicated to examining leadership and management practice within IDC was recently published. The results of this Delphi study (Deveau *et al.*, 2019) show that senior managers in IDCOs both associate short-term reactive decisions with long-term strategic decisions and include staff in the decision-making process. The authors recommend further exploring the strategic decisions of senior management using different research methods that focus on aspects like contact with staff via visiting the services; this potentially influences both leadership and management practices and culture-building. Finally, Ayatollahi and Zeraatkar (2020) point to the key role of CEOs of health-care organizations in successfully implementing knowledge management by improving the sharing of knowledge and encouraging employees to accept a knowledge-sharing culture.

With regard to the policy of CEOs, the term "knowledge management" refers to measures aimed at locating, retrieving, sharing, adapting and using knowledge to promote organizations' objectives (Karamitri *et al.*, 2017). Knowledge management encompasses different strategies, i.e. descriptions of how the organization will realize its targets (Weggeman, 2007). Knowledge management strategies in the business sector include training programs, communication technologies, process mapping and communities of practice (Kothari *et al.*, 2011). According to Nieboer and Strating (2012), organizations

aiming to strengthen an innovative culture need to ensure that their human resource practices are aligned with their innovation strategies and approach to knowledge management.

To the best of our knowledge, there is a lack of insight into the strategies used by CEOs in IDC when it comes to managing knowledge in their organizations, as well as into their motives for deploying these strategies. The research questions underpinning this exploratory, qualitative study are:

*RQ1*. What are the motives of Dutch CEOs with respect to stimulating the sharing and application of knowledge in the care and support for people with intellectual disabilities?

*RQ2*. What are the strategies used by Dutch CEOs to stimulate the sharing and application of knowledge in the care and support for people with intellectual disabilities?

*RQ3*. Which enabling/disabling factors influence the execution of strategies used by Dutch CEOs to stimulate the sharing and application of knowledge in the care and support for people with intellectual disabilities?

The motives and strategies themselves will be addressed in this article, while another article will focus on the enabling and disabling factors (Kersten *et al.*, 2022). This paper is structured as follows: Section 2 presents the theoretical framework. Section 3 delineates the method deployed in the study as well as the study setting. Section 4 presents the main results on CEOs' motives (sub Section 4.1) and strategies (sub Section 4.2). In Section 5, the results of the study are discussed (sub Section 5.1) and the findings are compared with previous research (sub Section 5.2); next, the theoretical (sub Section 5.3) and practical (sub Section 5.4) implications, as well as the limitations (sub Section 5.5) of the study, are presented. Section 6 provides a conclusion and suggests avenues for future research.

## 2. Theoretical background

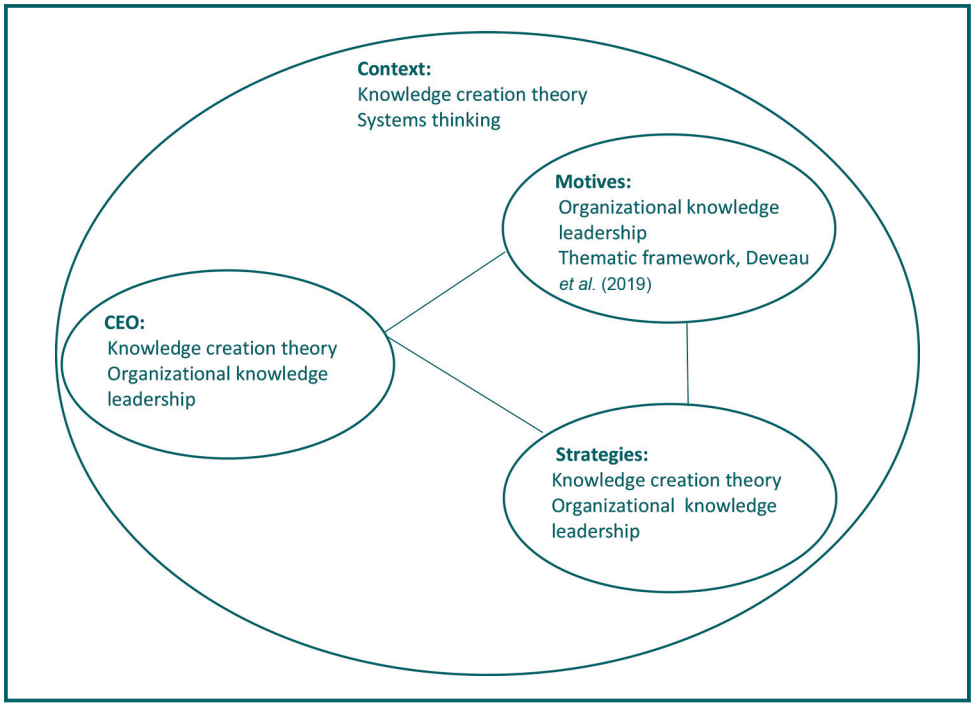
(Figure 1)

### *2.1 Knowledge, knowledge sharing and knowledge hiding*

In this article, we define knowledge as the ability of professionals to perform their tasks, which derives from information, experience, skills and attitude (Weggeman, 2007). In other words, knowledge encompasses explicit knowledge (information) as well as tacit knowledge (experience, skills and attitude). We, thereby, acknowledge the importance of the latter in IDC, with its limited explicit body of knowledge. Knowledge sharing at an individual level is imperative to processing knowledge at all other organizational levels. This process, defined by Ipe (2003) as the act of making knowledge available to others within the organization, involves the process of converting knowledge held by an individual into a form that other individuals can understand, absorb and use, which thus demands a conscious action on behalf of the knowledge holder.

In their theory of knowledge creation, Nonaka *et al.* (2000) point to the four mechanisms applied in this conversion to accommodate to the specific nature of the knowledge: Socialization (t→t), Externalization (t→e), Combination (e→e) and Internalization (e→t). They refer to this process of sharing either explicit (e) or tacit (t) knowledge as the SECI model. These authors show that the conversion of knowledge involves a spiral of knowledge creation, which expands both within and across organizations. Given that professional and experiential knowledge in IDC primarily concerns implicit knowledge, the mechanisms of socialization and externalization are of major importance when seeking to share knowledge in this specific field of care.

**Figure 1** Theoretical framework




Notwithstanding the nature of the knowledge (tacit and explicit knowledge and value of knowledge), the sharing of knowledge is also influenced by both the motivation (internal power and reciprocity; external relationship with recipient and rewards for sharing) and opportunities (purposive and relational learning channels) to share knowledge as well as the culture of the work environment. These four main factors appear to be interconnected, thus influencing each other in a nonlinear fashion (Ipe, 2003). The alignment of CEOs' strategies in IDC with these factors warrants investigation. Wang and Noe's (2010) review demonstrates that these factors developed further into individual, interpersonal and team characteristics; perceptions related to knowledge sharing; and organizational context. However, these authors suggest the need for further research into, among other things, environmental factors related to the organizational context: culture/climate, leadership characteristics and context (online, face-to-face). Interestingly, they themselves address the reasons for sharing or not sharing knowledge, such as impression management and attribution, power and social costs.

