

# Crossing Knowledge Boundaries: Health Care Providers' Perceptions and Experiences of What is Important to Achieve More Person-Centered Patient Pathways For Older People

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## Research Article

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# Abstract

**Background:** Improving the transitional care of older people, especially hospital-to-home transitions, is a salient concern worldwide. Older people's patient pathways may be unpredictable and complex, posing significant challenges for health care providers (HCPs). In particular, appropriate follow-up in primary care after discharge is key. Current research in the field endorses person-centered care as crucial to improving the patient pathways of older people. The aim of this study was to explore HCPs' perceptions and experiences of what is important to achieve more person-centered patient pathways for older people.

**Methods:** This was a qualitative study. We performed individual semistructured interviews with 20 HCPs and three key persons who participated in a Norwegian quality improvement collaborative. In addition, participant observation of 22 meetings in the quality improvement collaborative was performed.

**Results:** A thematic analysis resulted in five themes: 1) Finding common ground through the mapping of the patient journey; 2) the importance of understanding the whole patient pathway; 3) the significance of getting to know the older patient; 4) the key role of home care providers in the patient pathways of older people; and 5) ambiguity toward checklists and practice implementation.

**Conclusion:** To understand the findings, it proved useful to see them in light of knowledge sharing and boundary crossing, which are central concepts in the literature on transitional care. HCPs in the collaborative shared and coproduced new knowledge of the patient pathways of older people based on a patient journey perspective. Mapping the patient journey and asking, "What matters to you?" facilitated the crossing of knowledge boundaries between the HCPs; hence, a new and more holistic view of the patient pathways of older people in the current context emerged. The centrality of getting to know the patient and the special role of providers working in home care services was a central finding. The study adds to existing knowledge by suggesting that the achievement of person-centered patient pathways for older people does not only depend on the crossing of knowledge boundaries among HCPs, but also between HCPs and older persons.

## 1. Background

Older adults often have multiple chronic diseases and, thus, complex and unpredictable pathways within the healthcare system [1, 2]; they require treatment and care from a wide range of health care providers (HCPs) and services concurrently and frequently make transitions between primary and secondary health care services [3, 4]. Transitional care is a broad term for care interventions that promote the safe and timely transfer of patients between levels of care and across settings [5–7]. The implementation of care pathways (CPs) is one such intervention receiving much interest in research and practice worldwide [8]. In the current article, we address care transitions for older people involving hospital discharge and the subsequent follow-up in primary care. Previous research has shown that these transitions pose significant challenges and risks for older patients [9–12]. Adverse events such as medication errors, falls, and infections during and immediately after hospital discharge are common [12], the reasons for which

range from patient complexity, low quality of assessing the older patients' needs and involving them in care, communication errors, and organizational and cultural boundaries [1, 13, 14]. Person-centered care is a central challenge in care transitions [15–18]. Older people's involvement during care transitions may be particularly impeded by disease-related factors such as pain and reduced cognitive processing, as well as the many care events happening within a short period in unfamiliar environments [19]. According to recent reviews, there is a need for more research concerning HCPs' experiences and perceptions on how to achieve more person-centered transitional care for older people, especially from a multidisciplinary perspective [1, 15–17].

Norwegian policy endorses person-centered care and coherent patient pathways for older people [20, 21]. To stimulate and support HCPs in improving care in this direction, Norwegian health authorities initiated a national quality improvement collaborative (QIC) called “learning networks for good patient pathways for older and chronically ill people” [22]. This current article reports on data from a study where we followed HCPs' work in one such QIC in a large Norwegian municipality. A QIC is a short-term learning system involving multidisciplinary teams from various health care settings that come together over several months to improve their provision of care; here, knowledge sharing is a central aim [23]. The current collaborative engaged HCPs from primary care and a local hospital involved in the transitional care of older and chronically ill people. The participating HCPs were introduced to two measures to guide their improvement efforts: 1) a person-centered turn from asking, “What is the matter with you?” to asking, “What matters to you?” (WMTY) [22, 24] and 2) local tailoring of “The Patient Trajectory in Home care” (PaTH), a patient-centered and checklist-based CP that was developed in Norway for the care of older people in need of follow-up by primary care after hospital discharge [25–27]. Based on this, a bottom-up approach where the HCPs were encouraged to come up with local improvement measures in their respective municipality was employed.

## 1. Literature review

### 1.1.1 Person-centered care

Involvement of the patient and informal caregiver is perceived as playing an important role in creating and sustaining quality and safety in transitions [28]. Overall, the transitional care literature endorses and emphasizes patient- or person-centered care (PCC) [7, 15]. These are slightly different concepts but are often used synonymously [29]. Central to both is a more holistic approach to care and patient and family involvement [18, 29, 30]. According to a recent systematic review [29], the common themes for both concepts are empathy, respect, engagement, relationship, communication, shared decision making, holistic care, individualized focus, and coordinated care. Holistic care is described as a behavior that recognizes and values whole persons and the interdependence of their parts [31]. In the context of transitional care for older people, the triad of HCP, patient, and informal caregiver is essential for PCC [7, 32]. Furthermore, in relation to PCC, the concept of “knowing the patient” has been explored, mostly within the literature on nursing, but with arguable relevance to other HCPs. According to Radwin [33], *knowing the patient* entails a complex process whereby the HCP acquires information about and an understanding of a specific patient as a unique individual; this consists of getting to know the experiences, behaviors,

and patterns of responses of an individual patient [33–35]. This is expected to enhance clinical decision making, the selection of optimal interventions, and patient outcomes [33, 35]. It is emphasized that time and involvement on behalf of the HCP is needed to get to know and build a relationship with the patient so that a HCP can make good care decisions [33].

### 1.1.2 Person-centered patient pathways

A *patient pathway* is defined by Norwegian health authorities as “a holistic, coherent description of one or several patients’ contacts with different parts of the health care system during a period with disease” [36]. Thus, a patient pathway is not a standardized model of care, such as a CP. A CP is defined as a complex intervention for the mutual decision making and organization of care processes for a well-defined group of patients during a well-defined period [37]. CPs are depicted as models or flow charts that map out chronological key activities in a healthcare process, and they are often outlined in procedures or checklists [8, 26]. A central aspect of a CP is the standardization of care processes; however, a CP is also seen as an operationalization of patient-centered care because the care is organized around patient journeys, not the organizational units of the health care system [37]. Patient journey mapping is a salient feature of CP development that aims at making the process more patient centered. Patient journey mapping refers to the mapping and visualization of patient journeys as experienced and told by the patients. It stands apart from the service providers’ perspective, and the goal is to increase the awareness of the patient perspective and keep the quality improvement process patient centered [38]. Hansen et al. [17] posit that the concept of a person-centered patient pathway necessitates a focus on the patient pathway as something more than the purely clinical journey; both *health* and *life* events should be considered [1, 18, 39]. Thus, the concept of a person-centered patient pathway contains both the perspectives of HCPs and that of the individual patient [18]. Finally, although it has been recognized that PCC leads to better health and that the principles are generally embraced by HCPs [35], it has proved difficult to implement into practice [40]. PCC is challenging enough within a single-care setting, such as on a hospital ward, but it may be even more difficult to practice when older vulnerable patients transition between services [16, 28, 41].

