Implementing a standardized care pathway integrating oncology, palliative care and community care in a rural region of Mid-Norway

Anne-Tove Brenne, MD, PhD*[1,2]; Erik Torbjørn Løhre, MD, PhD*[1,2]; Anne Kari Knudsen, MD, PhD[3,4]; Morten Thronæs, MD, PhD[1,2]; Jo-Åsmund Lund, MD, PhD[1,5]; Nina Kongshaug, MD[1,2]; Marte Nilssen Neverdal, MSc[6]; Kristina Rystad, MSc[6]; Marianne Haug Johansen, MSc[2,7]; Tone Inga Braseth, MSc[2,7] and Stein Kaasa, MD, PhD[3,4,8]

* Contributed equally

Author affiliations:

[1]Department of Clinical and Molecular Medicine, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology, Trondheim, Norway

[2]Cancer Clinic, St. Olavs Hospital, Trondheim University Hospital, Trondheim, Norway

[3]European Palliative Care Research Centre (PRC), Department of Oncology, Oslo University Hospital, Oslo, Norway

[4]Section for Palliative Care, Department of Oncology, Oslo University Hospital, Oslo, Norway

[5]Department of Oncology, Ålesund Hospital, Møre og Romsdal Hospital Trust, Ålesund, Norway

[6]Department of Industrial Economics and Technology Management, Faculty of Economics and Management, Norwegian University of Science and Technology, Trondheim, Norway

[7]Department of Circulation and Medical Imaging, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology, Trondheim, Norway

[8]Institute of Clinical Medicine, Faculty of Medicine, University of Oslo, Oslo, Norway

Corresponding author: Anne-Tove Brenne. Address: Department of Clinical and Molecular Medicine, Faculty of Medicine and Health Sciences, NTNU - Norwegian University of Science and Technology, Postbox 8905, NO-7491 Trondheim, Norway.

Phone: +47 72825642

E-mail: anne.tove.brenne@ntnu.no

Supplementary Material

Educational program for healthcare professionals

When	What	Who	N of participants
Spring 2014	Information meeting	Healthcare professionals from participating institutions	N.A.[a]
	Information meeting	Health leaders of participating municipalities (home care and nursing homes)	N.A.
	Information meeting	Leaders of departments Orkdal hospital	N.A.
	Cancer- and palliative care seminar 1 day (x 2)	Nurses hospital and primary care	52 + 23
	Project group members visit the municipalities	Primary care physicians, primary care nurses and nurse assistants	N.A.
	Internal medicine Orkdal hospital 45 min x 2	Physicians	N.A.
Autumn 2014	Basic palliative care course 5 x 3 h	Primary care physicians and hospital physicians	16
	Kick-off standardized care pathway, municipality and hospital 1 day	Process facilitators Study contacts Cancer nurses from network	39
	Cancer- and palliative care seminar 1 day (x 2)	Nurses hospital and primary care	63 + 43
	Information about the study and the standardized care pathway 2 h (x 5)	Health leaders Process facilitators Study contacts Cancer nurses from network Primary care physicians	5 + 8 + 12 + 10 + 15
	Internal medicine Orkdal hospital 45 min x 3	Physicians	N.A.
Spring 2015	Collaboration seminar 1 day	Leaders Process facilitators Study contacts Cancer nurses from network Healthcare providers with interest in palliative care	50
	Internal medicine Orkdal hospital 45 min x 3	Physicians	N.A.
Autumn 2015	Basic palliative care course 5 x 3 h	Primary care physicians and hospital physicians	5
	"Meet the dying" 4 x 6 h	Chaplains	27
	Cancer- and palliative care seminar 1 day (x 2)	Nurse assistants working in hospital and in primary care	49 + 50
	Internal medicine Orkdal hospital 45 min x 3	Physicians	N.A.
	Cancer- and palliative care seminar 1 day (x 2)	Nurses hospital and primary care	35 + 42
Spring 2016	Collaboration seminar 1 day	Leaders Process facilitators Study contacts Cancer nurses from network Health care providers with interest in palliative care	43
	Cancer- and palliative care seminar 1 day	Nurses hospital and primary care	43 + 50
	Internal medicine Orkdal hospital 45 min x 2	Physicians	N.A.
Autumn 2016	Basic palliative care course 5 x 3 h	Primary care physicians and hospital physicians	1
	Internal medicine Orkdal hospital 45 min x 2	Physicians	N.A.
Spring 2017	Collaboration seminar 1 day	Leaders Process facilitators Study contacts Cancer nurses from network Health care providers with interest in palliative care	44
	Internal medicine Orkdal Hospital 45 min x 1	Physicians	N.A.
	Project group members visit the municipalities	Primary care physicians, primary care nurses and nurse assistants	N.A.
Spring 2018	Collaboration seminar to close the project	Leaders Process facilitators Study contacts Cancer nurses from network Healthcare providers with interest in palliative care	53