While not sharing knowledge does not appear to be an intentional behavior but rather stems from mistakes, accidents or ignorance, knowledge hiding does involve intentional behavior. The latter is a separate construct created by Conelly *et al.* (2012), who define it as an intentional attempt to withhold or conceal knowledge that has been requested by another person (p. 65). In their bibliometric analysis of knowledge hiding in business organizations, Di Vaio *et al.* (2021) underscore its potentially detrimental effect on relationships between teams, creativity and strategic performance, as well as point toward the influence of leadership on sharing and hiding knowledge. Although the antecedents and consequences of knowledge hiding have been researched in business settings (Caputo *et al.*, 2021; Chatterjee *et al.*, 2021; Zhang *et al.*, 2020), there remains a relative dearth of insights on knowledge hiding in nonprofit organizations generally and IDCOs specifically.

### 2.2 Context, systems thinking

Since the process of knowledge sharing is influenced by the environment in which it takes place, closer examination of its content is critical. To this end, the construct "context" proves to be helpful. Schalock *et al.* (2020) define context as "a concept that integrates the totality of circumstances that comprise the milieu of human life and human functioning" and demonstrate its applicability in a multilevel model – that is, in the primary process, at both the organizational and the systems level. In their aforementioned knowledge-creation theory, Nonaka *et al.* (2000) state that a shared context is imperative to knowledge sharing at an organizational level. This shared context ("Ba") consists of physical space (e.g. the office), virtual space (e-mail) and mental space (shared ideas). Konno and Schillaci (2021) recently reexamined knowledge-creation theory to assess its value to innovation management in the era of Society 5.0 ("super smart society"). They purport that social innovation in contemporary society requires the exchange of intellectual capital beyond the boundaries of organizations. To this end, they propose open innovation enabled by key players' (enterprises, public sector, academics, user community) application of the SECI model. While all key players internally design their own means through which to apply the SECI model, they must all acknowledge a common purpose, which serves as Sharing "Ba" (open place, dynamic context). Consequently, internal and external systems are connected. Konno and Schillaci (2021) put forward living labs, innovation centers and future venues as examples of such intellectual capital open ecosystems.

To gain a better understanding of the context of knowledge processes, we have followed the recommendation of Best and Holmes (2010) to apply the perspective of systems thinking. In contrast to linear thinking, which focuses on the components themselves, systems thinking involves focusing on the relationships between system components (Monat and Gannon, 2015). Within a systems-thinking approach, the organization is perceived as part of a larger system that is shaped by culture, structures, priorities and capacities. Given that changes to one part of the system can influence other parts of the system, the system is dynamic and constantly changing (Best and Holmes, 2010). In line with Duryan *et al.* (2012, 2014), we perceive IDCOs to be complex systems characterized by three levels. IDC operates at the macrolevel, IDCOs at the meso level and the primary process via which professionals care for and support persons with intellectual disabilities at the microlevel. As the focus of this study is on IDCOs, following Greenhalgh *et al.* (2004), we conceptualize all of the stakeholders within the organization as well as organizational aspects as belonging to the internal context, while stakeholders and phenomena (e.g. the labor market) at the macrolevel are perceived as belonging to the external context.

Within the field of health care, systems thinking has proven to be valuable in terms of health-promoting practices (Naaldenberg *et al.*, 2009), supporting decision-making in IDC (Duryan *et al.*, 2014) and advancing evidence-based practice (Augustsson *et al.*, 2019). While reflecting on systems thinking in education, Gibbs *et al.* (2021) underline the necessity to shift the focus away from the intervention itself toward the specific context in which it is applied, including leadership, the delivery system, landscape and cultural and political norms, before identifying the other requirements in the system. In accordance with Best and Holmes (2010), we investigate the nature of evidence and knowledge, leadership, networks and communications within the organizational context.

### 2.3 Leadership

In line with our focus on the role of CEOs in knowledge management, leadership proved to be a key component of our theoretical framework. Within theory on knowledge creation (Nonaka *et al.*, 2000), the important role played by senior management in organizational knowledge creation is described in terms of four tasks:

1. providing a knowledge vision;
2. developing and promoting knowledge assets (inputs, outputs, and as moderators of the knowledge creation process);
3. creating a shared context in the form of unifying physical space (e.g. the office), virtual space (e-mail) and mental space (shared ideas); and
4. promoting the continuous spiral of knowledge creation.

Besides the key role played by senior management, these authors also acknowledge the crucial role played by middle management.

With respect to the role of leaders in knowledge management, Lakshman (2007) developed a grounded theory of organizational knowledge leadership consisting of the following components relating to organizational performance and leadership perceptions:

- leaders' realization of the significance of knowledge management;
- leaders' realization of the importance of customer-focused knowledge management;
- leaders' effective use of technology and people in establishing knowledge networks;
- leaders providing opportunities for all employees to obtain information from internal and external customers by using information networks; and
- leaders' personal participation in the process of sharing information via day-to-day activities and dedicated information networks.

According to Lakshman (2007), personal participation by CEOs in knowledge management might constitute the crucial link between knowledge management and leadership. To this end, he introduced the notion of "organizational knowledge leadership."

Finally, to attune to the role of CEOs in the context of nonprofit organizations, the thematic framework presented by Deveau *et al.* (2019) appears to be useful. This framework posits that there are two sources of opportunities and challenges for senior managers in IDC:

1. intraorganizational: understanding and influencing staff members' work experiences, culture and practice; and
2. extraorganizational: government policy, service commissioners, care quality commission and advocates.

## 3. Method

### *3.1 Study setting*

This exploratory study was conducted among 11 CEOs of IDCOs in The Netherlands, as this country provides a context that has recently witnessed major changes in the care system. Moreover, the relatively small size of this system allows for in-depth insight into both the key players and the interaction between the macro and the organizational levels. Most of the 142,000 residents of The Netherlands who have intellectual disabilities receive support from one of approximately 170 specialized service organizations (Vereniging Gehandicaptenzorg Nederland, 2019). The working area of most of these organizations is restricted to a specific region, and a few operate throughout the entire country. Their size ranges from under 100 to over 10,000 service users and staff. Regardless of size, all of these organizations have several locations, scattered over a smaller or larger area. Most organizations provide services to persons whose disabilities range from mild to profound, so the nature and amount of support provided ranges from several hours a week to 24/7 staffed residential care customized to specific target groups. Almost all IDCOs in The Netherlands belong to the Dutch sector organization VGN (https://www.vgn.nl/leden), which represents their interests in national policy

discussions across a broad spectrum of themes such as quality, governance, financing and knowledge (https://www.vgn.nl/themas). Despite this unified representation, IDCOs compete for the provision of services, particularly at the local and regional levels. This competition has increased due to a major change in the Dutch care system. Prior to 2015, the central government was in charge of access to care and support for all long-term care users, whereas now it is the local municipality which finances care and support for people who require low-level care, while the central government does the same for those who require high-level long-term care (Kroneman *et al.*, 2016).

### 3.2 Study design and sample

A qualitative interview study was conducted, which facilitates obtaining rich information and deeper insight into phenomena, therefore reflecting our aim of studying knowledge management among CEOs within the context of the organizations they run. The CEOs of Dutch IDCOs pursue their own knowledge policy, to which they attach varying degrees of priority. Data were, therefore, collected through individual in-depth, semi-structured interviews with the CEOs of a number of these organizations. Respondents were recruited in three stages. In the first stage, we drew up a list of CEOs who were known to be actively involved in the development and application of knowledge management in their own organization, as this would enable us to gain insight into their organizational knowledge leadership. Also, they would be able to provide first-hand background information. The criterion of active involvement in knowledge management was based on the work of a national group of experts on knowledge processes and on our own knowledge of the field of IDC in The Netherlands. Using publicly available information, in the second stage, we further narrowed down our selection to organizations that had an earmarked budget for activities that center on sharing and application of knowledge and which participated in collaborative relationships (e.g. with other care organizations or knowledge institutes). The criterion of participating in collaborative relationships follows a recommendation of Best and Holmes (2010) that networks should be included when studying knowledge transfer. Based on this selection of organizations, in the third stage, a purposive sampling strategy (Etikan *et al.*, 2016) was used to ensure variety in the background of the CEOs recruited and the characteristics of the organizations they manage. In line with Van der Scheer (2013) and using publicly available demographic and professional information on the CEOs, we sampled respondents based on educational background (both general and specific to IDC), gender and length of time working as CEO in the current organization. For organizational characteristics, we also used publicly available information for our sampling strategy, taking into account the size of the organization the CEO manages; the organization's geographical location; the period for which a knowledge management strategy had been formulated; and whether or not professionals work in autonomous teams.