### 1.1.3 A context characterized by knowledge boundaries

Central to understanding these challenges is the considerable complexity of the transitional care context in which it takes place, especially with the presence of several types of boundaries [9]. Examples of such boundaries are spatial and organizational boundaries, cultural boundaries, and knowledge boundaries [9]. The successful crossing of these boundaries is essential to improving quality and safety in transitions [9, 15]. Because we followed a QIC, *knowledge boundaries* are of particular interest in the current article. Knowledge boundaries relate to the different ways in which actors and social groups give meaning to patient care, quality, and patient pathways and where different views underpin fragmentation [9]. Given our focus on PCC in this setting, it is essential to understand that knowledge boundaries do not only exist between collaborating HCPs, but also between the HCPs and their patients [42]. Important in this respect is the concept of *epistemic communities*, which refers to the social groups that produce, use, and value knowledge in different ways. Members may come from different social backgrounds, but they tend to have shared *ways of knowing* [43–45].

Knowledge sharing is recognized as an important strategy for overcoming boundaries in transitional care. Waring [46, 47] emphasizes that knowledge sharing is more than the communication of information; it entails the exchange and use of meanings, practices, and taken-for-granted assumptions between different groups to create shared understandings and collaborative practices [48, 49]. In many improvement strategies, knowledge is understood as an explicit, abstract, and tangible resource that can be accessed and shared with others in the form of documents or evidence. This contrasts with the idea that knowledge or know-how is often experiential, tacit, and situated in practice; it is not a “thing” that a community “has,” but rather, it is what they “do” and who they “are” [47]. This distinction is important because efforts to cross knowledge boundaries in transitional care, such as the current QIC, should not only focus on the formal assemblages of knowledge, but also the more informal expressions of know-how [47].

To facilitate the crossing of knowledge boundaries, the literature refers to information or knowledge *brokers*, which are the more or less formal roles people take to pass on knowledge and information between actors or epistemic communities [32, 44, 47]. Furthermore, the literature often refers to *boundary concepts* and *boundary objects*, which can be used to facilitate boundary crossing between actors and distinct social groups [8, 50]. These concepts and objects share the common attribute of being loose enough to encompass the meanings and values of diverse actors but at the same time concrete enough for these actors to be able to tie them to their own specific social world while maintaining their own identity [50, 51]. CPs such as the PaTH, which was used in the current context, are a classic example of a boundary object, that is, an object that inhabits several social worlds and that fulfills a role in structuring relations between them [51, 52]. Thus, it can be argued that boundary crossing is important to accomplish person-centered patient pathways for older people, and in many ways, a QIC is intended to be a tool for this.

#### 1.1.4 Aim

With this background, the aim of the present study was to explore HCPs’ perceptions and experiences of what is important to achieve more person-centered patient pathways for older people; this was by following the work in the above described QIC. The article contributes important knowledge that could be useful for the future quality improvement of transitional care for older people.

## 2. Methods

The present article is based on data from a larger qualitative study of HCPs’ understandings and experiences of working towards more person-centered patient pathways for older people. A previous publication from this larger study presents the HCPs’ experiences and perceptions of the WMTY approach [24]. Whereas this article focuses on a different research question, namely; *According to the HCPs’ perceptions and experiences, what is important to achieve more person-centered patient pathways for older people?* We triangulated methods and data [55] from semistructured interviews of 20 HCPs, participant observations of 22 meetings, and central documents in the QIC. The current study was informed by a constructivist epistemology [56], and the article follows the consolidated criteria for reporting qualitative research (COREQ) [53].

## 2.1 Research context

In Norway, healthcare is universally accessible and primarily publicly funded. There is a two-level model of care where specialist care and hospitals are owned by state authorities and primary care is run by the municipalities [54]. General practitioners (GPs) are self-employed and are medically responsible for home-dwelling older people [54, 55]. The chosen QIC took place in a municipality with a complex organization comprising several local hospitals, home care service organizations, intermediate care services, and numerous GPs.

The QIC was based on the model called *The Breakthrough Series*, which was developed by the Institute of Healthcare Improvement in Boston [23, 56, 57]. The current collaborative included around 90 participants who met over a period of 18 months and comprised local improvement teams of mainly front-line workers from different professions, each with a designated team leader. The participants met at four communal *learning sessions* that consisted of expert lectures and group discussions. In between these, the participants worked within their teams to implement their chosen local improvement measures. Team leader meetings were held regularly to keep track of the work and share knowledge and to locally tailor the PaTH. The PaTH served as a framework when Norwegian municipalities develop CPs for older and chronically ill people [58, 59]. Based on qualitative studies [2, 25], it was established that disease-specific CPs were not feasible in primary care. Thus, the PaTH was designed as a generic and function-based CP that aimed to be patient-centered by incorporating the WMTY question into the checklists [2, 41].

Because of the size and organizational complexity of the municipality, only a select sample of the total primary care institutions (intermediate rehabilitation units and acute municipal care), GPs, and home-service organizations—here with their local hospital—participated in the current QIC. For the same reason, a separate project team was established to facilitate the local improvement work. The plan was to scale up the implementation of the locally tailored CP to the whole municipality after the initial 18-month period of the QIC.

The current research project was independent of the QIC. We adopted an exploratory approach instead of an evaluative approach. Hence, the study's aim was not to describe the whole range of different topics discussed in the QIC but instead to focus on the participants' meaning-making as it relates to person-centered patient pathways.

## 2.2 Recruitment

The inclusion criteria for participating in the present study were to be an HCP and involved in the activities of the relevant QIC. The QIC administrators gave permission and access to the field. Prior to the first learning session, an email containing project information and written consent forms was sent to the QIC participants. The consent forms contained optional check boxes for observation and interviews, respectively. Among the ones consenting to individual interviews, a purposively collected sample [60] was chosen based on the need for variation and information richness [61]. Improvement team leaders were chosen because they were well-informed regarding the topics of interest. Participants from all settings

were selected; however, we prioritized workers from primary care, especially home care, to reflect on the topics discussed in the QIC. Recruitment continued throughout the collaborative period because there was a degree of turnover in the improvement teams. We assessed that there was enough information power [61] and stopped recruiting for interviews after 20 HCP interviews, which was close to the sample size we had estimated.