[a] N.A.: Not assessed

Summary of interview data from interview guide 2

Categorization of challenges into three main themes:
1. Organizational cultural differences
2. Organizational factors that hamper standardization
3. Decentralized decision-making and different priorities

	Hospital care	**Primary care**
Perception of the SCP	Superior, strategic vision of the SCP	Few signs of anchorage of the SCP in the organizations
	SCP should contribute to increased competence about special patient groups	The SCP must be based on patients' functional status
	The project and the SCP is a gift to primary care, has great transfer value	Too much focus on cancer- the municipalities may have a need for giving priority to other health fields
	"Cancer" not a diagnosis, the SCP is not diagnosis-based	"Cancer" is a diagnosis, the SCP is diagnosis-based
	The SCP may be narrow, but should be generalized to include all cancer patients	The SCP should be made general beyond cancer patients after project end
	A living document- the SCP must be electronic and web-based	The SCP must be adapted to a working day in the "field", must be printed or adapted to the local ICT system
Challenges in implementing an SCP across care levels	HCPs consider the SCP as not being appropriate and user-friendly	A too big and unrealistic project
	A feeling that specialist care is "pulling the SCP down on" primary care	Unrealistic resource claims form specialist care
	Too little involvement from primary care	The municipalities must allocate resources to many activities and resources
	Lack of priority from the municipalities	Too little information and too little involvement from primary care
	GPs reimbursement system	GPs organization, reimbursement system, and reluctance to check lists
		Few cancer patients in each municipality

SCP: standardized care pathway

GP: general practitioner

ICT: information and communications technology

Summary of interview data from interview guide 3

Three main categories were identified, subdivided into subgroups:		
Competence	**Coordination**	**Patient/ carer**
Project leader's role. Seminars, meetings, the network of resource nurses' meetings	Routines at admittance and discharge	Quality assurance of health care
Process facilitator's role	Contact between hospital and municipality	User involvement
Education in use of SCP at the workplace	Cancer nurse as coordinator	Transferable to other patient groups
Staff and practical skills in palliative care	Management anchoring	
Evaluation and update of SCP	Nurse assistants' role in SCP	

Barriers and success factors for use of standardized care pathway				
	Competence	**Coordination**	**Patient/ carer**	**Practical factors**
Success factors	Ownership to SCP	Seminars, meetings, the network of resource nurses' meetings	Increased use of assessment tools gives better symptom control	Reminder of actual patients via electronic communication, visit notes or telephone
	Process facilitators	Low threshold for contact between hospital and primary care	Flexibility between home and nursing home make the patient stay in the municipality	Evaluation and update of SCP
	Practical education in use of SCP	Home visits from hospital's palliative team	Transferable to other patient groups	SCP adapted to local ICT-systems
	Transfer of knowledge in palliative care from hospital to community	Electronic exchange of information		
	Job training	Management anchoring		
	Management anchoring			
Barriers	Lack of time to education and to put SCP into system	Not well-defined claims from hospital to GPs	Few patients actual for the SCP in each municipality	ICT-issues
	Lack of resources and competence	GPs not enough involved	Difficult to identify the patients	The system not user-friendly
	Lack of management anchorage	Lack of management anchorage		Fire wall between hospital and GPs. In and out of ICT systems
	Nurse assistants lack knowledge of SCP	A big responsibility for a few persons		

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