In an iterative process, the researchers analyzed data, recruited participants and conducted interviews, thereby enabling purposive sampling based on data gathered from the interviews that had already been conducted. The sample size was guided by data saturation (Guest *et al.*, 2006). After interviewing eleven CEOs, the research team (MK, EF, MW and PE) concluded that no additional information relevant to the sample had emerged since intermediate analyses showed that interviewees had not mentioned new motives or strategies. The key characteristics of the sample are described in Table 1.

### 3.3 Data collection

After ethical approval was granted by the Ethics Review Board of Tilburg University (EC-2017.80), recruitment of respondents began. The researchers sent an information and consent letter to all 13 CEOs who were invited to participate in this study. Eleven agreed to participate and signed the informed consent form. The other two CEOs indicated that participation did not fit in with their priorities. The first author (MK) conducted all of the semi-

**Table 1** Sample characteristics ($n = 11$)

| CEOs | | Organizations | |
|---|---|---|---|
| *Variable* | *Spread* | *Variable* | *Spread* |
| Gender | 6 (male); 5 female | Size in service users | 1 (<1,000); 6 (1,000–3,000); 4 (>3.000) |
| Age | 2 (< 55 ); 5 (55–59); 4 (>59) | Size in employees | 2 (<1,000); 4 (1,000–2,000); 2 (2,000–3,000); 3 (>3,000) |
| Highest educational level | 2 (university of applied sciences); 8 (university); 1 (PhD) | Corporation | 4 (yes); 7 (no) |
| Field of education | 9 (care-related); 2 (noncare-related) | Autonomous teams | 6–7 (yes); 3–4 (no) |
| Fields of work experience | 2 (IDC only); 5 (IDC and other care sectors); 3 (university of applied sciences); 1 (business); 1 (education); 1 (public administration) | Region | 3 (north); 5 (central); 3 (south) |
| Number of years in current position | 5 (<5); 1 (5–10); 5 (>10) | No. of years of formal knowledge policy | 3 (<5); 6 (>5); 2 (no formal knowledge policy) |

**Note:** IDC: intellectual disability care

structured interviews between February and August 2018 at a location chosen by the interviewee: their workplace or another convenient location (e.g. a hotel lobby). Average duration of the interviews was 93 min (range: 78–101 min). The individual interviews were audio-recorded and transcribed verbatim. The full transcripts were sent to the interviewees, all of whom approved the data as presented. At this stage, the background data on the CEO and the organization that had previously been gathered from the publicly available information were checked and supplemented by the CEO where necessary.

As the aim of this study was to investigate the motives and strategies of CEOs in stimulating knowledge processes among professionals in their organizations, the first part of the interview guide (Table A1, Appendix) was based on insights about knowledge management. The goal was to establish a dialogue with the participants, using the interview guide to ensure that the main topics were discussed while remaining open to any other relevant issues that participants might raise. As such, attention was paid to each CEO's perception of knowledge (Weggeman, 2007) and to possible differences in professionals' processing of explicit and implicit knowledge (Nonaka *et al.*, 2000). Following Greenhalgh *et al.* (2004), the researchers also collected information about the professional background and motives of the CEOs. They were asked extensively about their motives and strategies, as well as the underlying reasons for these strategies.

### *3.4 Analysis*

Aiming to benefit from the insights obtained at each consecutive phase of data collection, data were collected and analyzed in an iterative process. An inductive, thematic approach (Braun and Clarke, 2006) was taken for the analysis of the data. First, the interview transcripts were uploaded to ATLAS.ti (Muhr, 2005), a software package that supports the coding process. After familiarizing themselves with all of the transcripts, two researchers (MK and EF) independently coded the first two interviews using a bottom-up approach. The codes were then discussed in an iterative process until consensus was reached (Bowden, 1996). The other interviews were coded by the first author (MK), while the second author (EF) coded 20% (Kratochwill *et al.*, 2010) of each of these interviews to ensure reliability. Again, these codes were jointly discussed until consensus was reached. All of the codes were then checked by the second author (EF) for clarity and possible overlap, resulting in adjustments to some of the codes following a discussion between the first and second authors. The first author (MK) drew up an initial proposal for clustering the codes into categories using an inductive approach. All of the authors (MK, EF, MW and PE) discussed the clustering in an iterative process until consensus was reached. The clusters and subclusters were based on bottom-up emerging themes such as identification of areas of

concern (motives) and acknowledgment and deployment of knowledge holders (strategies). At the next stage of the bottom-up analysis, the authors outlined internal and external context as the relevant framework for analyzing the motives that emerged from the data provided by the CEOs.

The final categorization was conducted into two stages. At the first stage, the first author (MK) analyzed all of the data separately for each respondent, and at the second stage, this author performed an overall analysis of the data. At both stages, the second author (EF) was involved in the categorization, and where differences arose, they were discussed until consensus was reached. A description was then provided for all of the themes, and a final check involving all of the authors was conducted.

## 4. Results

### *4.1 Motives*

In analyzing what motivated CEOs to stimulate professionals in their organization to share and apply knowledge, motives related to both the internal (the organization) and the external context (the sociopolitical environment) were identified. The motives related to the internal context were the CEOs themselves and the professionals in their organization; the motives related to the external context were policy and other motives (e.g. the labor market, membership in collaborative partnerships). Figure 2 visualizes an overview of the results: the categories of motives and knowledge strategies.

Overviews of categories of motives for stimulating professionals' sharing and application of knowledge are presented in Table 2 (motives in the internal context) and Table 3 (motives in the external context).

*4.1.1 Motives related to the CEOs themselves (1).* The first group of motives concerns CEOs' background, their perceptions of knowledge, and how they perform their task. First, analysis indicates that the background, drives and perceptions of CEOs (1.1) are a major component of their motivation to improve the knowledge processes in their organizations. Several CEOs referred to personal variables: their own personality traits, such as curiosity, and their personal and/or professional background in IDC:

> [. . .] I started as a supply worker [filling in for other members of staff]. Yes, I did that for three years, then worked for two years at a day care center, and that got me involved in the sector. At a certain point you start responding emotionally to residents, clients and visitors at a day center. That makes you think: it's important that they should be able to live with dignity and I have the feeling that I can contribute to that. (CEO 2)