## 2.3 Data collection

Data collection spanned the QIC period of 18 months between 2017 and 2019. The first author conducted the interviews and observations. A thematic interview guide that was published with the first article from this study [24] was used; this guide was based on exploring HCPs' experiences and understandings of how to improve older patients' pathways. For example, the researchers inquired about the perceptions of and experiences with asking WMTY and involving older people in care, the perceptions of a good and bad patient pathway for an older person, the experiences and challenges with current patient pathways, and experiences with tailoring the PaTH. Central documents, such as the PaTH and WMTY tools, were often used in the interviews to facilitate reflection. An open approach was chosen to allow the participants to reflect on and talk about the improvements they were working on during the process and to clarify any issues that might come up during the observations. Thus, the interviews and observations complemented each other to ensure the credibility of findings [60, 62]. The interviews were conducted in the participants' respective workplaces. They lasted from 60 to 90 minutes, were digitally recorded, and were transcribed verbatim.

The first author was a moderate participant observer [63] at six local improvement team meetings ( $n = 3-10$ ), 13 team leader meetings ( $n = 10-18$ ), and three administrators' meetings ( $n = 5-7$ ) (61.5 h in total). The participants with expertise in relevant areas, such as electronic health record systems, often attended the QIC meetings and provided support to the HCPs in the process. The meetings were held in the respective workplace environments and in the administrators' localities and lasted from one to seven hours. The researcher was also present at the learning sessions, which took place in conference venues.

During observations of the meetings, the researcher sat together with the participants and engaged in appropriate actions and small talk but did not take part in the participants' discussions. This was in line with what Spradley [63] describes as moderate participation, where the researcher has to balance the role of being an outsider and insider. Features of the setting, actions performed, and the tools used were written down, along with what the participants discussed. The participants knew the professional background of the researcher and that she had previously worked in some settings represented in the QIC. They were also informed about the purpose of the study and the independence of the research project from the QIC. Because the researcher met with some participants frequently, a relationship was built, and this facilitated data collection.

## 2.4 Data analysis

Relevant QIC documents were scrutinized and served to clarify and validate the other data. We followed a thematic analysis approach in six interrelated steps as described by Braun and Clarke [64] to identify

meaningful patterns of information in the data. Primarily, the codes and themes were inductively developed (see Table 1). We focused specifically on the parts of the data that revealed something important regarding the current research question. Codes that revealed similar aspects of the data were grouped into preliminary themes, which were checked for consistency and variability within and across interviews and observations. The interpretation of these themes involved a process of reading and writing, as well as reference to relevant literature and consultations among authors, eventually resulting in five interrelated themes. Observation data and interview data contributed equally to the analysis; however, quotes were mostly chosen from the interview data based on their readability. NVivo software [65] was used to manage the analysis process. An analytical memo was kept by the first author.

Table 1  
Example of the analysis process; codes, preliminary- and final themes

Examples of codes	Preliminary themes	Final theme
<ul style="list-style-type: none"> <li>- Patient journey- new discoveries</li> <li>- Trusting each other more</li> <li>- Checklists clarify responsibility</li> <li>- Checklists increase predictability</li> <li>- Learning about and from others</li> <li>- Getting to know each other</li> <li>- From the patient's point of view</li> <li>- Wanting the best for the patient</li> <li>- Colleagues around the user</li> <li>- Working together for the sake of the user</li> <li>- Common understanding- common goal</li> </ul>	<ul style="list-style-type: none"> <li>Formal and informal practice is revealed</li> <li>New discoveries about the patients, new discoveries about each other</li> <li>Negotiating checklists to improve the patient journey</li> <li>What we have in common is the patients</li> <li>Facilitating a new common understanding of the patient journeys</li> </ul>	<ul style="list-style-type: none"> <li>Finding common ground through patient journey work</li> </ul>
<ul style="list-style-type: none"> <li>-Thinking in more holistic terms</li> <li>-A more holistic approach</li> <li>-“Patient pathway” triggers patient-centeredness</li> <li>-Task orientation</li> <li>-More proactive thinking</li> <li>-WMTY-Working with, not for, the user</li> </ul>	<ul style="list-style-type: none"> <li>From task orientation to more patient-centered care</li> <li>Not just here and now, not just me</li> <li>Patient has a past present and a future</li> <li>Expanded knowledge about the pathway</li> </ul>	<ul style="list-style-type: none"> <li>The importance of understanding the whole patient pathway</li> </ul>

Examples of codes	Preliminary themes	Final theme
<ul style="list-style-type: none"> <li>- Finding someone who knows the patient</li> <li>- Signaling we know you</li> <li>- Being knowledgeable and professional</li> <li>- Home-care knows them well</li> <li>- Getting acquainted</li> <li>- WMTY-getting to know new things</li> <li>- Task orientation</li> <li>- Safety for the patients</li> <li>- Talking to next of kin</li> <li>- Next of kin as resource</li> <li>- More information about the patient</li> <li>- Being knowledgeable and professional</li> <li>- WMTY- managing at home</li> <li>- Establishing a common language</li> <li>- Focus on information exchange</li> </ul>	<ul style="list-style-type: none"> <li>The home as the alfa and omega of the pathway</li> <li>Knowing the patient in different ways</li> <li>Seeing a different version of the patient</li> </ul>	<ul style="list-style-type: none"> <li>The significance of getting to know the older patient</li> </ul>

Examples of codes	Preliminary themes	Final theme
<ul style="list-style-type: none"> <li>- More proactive thinking</li> <li>- It's often too late</li> <li>- Out of sight, out of mind</li> <li>- Keeping them home</li> <li>- WMTY- physical function at home</li> <li>- Safety at home</li> <li>- Focus on standardized assessment</li> <li>- More proactive thinking</li> </ul>	<ul style="list-style-type: none"> <li>Home care nurse as a link between the before and after in the patient's journey</li> <li>They know the patient and their home-situation best</li> <li>From task orientation to more comprehensive care</li> <li>Keeping older people safe at home</li> </ul>	<ul style="list-style-type: none"> <li>The key role of the home care provider</li> </ul>
<ul style="list-style-type: none"> <li>- Skepticism towards the QIC work</li> <li>- Checklists- not being used</li> <li>- Checklists- not the whole solution</li> <li>- Checklists- enthusiasm</li> <li>- Checklist- skepticism</li> <li>- Importance of anchoring with leaders</li> <li>- Unpredictable pathways</li> <li>- Overwhelming complexity</li> <li>- Need for resources to implement</li> </ul>	<ul style="list-style-type: none"> <li>Checklists as universal remedy</li> <li>Unpredictable patient pathways within a more systematic frame</li> <li>The checklists are a symptom- not the whole solution</li> <li>From random to systematic care for the older patient</li> <li>Bottom- up is good but necessitates top-down support</li> <li>Resources are crucial for implementation</li> </ul>	<ul style="list-style-type: none"> <li>Ambiguity towards checklists and practice implementation</li> </ul>

To enhance the quality of the research process, we employed the criteria for trustworthiness described by Lincoln and Guba [62]. Credibility was enhanced by an open and complementary data collection approach, prolonged engagement with the field and the material, and a comprehensive description of the methods. To establish dependability, the first and last author read the transcripts and observation notes, and the first author's coding process was validated by the last author. The final themes were agreed upon through continuous reflexive discussions among all the authors [62, 66]. A presentation of the quotes and

use of previous research to substantiate the findings contribute to the confirmability and transferability of this study [62].

