

## POSTER ABSTRACT

# Development of a Model for Implementation and Normalization of Care Pathways – poster

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### ***Introduction***

Care pathways (CPs - including CPs for integrated care) are used worldwide to organize and coordinate care processes. Although multiple implementation theories and many practical examples of CP implementation are available, there is no theory-based specific implementation model for CPs. The aim of this paper is to develop a model for implementation and normalization of CPs.

### ***Theory/Methods***

Our model is developed based on a recent process evaluation of the implementation of a CP in 10 European hospitals, designed according to the Medical Research Council Guidance for process evaluations of complex interventions. It consisted of a quantitative (pre-posttest measurement) and qualitative (in-depth interviews with involved professionals) track. Based on quantitative findings, a ranking of the hospitals was developed showing their respective implementation results. High performance cases were compared with low performance cases, to study differences in implementation process.

### ***Results***

In total 381 patients were included in pre-posttest measurements, and 32 healthcare professionals were interviewed. Relevant factors in the implementation process that could explain differences between the hospitals were: shared goals and teamwork within the team, focus on integration of the CP into daily processes, support from management and use of audit and feedback.

Findings were then mapped in the central concepts of extended Normalization Process Theory. These concepts are capability, i.e. the workability and integration of the CP. The next concept is potential, i.e. the potential within the context to use CP methodology. The third concept is capacity, i.e. the ability within the context to cooperate and coordinate actions. The final construct is contribution, i.e. what people do to implement a CP. Contribution is influenced by the other three concepts. The proposed links between concepts are visualized in our model.

### ***Discussions***

We augmented the results of the process evaluation with our experience in CP research and practice, which led to the distinction of three levels in the model: organizational, team, individual. The interview data partially support this distinction in three levels; the organizational level was less

reported in the interviews, possibly because we did not include (higher) management in the interviews.

### ***Conclusions***

Implementation and normalization of a CP asks for the contribution of multiple involved professionals. A practical CP which can be integrated improves capability. Potential and capacity for implementation must be provided by the context.

### ***Lessons learned***

Teams wanting to implement CPs should invest in shared goals, teamwork and contribution of those professionals involved, including the use of audit and feedback. Clinical data management systems could support the use of audit and feedback.

Because our lessons are visualized in a model, a poster presentation would be the most suitable format.

### ***Limitations***

Our model has to be tested in other patient groups than colorectal cancer surgery. However, we were able to explain the failed and successful implementation in respectively the lowest and highest ranking hospital. We believe this gives credibility to our model.

### ***Suggestions for future research***

We suggest further empirical research, quantitative or qualitative, to establish the relevance of our implementation model.