**Figure 2** Motives and strategies to stimulate the sharing and application of knowledge

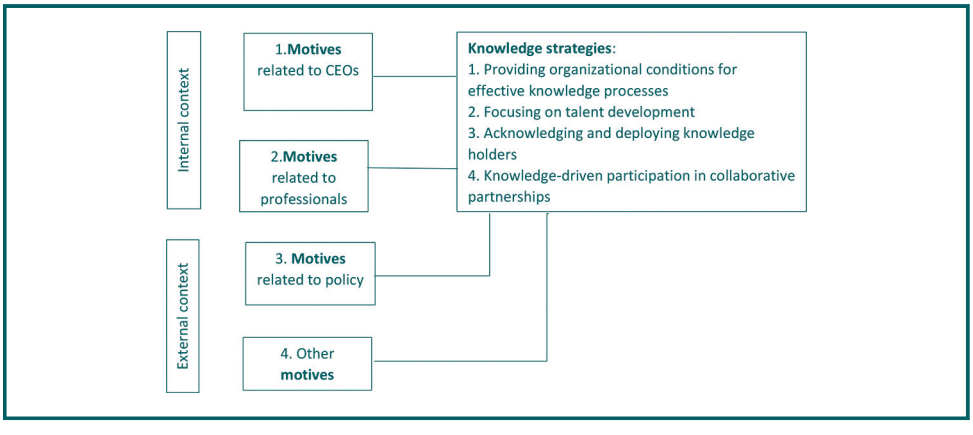


**Table 2** Categories of motives in the internal context for stimulating professionals' sharing and application of knowledge

*1. Motives related to CEOs*

1.1 Background and perceptions of CEOs

- *Personal variables:* personal characteristics, personal and professional background (having a family member with an intellectual disability or a former job in education)
- *Motivations*
- *Perceptions of knowledge:* definition of knowledge; availability of implicit and explicit knowledge; importance of scientific knowledge†; function of knowledge (contributes to quality)
- *Perceptions of knowledge sharing:* on learning (conditions); design and conditions of knowledge sharing (dialogue); importance of knowledge sharing; sharing knowledge with the outside world (open source)
- *Perceptions of collaboration:* on multidisciplinary collaboration within and between organizations
- *Other perceptions:* on the role of knowledge in care development; the relationship between knowledge and professionalism (professional behavior is based on knowledge); managerial control (facilitating bottom-up development)

1.2 CEOs task performance

- *Identifying areas of concern:* innovation and implementation of knowledge*,†; absence of a knowledge culture*; knowledge sharing*,†; level of equivalence of knowledge sources*,†
- *Strategic planning role* (specialization on complex care needs of clients)
- *Initiating role* (company trainings)
- *Responsibility for quality* (signals that quality improvement is required)
- *Role as employer* (avoiding staff layoffs after budget cuts)

*2. Motives related to professionals*

2.1. Basic knowledge and competencies

- *Required knowledge base and competencies**,†
- *Required motivation, attitude, readiness for action**,†

2.2 Specific knowledge and competencies

- *Required knowledge about complex care needs of clients (with challenging behaviors)**,†

2.3 Education and training

- *Aligning the design of learning with professionals' needs**,†

**Notes:** Examples given in parenthesis. * = cluster contains codes identifying areas of concern; † = cluster contains codes on challenges

**Table 3** Categories of motives in the external context for stimulating professionals' sharing and application of knowledge

| *3. Motives related to policy* | *4. Other motives* |
|---|---|
| 3.1 National policy on disability<br>■ *Focus on involuntary care**<br>■ *Focus on inclusion**,†<br>■ *Laws and regulations*<br>3.2 Policy of other organizations providing care and support for persons with intellectual disabilities<br>■ *Policy decisions on client target group*<br>■ *Autonomy of knowledge policy**,† | 4.1 Labor market shortage*,† (quality of care threatened by lack of qualified professionals)<br>4.2 Insufficient educational provision (lack of state-of-the-art knowledge on IDC)<br>4.3 Participation in collaborative partnerships* (eye-opener to CEO)<br>4.4 Negative public image of organization (caused by incidents) |

**Notes:** Examples given in parenthesis. * = cluster contains codes identifying areas of concern; † = cluster contains codes on challenges.

Commitment to IDC and personal and/or professional background influence each CEO's mindset when it comes to knowledge processes in IDC. This mindset covers a broad spectrum of perceptions about knowledge, knowledge sharing, collaboration within and between organizations, the role of knowledge in the development of care, the relationship between knowledge and professionalism and managerial control. First, this is evidenced by the way CEOs explain their motives in terms of the added value of knowledge to the performance of their organization (quality of care/quality of life) and their responsibility in these knowledge processes. One CEO described knowledge as "the package an employee brings with them [to the job] and that enables them to act" (CEO 3). Another CEO said:

> I think you owe it to your clients. I really think that if you are admitted to a care organization in the Netherlands, you should be able to count on receiving state-of-the-art support, guidance, treatment, whatever. So really I think that it's a task for the care organization. (CEO 9)

Second, the motives described by CEOs give insight into how they perform their task (1.2): the issues they identify as areas of concern, the strategic objectives they formulate, the initiatives they take and the responsibility they feel for delivering quality care and as employers.

The areas of concern identified by CEOs reveal a range of different motives for stimulating professionals' sharing and application of knowledge. When asked about the major challenges with respect to knowledge in his organization, one CEO answered, "It's mainly about gathering knowledge, sharing knowledge and applying knowledge" (CEO 6). In addition to these knowledge processes, CEOs also referred to the challenges presented by the organizational culture. The absence of a knowledge culture was mentioned in several interviews. For example, "The culture is not always knowledge-driven. So you really need to make a deliberate effort to form a clear picture of what people know now and what they actually need to know to do their job well" (CEO 1). Another CEO pointed out the inequivalence of knowledge sources in his organization:

> I also want to mention equality and how valuable it is. In many care organizations there is no equality: the doctor or the psychologist or the psychiatrist is always a cut above the rest. And that's why those processes always run so badly. I really think it's a theme within our organization: how come people focus on their position and their power instead of equality and open dialogue? (CEO 2)

Next, the aims that CEOs formulate for their strategy and initiatives also reveal motives for improving knowledge processes. In several cases, they relate developing a knowledge strategy to the overall business strategy of the organization, as the following quote shows: "Ultimately [it's about] the motivation behind the insight, that there is an explicit choice to continue with the hardest problems and in different areas also the search: so is it going well enough?" (CEO 4). This CEO thus explains that specialization in complex care needs involves a constant search of whether the organization provides quality care to its clients by using state-of-the-art knowledge.

Other CEOs explained their own leading role in determining the vision and strategy of their organization in terms of playing an initiating role (by starting a business training program, setting up a network, explaining and introducing a method). Finally, CEOs mentioned their responsibility for the quality of care as a motive for stimulating the sharing and application of knowledge: "Based on signs that things are not going well or are lacking in our healthcare practice. But whether that is a reluctance to act . . .? So there are often reasons why I say: we should do that [adopt a certain strategy]" (CEO 8).