Regarding the researchers' positions and preconceptions[60], the first author's first hand experiences with the challenges and dilemmas of achieving person-centered patient pathways for older people influenced the study. For example, the choice of research question was both based on an identified knowledge gap and on personal interest. Also, the choice to highlight the role of home-care providers was both based on the data and on prior work experiences of the usefulness of their competency. Even though all the authors have professional and research interests in the field of health science, there was a diversity among the authors' backgrounds (nursing, anthropology, physiotherapy, and dietetics), which led to interesting discussions and enhanced reflexivity [67]. The experiences of the researchers of the present study within health care means that there were probably certain things that we were "blinded" to and took for granted; however, it also means that we were well positioned to understand the context of and perform the study [66, 68].

### 3. Results

#### 3.1 Participants

The interviewed HCPs, which included four men and 16 women (mean age: 43.9), were all chosen by their respective superiors to take part in the QIC activities. Seven of the participants were leaders of their local improvement team. Seventeen of the participants worked on the front line with patients, some with mixed administrative or educational tasks. Three did not currently work on the front line. Three key persons who were leaders or administrators of the QIC were interviewed to gain an understanding of the background of the QIC. Table 2 presents more information. To maintain anonymity, the participants are only referred to with participant number (according to appearance in the text) and as either working in home health care services or in an institution (comprising intermediate care institutions and hospital).

Table 2  
Characteristics of the participants

Male/ female	Profession	Age	Work setting	Time in current position	Years of education after high school
4/16	Nurses 12 Physiotherapists 5 Medical doctor 1	Mean 43.9 years	Home care 13 Hospital 2	Mean 5.1 years	Mean 5.1 years
	Nurse assistant 1 Occupational therapist 1	Range 29– 59 years	Intermediate care (acute or rehabilitative) 5	Range 6 months – 17 years	Range 3– 10 years.

The following results are presented as five interrelated themes, which, to a greater or lesser degree, are all related to patient journey mapping and seeing the patient pathways from the older patient's point of view.

## 3.2 Finding common ground through the mapping of the patient journey

Overall, the participants emphasized that it was crucial for the QIC work to see the patient pathway from the older patient's point of view. In line with CP development methods, mapping the patient journey, interviewing patients, and working with user representatives became important reflection tools. These activities seemed to facilitate new and shared ways of thinking about and understanding care:

*We learnt a lot about how the user experienced it, it gave a couple of aha- experiences. I had not seen it from their perspective before.* (Participant 1, home health care services)

When working on the patient journeys, the participants identified improvement needs in their local work processes, as well as in work, across settings. In particular, the WMTY question was discussed extensively. During the mapping of the patient journeys, it became apparent to the participants that there was no real system in place to assess what mattered to the patient as the patient moved through the system. Consequently, HCPs from all the different work settings in the QIC worked to get a system in place for how to engage in the WMTY approach. The participants highlighted that through the QIC work, they understood that they all cared about what mattered to the older patients. Thus, trust in collaborating partners to care for older patients increased.

Furthermore, the issues raised by the patient journey work were believed to at least be partially solved through the local tailoring of the PaTH checklists. The participants believed that by working more systematically both with the WMTY approach and with the content of the checklists, older patients' experiences of their journeys would be improved. However, this was viewed as a big challenge. One participant said the following:

*Well, it requires a total reestablishment of everything, everything from reports to how things are put into words, the use of terms and, well, thinking holistically about people.* (Participant 2, home health care services)

Toward the end of the QIC work, the improvement team leaders from the different care settings initiated a negotiation process to locally tailor the PaTH checklists, here focusing on "what we need from you and what you need from us." Hence, during the QIC process, the participants developed new understandings of their own and other collaborative partners' work. Many important bottlenecks were discussed, and dilemmas and tensions were brought to the surface. The knowledge that they shared was both of a formal and informal character, and both were deemed important from the HCPs' point of view. For example, it came up at a checklist meeting that the home care services did not have their own medication storage and depended on community pharmacies to get medicines for patients. Despite having collaborated with the home care services for many years, the HCPs from the hospital did not know this. It was an important discovery because it made more sense to them why prescriptions and a certain supply of medication were so important at hospital discharge. During the QIC, the participants learned both *what*

other HCPs were doing and *why* they were doing it. A participant who was interviewed toward the end of the process said the following:

*So, just getting to know each other a bit better and getting a better understanding of the routines of the hospital. That we get a bit closer, that it is not just you and me, but that we are really colleagues working around the user. That we wish to accomplish the same things. I think that has been very useful. That we understand each other's everyday life better.* (Participant 3, home health care services)

Hence, working together in the QIC to improve the patient journey seemed to give the participants a sense of common purpose and goals; hence, mutual trust increased. During a meeting, a participant said: *What we have in common is the patients.* (Observation note, team leader meeting)

### **3.3 The importance of seeing the whole patient pathway**

The increased focus on the patient journey seemed to enhance the participants' awareness of the totality of the patients' pathways from hospital discharge through the different intermediate care facilities and home care. Therefore, the participants emphasized that to make the patient pathways more person-centered, all HCPs in the care pathway had to assume a shared responsibility for the whole patient journey. Also, they had to understand that their own daily work processes, although isolated in space and time, were part of a larger system of care around the older patient and their next of kin. Many of the participants expressed that this was a less-fragmented and more rewarding way of thinking and working. The ideal appeared as seeing care more in terms of an ongoing process with an overreaching goal rather than as time-limited tasks to be performed separately without an underlying purpose. One participant said the following:

*Holistic, really, not so that when I go to him [the user], do this and that, and my tasks without thinking about what has been and what will be. You know, that I do not just do my things and get them over with.* (Participant 4, home health care services)

What the participants called a more *holistic* approach meant thinking beyond each HCP's own work setting and tasks and seeing the totality of the patient's journey; it meant seeing care as many interconnected steps that together made up the patient pathway. To achieve good patient pathways, it was important to understand that the older patient followed their own unique journey with a past, present, and future, which also involved other professionals and other settings.

### **3.4 The significance of getting to know the older patient**

The participants agreed on the importance of knowing the older patients and their next of kin. Knowing the patient was perceived as important for the patient's sense of safety and trust in HCPs during the vulnerable phase of transitions. However, between the different settings, there were different understandings regarding what it meant *to get to know* the patient. It became clear that although the WMTY question signified patient involvement, it also meant different things in different settings and to

different professionals. The differences between settings were discussed to a much larger degree than the differences between professionals.

It appeared that the HCPs in the different settings did not see the same “version” of the older person. In hospital and institutions, they often described a frail older person, mostly lying in their bed with hospital clothing and going through some worsening of a chronic condition and physical function. Getting to know the patient meant assessing their medical condition first and foremost, *then* focusing on physical function, and *then* asking what matters. One stated the following:

*We write a lot of electronic reports based on our experience of how we see the patient when he is admitted here. And then maybe we see a frail older person and we haven't looked into how they are able to function at home. And then immediately we think “oh they need a nursing home placement, oh poor person.”* (Participant 5, institutional care)

The work in the QIC made them realize that they only had a momentary picture of the patient and, hence, could misunderstand or misinterpret the patient’s ability to manage their life at home after discharge. There seemed to be enhanced awareness that there was more to know about the older patients.

Workers from the home care services saw the older person in their own home environment. Getting to know the patient meant getting to know their family and life situation, which involved attaining more detailed knowledge of their daily habits, preferences, and ways of living. This was perceived to be easier when working in the home of the older person. HCPs from the home care sector expressed some concerns regarding the way older patients were assessed and treated in institutions. The home care workers were concerned that patients became “institutionalized” in the hospital, especially in intermediate care settings. They were concerned that the patients were deprived of the possibility of trying to manage things on their own, leading to larger loss of function than necessary. Another participant who worked with patients in their home said the following about how HCPs should be thinking regarding older people’s patient pathways:

*So that already in specialist healthcare one starts to think that, well actually, this person should try to manage in the shower alone, try to handle the medicines, try to walk the stairs by themselves, do all those things as soon as possible because that is what the user is going back to.* (Participant 6, home health care services)

It was emphasized that when older patients returned home after institutional stays, they often managed better than what was anticipated by the HCPs in hospitals and intermediate care. Assessing *what matters*, which can be understood as motivation for self-care and independent function, was perceived to be easier when working in the older person’s home.

The importance of knowing the patient and patient’s journey to improve the patient pathways was also reflected in the participants’ perceptions of documentation, information exchange, and discharge

communication. Thus, the ideal was that more of the situation around the patient be described, for example, how they usually managed at home and their relationship with their next of kin.

Knowledge about the information needs of their colleagues in other settings in the pathway was deemed crucial for good documentation. Establishing a common language was highlighted as important. Likewise, in addition, the WMTY question was to be included in the discharge notes and hand-over reports from all settings, which would help place the patient's needs at the heart of communication and information exchange. This was believed to facilitate appearing as an informed unit toward the patient. Signaling to the patient "we know you" was seen as important. One participant said the following:

*That the user doesn't have to repeat herself at each new place, but feels like the people I relate to here, they communicate, they know who I am [...] that the user feels like when they ask me questions they ask them as if they already know me a little. (Participant 7 – home health care services)*

However, there was a perception among many of the participants that communication around what matters to the patient solely in written and by electronic means was not always sufficient and that phone calls and face-to-face encounters were necessary in many cases.

## **3.5 The key role of home care providers in older people's patient pathways**

Because of their particular knowledge about the older person in the older individual's own context, it was discussed how the providers of home care services, especially nurses, should serve as a spokesperson for the older patient during transitions. This included following up on the patients to a larger extent with GP visits during institutional stays and care transitions. For example, one improvement measure discussed at the meetings was making a routine out of involving HCPs from home care services in the multidisciplinary family meetings with the patients and next of kin at the intermediate care units. One participant who had experienced this said the following:

*The users are very happy to see someone they know and for us it means being a part of the service they get when they get home to larger extent [...] you get more insight into what has happened and what their needs are further on and it becomes easier to assess their needs when they come home. (Participant 1, home health care services)*

These meetings could be regarded as being an important link between the before and after in the older patients' journey. The greater involvement of home care services increased the chance that suitable services were given after discharge and that what mattered to the patient was followed up on at home.

However, to fulfill their new roles and responsibilities in the pathway, there was also a perceived need to get to know the older person better or even differently in home care. In line with the PaTH, there was a perceived need to plan ahead and, to a larger degree, be proactive about care, the ultimate goal being to keep the older patients safe at home. HCPs in home care should think more in terms of early detection of

symptoms of a worsening chronic condition and should take measures to prevent deterioration in physical function in older care recipients. One participant said the following:

*A patient's life, even though affected by chronic disease, it changes all the time. So we have to be good at uncovering changes, be good at evaluating, very good at evaluating, very good at contacting the right services, that people can be of help. The culture in our services has to change so that we take more responsibility for our users, so it becomes a mantra that they should be living at home for as long as possible, because I believe that we can do very much to keep them at home, given that they wish to themselves.* (Participant 8, home health care services)

It was emphasized that in the current home care system, the symptoms of a worsening condition were often overlooked because there was a tendency for task orientation in home care, which was precipitated by tight time schedules. The participants were concerned that some HCPs just did their assigned tasks without looking at the totality of the older person's medical situation. In many ways, this new way of getting to know the patient resembled the ways HCPs in the hospital and institutions reasoned and worked, for example, with a larger focus on frequent standardized assessments of vital signs and physical function and a greater focus on knowing the diagnoses and medical history of the users. In this respect, home care workers would also appear more professional and knowledgeable, which was perceived to be important to gain trust and increase the patient's and family's sense of safety. Conclusively, a central feature of working more *holistically* and in a person-centered way seemed to be combining knowledge from all the HCPs in the different settings in the patient pathway.