*4.1.2 Motives related to professionals (2).* A second group of motives identified in the internal context is *motives related to professionals*. In the first place, the CEOs mentioned motives related to professionals lacking the required knowledge base and competencies, motivation, attitude and readiness to take action (2.1). They recalled how professionals are expected to change in line with the current perspectives on IDC, for instance, by taking on the new role of empowering service users instead of simply taking care of them, and the effect this has on how professionals should approach their job:

> The most important motive is self-responsibility. Look, if you want to give control to clients, then you should give more control to the employee. And while that may have been agreed verbally, it hasn't yet become a reality. Having done that program for a couple of years, now it should be time to say: the employee has control. Because it's in their relationship with the client [that empowerment needs to happen]. And they should be given all the space they need to implement it and every opportunity for personal development. (CEO 11)

Besides professionals lacking basic knowledge and competencies, CEOs mentioned their lack of specialized knowledge and competencies about the complex care needs of particular clients (2.2), such as persons with profound intellectual and multiple disabilities and/or challenging behaviors, possibly resulting in inadequate provision of professional support and increased risk of incidents. As illustrated by the next quote, respondents perceive the role of professionals in achieving quality of care as being key and therefore as a legitimation of their approach to knowledge management:

> Then, of course, your start by explaining your vision of why knowledge management is on the agenda, which also involves hiring people and spending about eighty percent of your money on that. They then get to work, with what you hope is knowledge in the broadest sense of the word, good skills, attitude and abilities. And that is proving to be a challenge at the moment. (CEO 1)

Another CEO also stated that awareness of the added value of professionals motivated the organization to improve the knowledge processes to enhance professionalism within the organization itself: "That people [within the organization] wonder: where do we stand when it comes to knowledge, when it comes to the added value an organization brings to what our people are doing?" (CEO 10).

Finally, their motives concern education and training (2.3): ways in which their organization is able to design learning to suit the needs of its professionals and thus share the organizational body of knowledge with them. According to one CEO, the big question is: "Do we have the means at our disposal to make sure that people who do not read well, who do not absorb knowledge well, and who have difficulty learning are still able to make it on their own?" (CEO 2).

*4.1.3 Motives related to policy (3).* In addition to categories of motives arising from the internal context, we also identified categories that arise from the external context of CEOs' care organizations. In this sociopolitical context, a first group of motives relates to policy (3). First, the respondents state that their knowledge strategies are stimulated by the national long-term care policy in The Netherlands (3.1), which is currently focused on diminishing involuntary care and stimulating the social inclusion of people with intellectual disabilities. For example, "This could also be about changes in the law and regulations, so if there is a new Care and Coercion Act, we need to develop knowledge in response to those changes, so you could say it's a matter of regulation and compliance" (CEO 8). Second, they mention the policies of other IDCOs (3.2), which in some cases come about as a result of national policy. A few CEOs pointed to the change in the national IDC system and how other IDCOs then responded by deciding to specialize in care for a target group of clients. These policy decisions influenced their overall business strategy to also focus on specific groups of clients:

> But what if everyone said "we're here to help the most difficult target group" and actually were, then those clients would be served everywhere, and they wouldn't have to come to us from all over the country. So it also has to do with the policy choices made by other organizations. (CEO 4)

*4.1.4 Other motives (4).* Several other motives related to the external context were identified. The most frequently mentioned factor was the labor market shortage (4.1), which motivated several CEOs to improve and explicate their knowledge processes with the aim of making knowledge a "unique selling point" to attract incoming professionals:

> So we make a conscious choice to free up money to spend on our employees, and of course there's a commercial side to that, but it also makes us an attractive employer because you know you're not going to be sent in to deal with a difficult target group empty-handed. So there's definitely a labor market aspect to it too. (CEO 7)

Another motive is found in the insufficient educational offerings for people entering the care profession (4.2): CEOs often see this as insufficient, resulting in a lack of relevant knowledge among their employees. This has led them to develop training activities within the organization: "[. . .] there is very little knowledge within educational institutions about current knowledge and expertise present in care organizations" (CEO 5).

Participation in collaborative partnerships (4.3) has been another factor motivating CEOs to improve the knowledge processes in their organizations. One CEO became increasingly aware that her organization did not meet the evidence-based knowledge criteria set by the academic collaborative center her organization is affiliated with:

> Often it's also about bridging the gap between what exists on paper and whether it is being used in reality. That can require a much greater effort than we realized when we started. But for me it's a constant wake-up call to share these things and to make sure that professionals are able and willing to put them into practice. (CEO 11)

## *4.2 Strategies*

Four strategies were identified among the CEOs to deliver on their aim of stimulating the sharing and application of knowledge:

1. providing organizational conditions for effective knowledge processes;
2. focused attention on talent development;
3. acknowledgment and deployment of knowledge holders; and
4. knowledge-driven participation in collaborative partnerships.

Table A2 (Appendix) provides an overview of these knowledge strategies and their various categories/subcategories, which differ in size. A selection of these are discussed below, accompanied by numbers that refer to the table. Our focus here is on the main categories and on those typical for the context of IDCOs, like explication of tacit knowledge and application of experiential knowledge, heterogeneity of service users and spread of locations in a smaller or larger area.

*4.2.1 Providing organizational conditions for effective knowledge processes (1).* In focusing on *explication and standardization of methods* (1.2), CEOs aim to create transferable and organizational knowledge. To this end, for example, CEOs assigned psychologists the task of formulating care pathways in which the knowledge and methods they used in dealing with specific target groups are shared with direct care staff. In another case, a CEO initiated research with the aim of explicating a specific care method. Hearing professionals describe the mechanisms of a method as "doing the usual" triggered the CEO to take action: "Together with another organization with much the same working method, we have commissioned a number of university researchers to provide a description of what "doing the usual" involves" (CEO 9).

CEOs also mentioned pursuing standardization, i.e. using the same methods, care pathways and underlying attitude at all of the organization's locations instead of using a variety of methods depending on personal and local preferences. This is a way to stimulate professionalism and quality of care:

> [. . .] if you think you should be or become a more professional organization, how do you do that? Well, eighty percent of our work is done by people. So if you are supporting clients with issues on the autism spectrum in city A, we also have people with the same issues in city B. How do I make sure that the staff in city B have a similar view on supporting them as the staff in city A? And we have over four hundred locations. (CEO 10)

*Facilitating the availability of knowledge within the organization* (1.4) is a strategy used by the CEOs of many organizations, using both online [information technology (IT)] and offline resources. Online data and explicit knowledge are shared. To this end, one organization has introduced an integrated digital knowledge platform containing digital client files, links to an online library, a digital learning system and communities. The platform is accessible 24/7 to all employees on their mobile phones. In this and other organizations, a conscious effort is made to use language that all direct support staff can understand.

To facilitate the sharing and, therefore, the availability of various kinds of knowledge (tacit and explicit, personal and organizational), CEOs called on the organization to set up face-to-face (thematic) meetings, task groups, knowledge networks, conferences and working visits. In some organizations, the CEO has appointed an internal knowledge coordinator to handle a range of activities: updating explicit knowledge, consulting on and supporting the implementation of new policies, collecting questions from staff and sharing knowledge on certain themes with staff. In addition, knowledge holders have been made easier to find, e.g. through digital communities:

> Well, people were either very reluctant to act or very convinced of their own abilities. And on different themes [. . .] we have a number of specialists. On medication security, for example. That is something we've researched extensively. The two employees who did that research managed to organize a meeting on short notice to tell people about their findings. And they were surprised by the number of people who participated. There was clearly a real thirst for that knowledge. (CEO 5)

CEOs also act in line with personal *guiding principles for sharing/not sharing knowledge externally* (1.6). One such principle is that only knowledge that is evidence-based can be shared. The interviews with some CEOs reflected the national context in terms of not sharing knowledge, whereas in a free market raising its external profile through knowledge can give a care organization a competitive edge. Plus, in contributing to the national and indeed

international aim of achieving greater inclusion of people with intellectual disabilities, sharing knowledge is also perceived as a duty toward society.

*4.2.2 Focused attention on talent development (2).* The CEOs also spoke about *designing learning to ensure its compatibility with practice* (2.2). They see this as a necessity due to the learning style of their employees, most of whom have secondary vocational level education. Practice-oriented learning, learning from incidents and reflection appear to be commonly used techniques. In one organization, for instance, it is part of the policy to include senior staff members in the team involved with on-the-job coaching.