## **3.6 Ambiguity toward checklists and practice implementation**

One important function of the PaTH checklists and the local tailoring of these was to ensure that the things they were discussing and agreeing upon in the QIC would actually be done in practice after the QIC was over. However, despite a general enthusiasm for the checklists' potential to improve the patient pathways of older people, there was also some skepticism toward these checklists. The checklists were maybe too simplistic of a solution. During one meeting, an improvement team leader said: *The checklists are a symptom and not necessarily a solution.* (Observation note, team leader meeting) Here, the need for the checklists was a symptom of the complexity of the current transitional care system, and this was not solvable through checklists alone. Likewise, scarce resources was a salient topic of discussion. Furthermore, there was an ambiguity in the findings because checklists were believed to make work more predictable; however, at the same time, the very unpredictable nature of the work with older people, as well as contextual constraints, could lead to a lack of prioritizing of the checklists:

*But then something happens and you don't have the time or if you are able to make the assessment, the technical equipment isn't in place and you have to go back to the office and write it on the computer, so then it is down-prioritized and the assessment form is just left somewhere.* (Participant 7, home health care services)

Many had experienced that the current checklists were not being used properly in practice but nonetheless believed that the new tailored checklists would be used in the subsequent scaled-up implementation if the HCPs only understood the purpose of them. One said the following:

*I don't think the implementation of the checklists will be easy, but I think if we manage to make people understand the value of them, and why we use them. It is to make it better for the users. That we can actually manage to see their needs and manage to keep them home for a longer time combined of course with them mastering their everyday life and living happy lives.* (Participant 3, home health care services)

The participants expressed appreciation of the bottom-up approach toward quality improvement because it facilitated ownership and local anchoring of the improvement work. However, it also seemed to create a great deal of uncertainty regarding mandates and a blurring of responsibility. One important reason was the lack of power the participants had to make decisions regarding the actual implementation of their chosen quality improvement measures. During a meeting, one participant said: *We can take more responsibility and identify challenges, but they have to be solved at a higher level* (Observation note, team leader meeting). Some expressed doubts regarding the possibilities of creating *real* change in older people's pathways as a result of the QIC. It was suggested that the municipality had "projectitis," meaning that too many projects were going on at the same time and that many of these projects did not lead to sustainable practice changes that benefited the patients. Some participants remarked that they were working on ideal and perhaps unrealistic patient pathways; they were concerned that the resources were not really in place to make the required improvements. During a meeting, one participant said: *I hope we haven't spent millions and done lots of work just to see it run out in the sand* (Observation note, improvement team meeting).

Leadership support from both front-line managers and leaders higher up in the hierarchy was deemed crucial to achieve more person-centered patient pathways in the municipality. This involved both the power to make decisions regarding practice implementation and to allocate the appropriate resources. Thus, improvements at the front-line level were perceived to be strongly connected with improvements at the organizational level.

## 4. Discussion

The aim of the current study was to explore HCPs' perceptions and experiences of what is important to achieve more person-centered patient pathways for older people by following the work of a QIC. The QIC provided an opportunity for situated encounters, enabling the sharing of both formal and informal knowledge, leading to the coproduction of new knowledge, and establishing common meaning and purpose related to person-centered patient pathways for older people. The following discussion focuses on how the results relate to previous research on central concepts relevant to person-centered patient pathways for older people, especially the crossing of knowledge boundaries.

## 4.1 Crossing knowledge boundaries with the help of the patient journey

Patient journey mapping appeared as one of several facilitators for the crossing of knowledge boundaries both among the collaborating HCPs and between HCPs and older patients. By interviewing patients, listening to their stories, and working with user representatives, the HCPs became more familiar with the meaning of the patient pathways from the older person's perspective. This can be compared with what Beedholm et al. [71] call the establishment of the *patient logic* into care. In line with patient journey work, the patient logic includes each individual patient's values and preferences and how they live their life [69], in other words, their *knowledge* of what it is like to be them. Hence, when working on the patient journey, a different type of knowledge was brought to the table, one that was highly personal and situated. In their study of the process of becoming a patient-centered hospital ward, Beedholm et al. [71] find that the HCPs believed they already knew what mattered to the patients but were surprised by what they learned through knowledge exchange with the patients. In line with this, our findings show how the HCPs experienced discovering something new when the patients' experiences of their journeys became known. Building on the notion of epistemic communities [44, 45], our findings show how the HCPs and patients had different ways of knowing the patient pathway in the municipality. Thus, it can be argued that patients and HCPs represent different epistemic communities. Central to PCC is the refutation of paternalism and seeing health care encounters as meetings between experts [70]. The patients are experts on themselves and possess a different kind of knowledge about the patient pathway than the HCPs, who see the pathway from a professional perspective. In line with Waring et al.'s [44] extensive work on knowledge sharing, the user representatives in the QIC could be seen as representing an epistemic community of users, making the older patients' *way of knowing* the pathway available to the HCPs and acting as knowledge brokers. Hence, the patient journey work in the current QIC operated as a facilitator for identifying knowledge boundaries and for making aware the patient logic to the HCPs. This implied a crossing of the boundaries between the HCPs' knowledge, which is based on working in the system, and the patients' knowledge of what it felt like for them to be in the system.

In line with these findings, the potential positive aspects of patient stories and patient journeys have been highlighted in previous transitional care research [9, 28, 38]. HCPs from different settings are limited in their view of the *whole* patient pathway by physical, organizational, cultural, and knowledge boundaries [9, 28, 38]. As our findings confirm, HCPs' knowledge of the patient pathway is often confined to what goes on in their own setting and in relation to their *version* of the patient. Scott [28] emphasizes how patients who go through care transitions are in a unique position to see the aspects of care that are otherwise unavailable to clinicians, such as the whole continuum of care services [73]. Previous research suggests that this kind of system thinking among HCPs is important to improve care transitions [9, 11]. Consistent with this, when the knowledge from patient journeys became available to the participants in the current study, it brought about a new, more shared understanding of the whole patient pathway for older people in the municipality. Ward et al. [71] show how groups of HCPs, such as the current QIC, not

only share and exchange knowledge, but also coproduce new knowledge through active engagement in perceived shared problems.

Consistent with this, the participants in the current study emphasized that learning about and from each other was important for pathway improvement, especially regarding how to assess and get to know the older patient.

## 4.2 Crossing knowledge boundaries with the WMTY question

Overall, it was emphasized that getting to know and knowing more about the older patient's life situation, especially their family and home situation, was crucial to making the patient pathways more person centered. The concept of *knowing the patient* can illuminate this aspect of the findings. *Knowing the patient* requires spending time with and being involved with the patient, which is essential to building a relationship with the patient [33]. As highlighted with the concept of knowledge sharing between HCPs, both explicit and tacit knowledge is involved in this process [46, 47]. Hence, knowing the patient requires involvement both on the part of the HCP and the patient and, for older people especially, their next of kin. Radwin [33] finds that knowing the patient is a core process in clinical decision making and impacts the specificity of individualized interventions. Similar to our findings, the author [32] also finds that *not* knowing the patient was described as just doing a job and being uninvolved.

In our findings, the WMTY question seemed to be an essential factor in the boundary-crossing process. Akkerman and Bakker [72] discuss how boundary crossing is essential for all learning. Asking "What matters to you?" has an important empathetic dimension [1] and can be seen as an incitement to share knowledge with the patient and next of kin, hence showing a willingness to *learn from* the patient [24]. In line with previous research, this is an important boundary-crossing process to achieve more person-centered patient pathways [1]. In a previous article, we have highlighted how HCPs see the WMTY approach as a complex process where *negotiation* is an important aspect [24]. Indeed, a WMTY conversation involves knowledge sharing where the provider and patient share and negotiate valid perspectives and make shared decisions [40, 73, 74].

The different ways of knowing the patient among providers from different settings was another important finding. This may illustrate how the participants in the QIC came from different *epistemic communities*, which is a central aspect of knowledge boundaries in care transitions [47]. Through discussions about bottlenecks and issues in the pathways, the participants were able to identify knowledge boundaries and mediate them to develop a more shared understanding of what is important to make the patient pathways more person centered. Consequently, the participants started seeing each other more like "colleagues working around the patient." Establishing a common language, common meaning, and common purpose was highlighted. This can be referred to as knowledge "bonding" and is suggested to be important to improve the quality of care transitions [75].

Consistent with previous studies of the PaTH [24], there seemed to be an expansion of the perspectives of the different collaborating HCPs, making it possible to see a more comprehensive or *holistic* way of working. In this sense, holistic could be understood as a more biopsychosocial approach [31, 76]. There seemed to be both an expanded awareness of older peoples' home situations among hospital and intermediate care workers and the perception that home care providers should focus more on disease and physical function. Interestingly, there seemed to be a pull toward a more psychosocial approach in the institutions and a more biomedical approach in home care. This is similar to previous research on person-centered patient pathways that has highlighted the tension between the biomedical and psychosocial approach: the *clinical* and *personal* journey [18]. Our findings may be interpreted as a move toward biopsychosocial care but a move where biomedical expertise is still highly valued. Previous research points in the same direction: biomedical goals are also important to patients [1]. Here, the importance of appearing as a knowledgeable professional to be trusted was an interesting aspect of the findings. It points to an important aspect of the meeting between equal experts [70] in that a certain level of expertise is expected of the HCP and that neither part should give up their expertise. In a previous article, we have highlighted how HCPs see the WMTY approach as a complex process where negotiation is an important aspect [24]. A WMTY conversation involves knowledge sharing, where the provider and patient share and negotiate valid perspectives and make shared decisions [40, 73, 74].

Furthermore, the WMTY question seemed to work as a boundary concept [52] in relation to cooperation between HCPs in the current context. The participants emphasized that the WMTY question might have different meanings in different contexts, but it also seemed to signify the same thing to everyone: it was seen as a tool to achieve more PCC. A boundary concept is a loose concept that makes it possible to talk about the same thing despite knowledge boundaries. It is because it can be interpreted in several ways whilst maintaining a core meaning, that it facilitates communication and cooperation between members of distinct groups without obliging members to give up the advantages of their respective social identities [50]. Löwy [50] illustrates the importance of loose concepts in the construction of interdisciplinary alliances in science. In the current context, the WMTY question made it possible to talk about achieving person-centered patient pathways, even though PCC meant something different according to the different contexts and professions present. Thus, our findings are in line with previous research [1, 24, 77] that argues that *what matters* to the patient can serve as a bridge between the different transitional care settings. Conclusively, both the patient journey mapping and the WMTY question had the potential to facilitate knowledge boundary crossing in the current context, both among HCPs and patients and between collaborating HCPs.

## **4.3 Home care providers as knowledge brokers during the patient journey**

Another important finding is the emphasis on the unique perspective of the HCPs who were accustomed to working in the older person's home and, thus, were much closer to the older person's life context. The importance of home care in the patient pathways of older people has been highlighted previously [6, 25]. A recent review [78] suggested that despite scarce resources, patient-centered care for older people may

be facilitated in home care because of the unique knowledge gained about the everyday lives of their users. As an epistemic community, it is interesting here to look at the type of knowledge HCPs working in the home were perceived as having. They had both explicit knowledge about home conditions, medications, and family relations, and their perceptions of “knowing the patient” also seemed related to a form of tacit knowledge acquired over time from direct and first-hand experiences with the older patients in their home. Consistent with the findings of Røsstad et al. [24], who investigate the development of the PaTH, home care providers’ knowledge seemed to *gain ground* among collaborating HCPs. This implies a potential turn toward focusing more on the older patient’s larger life context and their possibility to self-manage and be able to live in their own home.

In particular, home care nurses were seen as important mediators and spokespersons for the patient and the family and could serve as a link between the before and after in the pathway of the older person. Dyrstad and Storm [32] discuss how in the context of hospital admission and discharge, the next of kin brings valuable information about the older persons’ medication and physical condition (what is normal and not), thus assuming the role of information broker during transitions [32]. Our findings suggest that because they take on an important function in providing information about the patient’s situation, providers of home health care services may be important information and knowledge brokers in the current context. This was particularly evident during admission meetings in intermediate care, where it was perceived to have the function of making the patient feel safe and known. Such meetings have previously been presented as a useful approach to involve both patients, next of kin, and relevant HCPs in discussions about what matters to the patient, their treatment, discharge plans, and follow-up care [73, 79, 80].

According to our findings, a central feature of getting to know the older patients was also the need for home care providers’ augmented effort to follow up on the older patients’ physical function and disease status at home. This coincides with an emphasis on more proactive care, which is emphasized in the PaTH and relevant transitional care literature [1, 84]. However, this aspect from the findings can also be connected to the concept of *knowing the patient* [33]. The examination of this process in clinical settings shows how nurses acquire context-specific knowledge about the patient, which is central to skilled clinical judgment. Knowing the patient causes certain aspects of the situation with a patient to stand out as important when compared with other aspects. Nurses can use this knowledge to make qualitative distinctions, comparing the current situation to known typical situations and then recognizing the relevant changes and early warning of clinical problems, eventually resulting in better informed clinical judgments that facilitate progress [81]. Hence, by *knowing the patient* and being properly involved during care, it is easier to detect when things are “out of the ordinary” for the patient and make clinical judgments based on this [34]. Conversely, the consequence of *not* knowing the patient is detrimental to care [34] and may lead to adverse events. This points to the issue of task orientation in home care, which was brought up by the HCPs in the current study.

## 4.4 Crossing knowledge boundaries with the help of checklists

The PaTH checklists were perceived as having the potential to solve many of the shared problems that the HCPs saw in the patient pathways of older people, especially the need for more systematic and predictable work. However, there was ambiguity regarding this. One of the strengths of standardized CPs, such as the PaTH, which has been highlighted in previous research, is their function as a boundary object that facilitates collaboration among distinct social groups [8, 51, 52]. We found that the PaTH had a similar function in the current context. In line with Waring et al.'s [47] conception of knowledge sharing, the participants of the current study shared both formal and informal knowledge when negotiating the local tailoring of the checklists. The PaTH checklists were presented as explicit and tangible documents to be shared among the participants, but as the participants worked on them, more experiential and taken-for-granted knowledge came to the surface. Knowing about the practical realities and motives of other settings seemed to increase trust and facilitated a shared understanding of the patient pathways for older people in the municipality. Hence, the checklists facilitated a process that seemed to be just as important, if not more important, than the actual checklists. Previous research suggests that such knowledge sharing at the local level may lead to improved interaction between HCPs, hence facilitating more patient-centered care [75, 82].