Besides aligning the design of learning with the needs of employees, the CEOs also aim to influence attitudes toward learning by actively *motivating staff to acquire new knowledge* (2.3). The CEOs mentioned that their organizations do this by means of content-based leadership to strengthen the sense of responsibility, by updating the job classification system and by using intrinsic or extrinsic motivation. This starts at the earliest stages when new staff are recruited:

> These days you're looking for people with a positive basic attitude, people you want to invest a lot in, rather than students from higher professional education who are actually thinking: I just want to find the nicest job as fast as possible. So you really need to keep your eyes peeled when you're selecting candidates. (CEO 1)

CEOs also focused on *knowledge level and knowledge exchange when making management decisions* (2.5), thus avoiding risks to quality of care due to the arbitrariness of individual professionals (as the quote by CEO 10 on standardization likewise shows). To this end, the knowledge requirement is determined by the organization's policy and directed by the multidisciplinary team, the psychologist or the manager, with the aim of ensuring client safety (e.g. from sexual harassment or aggression). One example of how to enhance knowledge exchange is a mobility policy: moving team members around to allow fresh input and enable them to keep an open mind. A CEO explains why they take this approach:

> You want stability in the teams, but you don't simply want to create a kind of status quo – a "this is how we do things" attitude – where there is no longer any interaction. So if you want to retain what we call the sense of wonder, you need to facilitate it effectively. And with that in mind, having a change in a team once a year is very healthy. (CEO 4)

Finally, CEOs aim to influence the *organizational culture*, to become *more knowledge-driven* (2.6) by using social innovation. For example, the lean method is used to improve collaboration within the organization, e.g. in the primary process between the staff, the service user and their relative(s).

*4.2.3 Acknowledgment and deployment of knowledge holders (3).* The third strategy aims to acknowledge relevant sources of knowledge, to make it clear where knowledge is located and how this knowledge can be used. Most of the CEOs emphasized the importance of acknowledging *the key* role *of psychologists in knowledge transfer* (3.1), for instance, by assigning a psychologist to each client as a responsible health practitioner who monitors whether the care process is being carried out properly and in line with the latest insights. As previously mentioned, CEOs described psychologists as being in charge of developing care pathways. They also mentioned designating *persons with intellectual disabilities as knowledge holders* (3.2), for example, by having them fulfill the role of experiential expert in an educational context:

> Both Regional Training Centers [for lower vocational education] and universities of applied sciences [for higher professional education] organize guest classes, usually in the first year when students are still a blank slate and have yet to choose their specialization or their internship [. . .] And then our clients come along to tell them what the intellectual disabilities sector entails. And they do it so well. (CEO 11)

Another category entails *appointing researchers in the organization* (3.3), aiming to establish a stronger focus on theoretical components of providing care and support and getting more professionals involved in research projects.

Several CEOs focused on *cocreative collaboration between knowledge holders* (3.4), a process that includes professionals, persons with intellectual disabilities, their families and sometimes also researchers. Equivalence among knowledge sources is another guiding principle mentioned. Although this is a difficult balance to achieve, one CEO recalled a good practice based on cocreative use of knowledge care provision for a person with challenging behavior. In this case, the parents provided valuable insights into the client and his life story, offering suggestions on how best to support him. The practice team supported the client very intensively:

> [They] talked a lot about these things with [the client's] mother. And that gave rise to something really wonderful. They have a psychologist over there. [. . .] We managed to raise him up from a very low point and into a very good support practice where all three of them are equally important. And it's like together they have been elevated to a higher level. (CEO 2)

*4.2.4 Knowledge-driven participation in collaborative partnerships (4).* Several categories can be distinguished for the knowledge partnerships the CEOs' organizations participate in and the aims of those partnerships. Nearly all CEOs reported *collaborating with other care organizations* (4.1). Some of these networks center on innovation in care (e.g. promoting e-health), others focus on aspects of health care (sexuality, palliative care) or on specific target groups (like persons with challenging behavior or profound and multiple intellectual disabilities). These networks provide opportunities for all kinds of professionals to connect and broaden their outlook, for example, by presenting good practices and openly sharing knowledge about complex cases.

In their efforts to create knowledge (e.g. by explicating and evaluating care pathways or methods), most CEOs indicated that their organizations were *engaged with universities and universities of applied sciences* (4.2). Through such collaborations with knowledge institutes, CEOs hoped to facilitate the transfer of evidence-based knowledge directly to professionals in their organizations.

Finally, many of the CEOs referred to *collaboration with educational institutions* (4.3), where reciprocity is an important principle. As one CEO put it, "Lower vocational education can learn things that will benefit the content of their curriculum and the healthcare organization can learn from educational aspects" (CEO 8). CEOs also mentioned other areas that benefit from collaboration, such as recruiting future professionals, educating their own staff and service users and learning about innovation.

## 5. Discussion

### *5.1 Reflection on the main findings*

In our study, we investigated the motives and the strategies of CEOs from Dutch IDCOs who aim to improve and innovate the care and support they provide for persons with intellectual disabilities by sharing and applying knowledge. With respect to the first research question, that is, their motives for engaging in knowledge management, we found that these center primarily on the internal context (aspects related to the CEOs themselves and the care professionals within their organization) as opposed to the external context (like the sociopolitical environment). We discerned many separate motives in the internal and external contexts (Tables 2 and 3), yet in reality, these motives interplay and accumulate within the multilevel system. For example, insufficient educational provision in IDC (macrolevel) is related to CEOs' responsibility for quality and the challenge of providing professionals with the required knowledge base and competencies in IDCOs (meso level).

The majority of motives for stimulating knowledge processes appeared to be related to the CEOs themselves, most notably their personal and professional background, how they perceive

knowledge processes and how they perform their task, which involves identifying areas of concern (e.g. about the knowledge of professionals and the labor market). These motives urge CEOs to adopt a leadership role with regard to knowledge: articulating a vision, analyzing and interpreting the internal and external context of their organization and advocating change.

With regard to the second research question, which concerns strategies, we found that CEOs adopted four strategies in response to these motives:

1. providing organizational conditions for effective knowledge processes;
2. focusing attention on talent development;
3. acknowledging and deploying knowledge holders; and
4. knowledge-driven participation in collaborative partnerships.

Out of these four strategies, the third is the most remarkable. Above all, this strategy reflects the specific character of IDC, including the recent empowerment of people with intellectual disabilities and the application of their experience-based knowledge.

Our study also revealed that these strategies within the same organizational context are used in combination and that this approach enables them to complement and reinforce one another. For instance, a care pathway developed in one organization (*providing organizational conditions for effective knowledge processes*) was subsequently validated by external researchers (*knowledge-driven participation in collaborative partnerships*) and became part of the organizational curriculum (*focused attention on talent development*).

To what extent are our findings transferable to other countries with other payer arrangements around IDC? Organizational issues (e.g. standardization of knowledge in all locations) demand much attention both in The Netherlands, where most IDC is provided through general and specialized IDCOs, and in other countries where mainstream organizations provide community care to their citizens with intellectual disabilities. Also, in The Netherlands, as well as in other countries, the lack of an explicit body of knowledge and bringing together knowledge from different sources are challenging. We, therefore, presume the presented strategies are also valuable for IDC in other countries.

Finally, it is worth reflecting on the relationship between motives and strategies. An additional overall, bottom-up analysis shows that they involve three themes throughout the internal and external contexts:

1. improving both the quality and number of professionals;
2. improving knowledge sharing and application; and
3. increasing the equivalence of knowledge sources.

These three encompass all of the motives and strategies established in this study. However, it is not advisable to perceive the relationship between motives and strategies as linear and causal: rather, motives and strategies should be seen as part of an iterative process in which they interact with one another.

### *5.2 Comparison of the findings with previous research*

When it comes to the motives of CEOs to improve the knowledge processes within their organizations, it is evident that their own perceptions of knowledge are of paramount importance. In conjunction with their active involvement in knowledge management within their organizations, this is indicative of what Lakshman (2009) refers to as "organizational knowledge leadership." We were able to describe CEOs' beliefs, values and roles in greater depth. In doing so, we explicated their added value to health-care organizations, as recently requested by Issel (2020). The internal orientation of the CEOs' motives is

consistent with the fact that the clients of nonprofit organizations are part of the internal context, unlike those of for-profit organizations, who are part of the external context. The CEOs, therefore, demonstrate what Lakshman (2009) calls "customer-focused knowledge management," which is visible in their strategies (Table A2). This table also shows that many strategies involve "knowledge management using socio-cognitive and technological networks," which according to Lakshman (2009), are integral to creating opportunities for all employees to obtain information from customers.

Our results indicate that the CEOs involved in our study are committed to quality improvement, which according to Nieboer and Strating (2012), correlates significantly with transformational leadership. The CEOs also fulfill the role of embedded agents connecting the internal and external worlds of the organization, and an aspect pointed out by Van der Scheer (2013). Like the framework of Deveau *et al.* (2019) indicates, they indeed respond to both intra- and extra-organizational issues. In many cases, the obstacles to knowledge processes appear to be related to the specific context of IDC, such as the tacit character of most of the knowledge as well as the organizations being dispersed across many locations (Nicolini *et al.*, 2008; Farrington *et al.*, 2015).

The four strategy clusters identified with regard to stimulating professionals' sharing and application of knowledge cover the total scope of knowledge management as defined by Karamitri *et al.* (2017): locating, retrieving, sharing, adapting and using knowledge to promote the organizations' objectives. Most of these categories target the sharing of knowledge, while the *application of knowledge developed within the organization* ("innovations") is only mentioned as a separate category by a few CEOs. This is another process worth enhancing by means of a concerted effort. With respect to not sharing knowledge, this was not conceived as a deliberate policy; therefore, we found no indication of knowledge hiding (Conelly *et al.*, 2012).

To process both explicit and implicit knowledge, a combination of IT-based, socially based and HR-driven tools was deployed, as is the case in the broader health-care sector (Nicolini *et al.*, 2008). This enabled us to offer valuable insights into the various ways in which the SECI process described (Nonaka *et al.*, 2000; Konno and Schillaci, 2021) is actually facilitated within IDCOs, including the exchange of intellectual capital within collaborative partnerships. For example, the strong emphasis on on-the-job learning is conditional on socialization. While CEOs aim to create a shared context, they also demonstrate active involvement in developing and promoting knowledge assets, fostering the continuous spiral of knowledge creation and providing a knowledge vision. The CEOs in this study, therefore, appear to fulfill all of the top-management leadership roles described by Nonaka *et al.* (2000). From an overall viewpoint, our results are aligned with the framework for leading transformation to performance (Latham 2013a, 2013b): we established that the forces, facilitators, approaches, behavior, culture and individual leader characteristics all interact.

### *5.3 Theoretical implications*

- Focusing on the specific context within all levels of the system is critical toward examining knowledge processes as well as the interventions for enhancing them. Both systems thinking (Monat and Gannon, 2015) and extended knowledge creation theory (Konno and Schillaci, 2021) have demonstrated their value in assessing this context.
- The theory of organizational knowledge leadership (Lakshman, 2009) proves to be valuable for comprehending the contribution of CEOs to stimulating knowledge processes.
- The "framework for leading the transformation to performance" (Latham, 2013a, 2013b), which identifies key components and points toward their interaction, provides a valuable integrative framework for future research.

### 5.4 Practical implications

- Long-term health-care organizations that are seeking to improve their knowledge processes must respond to a challenging context involving multiple disciplines, knowledge sources and complex systems. This study presents these organizations with an overview of the available strategies, which reflect customer-focused knowledge management and can both serve as a source of inspiration and be adapted to fit specific organizational contexts.
- This study indicates that using complementary strategies enhances their effect, so we recommend that organizations design and implement a coherent set of strategies.
- While improving the quality of care necessitates a combination of evidence-based, practice-based and experience-based knowledge, it is important to ensure that all knowledge holders (including persons with intellectual disabilities and their relatives) are acknowledged and deployed, with a view to enhancing their cocreative collaboration.
- The personal participation of CEOs in (customer-focused) knowledge management is likely to enhance its impact and, in turn, contribute to improved organizational performance.

### 5.5 Limitations

To the best of our knowledge, this is the first study to focus specifically on the motives and strategies of CEOs in stimulating the sharing and application of knowledge in IDC. This exploratory study has harnessed the power of a qualitative methodology to provide in-depth insights into the background of these motives and strategies and how they are related. Despite our efforts to apply a purposive sampling strategy to ensure a variety in perspectives, selection bias may have been a limitation, albeit one which is justified by the use of purposive sampling.

## 6. Conclusions and future perspective of the research

In this article, we reported on the motives and strategies for stimulating the sharing and application of knowledge in the care and support for people with intellectual disabilities. In so doing, the impact of organizational knowledge leadership became visible. Despite facing challenging contexts, the CEOs who participated in this exploratory study nevertheless put considerable effort into both applying sociocognitive and technological networks and customer-focused knowledge management. The latter was primarily evident in the strategy "Acknowledgement and deployment of knowledge holders," which appeared to include persons with intellectual disabilities as knowledge holders, the application of their experience-based knowledge and cocreative collaboration between knowledge holders. In another article (Kersten *et al.*, 2022), we have addressed the contextual factors that influence the execution of these strategies. We recommend follow-up research involving more CEOs, other fields of care and other countries using knowledge creation theory, systems thinking, the theory on organizational knowledge leadership and the framework for leading transformation to performance. Building on our qualitative study, a survey could provide more insights into why certain strategies are adopted over others as well as which organizational and CEO-related motives are important.