However, previous research has shown that CPs in general and the PaTH in particular are challenging to implement, often because of the very boundaries they are supposed to cross [8, 27, 41, 83]. The participants' skepticism toward the checklists is supported by previous research that shows that when checklists meet the complex and *messy* realities of practice contexts, they are often abandoned [8, 41, 83]. Because of the contextual complexity of transitional care, Waring et al. [78] point out that standardized interventions such as checklists may fail because they are based on a too technical-functional view of service organization; the authors emphasize that more holistic and multilevel strategies are needed to improve care transitions. Furthermore, recent reviews on safety and quality in care transitions [15, 83] have highlighted the need to consider patient-centered knowledge sharing interventions that emphasize relationships and interaction to overcome boundaries, which is also reiterated by our findings. Checklists may be useful for the systematization of work and as a reminder for keeping a person-centered focus across settings [27], but they should be regarded as only one aspect of a more holistic approach.

## **4.5 A call for top-down support**

The main challenge outlined by the participants seemed to be moving from working on the ideal patient pathway and the local tailoring of checklists to the actual implementation of their improvement measures into sustainable practice changes. Previous research shows how PCC is often embraced by HCPs at the principle level, but because of contextual constraints, such as scarce resources, organizational frames, and leadership issues, implementation into practice is challenging [35, 40].

The QIC participants perceived the challenges in implementing their proposed improvement measures because of the lack of power they had to effectuate change and allocate resources. Whitemore [34] noted that the concept of "knowing the patient" is severely undervalued in modern day healthcare because of bureaucratic obstacles, organizational arrangements, and economic restraints. Taking into

account the significance of spending time with older patients to get to know them [34], one cannot overlook the significance of appropriate resource allocation, especially in primary care, to achieve person-centered patient pathways for older people. The time and resources available to home care providers arguably influence their abilities to take on extended roles and responsibilities. A recent review finds that as perceived by multidisciplinary HCPs, organizational constraints and a lack of resources were important barriers for patient-centered care for older people in the home context [78]. Supported by previous research [14, 61], appropriate support from the organizational and political levels is important to get the HCPs' bottom-up efforts from what can be called a work-as-imagined level to a work-as-done level [84].

## 4.6 Strengths and limitations

The strengths of the current study include a complementary data collection method [62] and the use of a well-known and structured form of analysis [64]. The complementary data collection allowed for informal member checking, but formal member checking was not performed and could be regarded as a limitation [62]. The first author was immersed in the field and had the challenge of balancing closeness and distance as a participant observer [63]. However, the inclusion of several researchers in a reflexive analytical process should enhance a study's trustworthiness [62, 66]. We have included important contextual information to clarify the potential transferability of the results [66]. It should be noted that the participants were chosen to take part in the QIC and, hence, may have a general positive attitude toward improvement work and practice change. Furthermore, there was a risk of social desirability bias [85], both in the interviews and observations. However, combining the two methods reduced this bias to some extent [60], and we have also accounted for the variety of the HCPs' experiences and perceptions in the results. Qualitative studies do not aim for generalizability [55]; however, we believe that the findings may have important implications for stakeholders and researchers with an interest in older persons' patient pathways.

## 4.7 Practice implications

Working on patient journeys and keeping the focus on the patient's experience of the pathway seems important for moving toward more person-centered patient pathways for older people. HCPs have to be engaged and involved with the older patients and ask WMTY to get to know both their clinical and personal journeys. Home health care workers usually have long-term follow-ups of older patients and family caregivers and may have a greater possibility of getting to know and building a relationship with them. Their role as knowledge brokers, especially regarding "what matters" to the patient and next of kin, represents a potential for more person-centered patient pathways in this context. Our findings reiterate the need for situated encounters to enable knowledge sharing between the collaborating partners involved in the patient pathways of older people. Preferably, arenas for the sharing of both formal and informal knowledge to solve shared problems, such as the current QIC, should be established in the long term as a part of ongoing practice, not as a time-limited project.

## 5. Conclusion

The QIC involved a coproduction of new knowledge and understandings of person-centered patient pathways as both a clinical and a person journey, hence reinforcing previous research on patient perspectives. Mapping the patient journey proved important to facilitate the inclusion of the patient perspective into care. A new understanding of care related to understanding care as following a pathway rather than being a separate set of isolated tasks and work processes emerged. The centrality of getting to know the older patient was found to be an essential aspect of achieving more person-centered patient pathways for older people in the municipality. In this respect, HCPs working in home care services, especially nurses, appeared as important knowledge brokers in the patient pathways; they were perceived to have important knowledge of the older patient, which could provide a key link between the before and after in the older patients' pathways, making the patient journey feel safer. The WMTY question also served as an important boundary concept and was perceived as important to keep a person-centered focus across all settings in the pathway, despite the HCPs' different approaches to PCC. The present study adds to the literature by suggesting that improving the quality of patient pathways for older people does not only depend on the crossing of knowledge boundaries among providers but also between providers and their patients. Several of the findings could be explored further from a patient perspective and/or by observing actual practice at the front-line. In particular the important role of home-care services in the patient pathways of older people warrants further exploration.

## Abbreviations

HCP- health care provider; QIC- Quality improvement collaborative; CP- care pathway; WMTY- *what matters to you?*; PCC- patient- or person-centered care; PaTH- patient trajectory in home care; GP- general practitioner; COREQ- consolidated criteria for reporting qualitative research.

## Declarations

### Ethics approval and consent to participate

The research project was preapproved by the Norwegian Center for Research Data (Reg No. 54438). The study was performed according to the Declaration of Helsinki [86]. Informed written consent was obtained from the participants. Before the meetings and interviews, the researcher gave a reminder of the main information in the consent form, the voluntariness, confidentiality, and freedom to refuse or withdraw from the study at any stage.

### Consent for publication

Not applicable.

### Availability of data and materials

The datasets generated and analyzed during the current study are not publicly available because of the terms of the data collection approval but parts of the data can be made available from the corresponding

author upon reasonable request.

### **Competing interests**

The authors declare that they have no competing interests.

### **Funding**

The project received no external funding.

### **Authors' contributions**

CFO designed the study, performed the data collection and analysis, and wrote the article. AB1 contributed to the conception of the article, the literature review, the analysis, and writing of the article. AB2 contributed to the analysis and critical revision of the article. JD critically revised the analysis and the article. AL contributed to the study design, the data analysis, and critical revision of the article.

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