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## Author affiliations

Marion Kersten is based at Tranzo, Tilburg School of Social and Behavioral Sciences, Tilburg University, Tilburg, The Netherlands and Vereniging Gehandicaptenzorg Nederland, Utrecht, The Netherlands

Elsbeth Taminiau is based at Tranzo, Tilburg School of Social and Behavioral Sciences, Tilburg University, Tilburg, The Netherlands

Mathieu Weggeman is based at the Department of Industrial Engineering and Innovation Sciences, Eindhoven University of Technology, Eindhoven, The Netherlands

Petri Embregts is based at Tranzo, Tilburg School of Social and Behavioral Sciences, Tilburg University, Tilburg, The Netherlands

## Appendix

**Table A1** Interview topics, related interview questions and sources

| *Interview topics* | *Questions posed to the interviewees* |
|---|---|
| Part A Motivation and thinking frame of interviewee | ■ Why do you work as CEO in the care and support for people with intellectual disabilities?<br>Naaldenberg *et al.* (2009)<br>■ What is your vision on the sharing and application of knowledge?<br>Naaldenberg *et al.* (2009), Best and Holmes (2010), Greenhalgh *et al.* (2004), Weggeman (2007), Nonaka *et al.* (2000)<br>■ What do you see as the biggest challenges to the sharing and application of knowledge in ICD? And what do you see as the biggest challenges to quality of care and quality of life?<br>*Fleuren* et al. *(2004),* Greenhalgh *et al.* (2004), Weggeman (2007) Nonaka et al.(2000) |
| Part B Knowledge policy of organization | ■ What is the policy of your organization on the sharing and application of knowledge?<br>*Fleuren* et al. *(2004),* Greenhalgh *et al.* (2004), Nonaka *et al.* (2000)<br>■ What partnership(s) does your organization share knowledge in?<br>*Based on* Naaldenberg *et al.* (2009), Best and Holmes (2010)<br>■ What are the key elements of your organization's knowledge policy?<br>Weggeman (2007)<br>■ Which person or department of your organization is responsible for the knowledge policy? |
| Part C Background of this knowledge policy | ■ Which characteristics of your organization influence the chosen knowledge policy? To what extent (large degree – small degree – not)?<br>Kersten *et al.* (2018*), Fleuren* et al. *(2004),* Greenhalgh *et al.* (2004)<br>■ Characteristics of the organization<br>■ Characteristics of the professionals<br>■ Characteristics of the management<br>■ Characteristics of the administrative staff<br>■ Characteristics of the team<br>■ Do other characteristics play a role?<br>■ Was there a specific motive? If yes, which one? To what extent (large degree or small degree) did this motivation play a role?<br>*Kersten* et al. *(2018), Fleuren* et al. *(2004),* Greenhalgh *et al.* (2004)<br>■ Can you describe the sociopolitical environment of your organization? Did this environment play a role in determining the policy toward the sharing and application of knowledge? To what extent (large degree or small degree) did this environment play a role? |

(*continued*)

**Table A1**

| *Interview topics* | *Questions posed to the interviewees* |
|---|---|
| | Naaldenberg *et al.* (2009), *Fleuren* et al. *(2004)*, Greenhalgh *et al.* (2004) |
| | ■ Was there a specific motive? If yes, which one? To what extent (large degree or small degree) did this motive play a role? |
| | Naaldenberg *et al.* (2009), *Fleuren* et al. *(2004)*, Greenhalgh *et al.* (2004) |
| Part D Questions about the system that influence the sharing and application of knowledge in the Dutch organizations providing care and support for people with ID | ■ Which stakeholders do you consider to play a role in the sharing and application of knowledge in the Dutch organizations providing care and support for people with ID? |
| | Naaldenberg *et al.* (2009) |

**Table A2** Overview of knowledge strategies to enhance the sharing and application of knowledge

| | |
|---|---|
| 1. Providing organizational conditions for effective knowledge processes | |
| *1.1 Determining the focus of knowledge management*[a] | 1.1.1 Conducting analyses to identify available and necessary knowledge[a] |
| | 1.1.2 Applying guiding principles[a] |
| *1.2 Explicating and standardizing methods*[a,b] | |
| *1.3 Validating and further developing knowledge* | |
| *1.4 Facilitating availability of knowledge within the organization*[c] | 1.4.1 Making knowledge readily understandable and digitally accessible[c] |
| | 1.4.2 Facilitating face-to-face meetings[c] |
| | 1.4.3 Appointing an internal knowledge coordinator[b,c] |
| | 1.4.4 Making knowledge holders easier to find[c] |
| *1.5 Facilitating external sharing of knowledge* | 1.5.1 Physically, e.g. through conferences[c] |
| | 1.5.2 Digitally, through platforms and magazines[c] |
| *1.6 Guiding principles for sharing/not sharing knowledge externally* | 1.6.1 Principle of reciprocity |
| | 1.6.2 External profiling |
| | 1.6.3 Contributing to knowledge expansion/development |
| | 1.6.4 Duty toward society |
| | 1.6.5 Only when the knowledge is evidence-based |
| | 1.6.6 Not sharing knowledge should not be a deliberate policy |
| *1.7 Applying knowledge developed within the organization*[a,b] | |
| ***2. Focused attention on talent development*** | |
| *2.1 Designing learning to ensure compatibility with professional practice* | 2.1.1 Practice-oriented learning[b] (on-the-job) |
| | 2.1.2 Learning from incidents |
| | 2.1.3 Bottom-up knowledge development[b] |
| | 2.1.4 Knowledge development through audits |
| | 2.1.5 Connecting with teams in line with their questions on knowledge |
| | 2.1.6 Reflection[b] |
| | 2.1.7 Coaching teams[b] |
| *2.2 Aligning educational content/curriculum with professional practice*[a] | 2.2.1 Curriculum for specific target group(s)[a] |
| | 2.2.2 Curriculum for new staff |
| | 2.2.3 Curriculum for unqualified staff |
| *2.3 Motivating staff to acquire knowledge* | 2.3.1 Introducing content-based leadership to promote a sense of responsibility[b] |
| | 2.3.2 Addressing intrinsic or extrinsic motivation |
| | 2.3.3 Updating the job classification system[b] |
| *2.4 Facilitating learning and development*[a] | 2.4.1 For professionals[b] |
| | 2.42. For clients[a] |
| *2.5 Guidance in line with knowledge level and knowledge exchange*[b] | |
| *2.6 Promoting a knowledge culture*[a] | 2.6.1 Focus on knowledge sharing[b] |
| | 2.6.2 Focus on cocreative cooperation within the organization[a] |
| *2.7 Organizational preconditions* | 2.7.1 Structuring education |
| | 2.7.2 Budget |
| | 2.7.3 Key principles for learning and development |
| ***3. Acknowledgment and deployment of knowledge holders*** | |
| *3.1 Key role for psychologists as knowledge holders in knowledge transfer*[a] | |
| *3.2 People with intellectual disabilities as knowledge holders*[a] | |
| *3.3 Researchers as knowledge holders* | |
| *3.4 Co-creative cooperation between knowledge holders*[a,b] | |
| *3.5 Guiding principle: equality among types of knowledge*[a] | |
| ***4. Knowledge-driven participation in collaborative partnerships*** | |
| *4.1 Cooperation with other care organizations*[a,c] | 4.1.1 Focused on care/care innovation[c] |
| | 4.1.2 Focused on health-care matters[b,c] |
| | 4.1.3 Focused on specific target groups[a,c] |
| *4.2 Cooperation with knowledge institutes*[a,b] | 4.2.1 Focused on examining your own practice/care programs/methods[a,b,c] |
| | 4.2.2 Directed toward knowledge development |

(*continued*)

| Table A2 | |
|---|---|
| | 4.2.3 Multiple alliances (need for focus if too many) |
| | 4.2.4 Choice of partnership |
| *4.3 Collaboration with educational institutions*[a,c] | 4.3.1 Reciprocity between care organization and educational organization[c] |
| | 4.3.2 Establishing contacts with disability care[a] |
| | 4.3.3 Facilitating basic and continued education of professionals and clients[a] |
| | 4.3.4 Facilitating innovation of care[c] |
| *4.4 Preconditions for successful cooperation* | |

Notes: [a] = customer-focused knowledge management; [b] = strategy exclusively or jointly aimed at promoting knowledge application; [c] = knowledge management using sociocognitive and technological networks


## Corresponding author

Marion Kersten can be contacted at: M.C.O.Kersten@Tilburguniversity.edu