1. Overview of theories, models and frameworks in implementation science

Per Nilsen

INTRODUCTION

Early implementation research tended to be empirically driven. For example, a review of guideline implementation strategies by Davies et al. (2003) noted that only 10 per cent of the studies identified provided an explicit rationale for their strategies. Eccles et al. (2005, p. 108) remarked that research that did not use theories seemed like ‘an expensive version of trial-and-error’. Mixed results of implementing evidence-based practice (EBP) in various settings were often attributed to a limited theoretical basis (Davies et al., 2003; Eccles et al., 2005; Kitson et al., 1998; Michie et al., 2005; Sales et al., 2006). Poor theoretical underpinning makes it difficult to understand and explain how and why implementation succeeds or fails, thus restraining opportunities to identify factors that predict the likelihood of implementation success.

Although the use of theories, models and frameworks today has many advocates in implementation science, there have been dissenting voices. In a light-hearted (but still fairly serious) article, Oxman et al. (2005, p. 113) presented their OFF Theory, which they summarized as: ‘you don’t need a theory’ (OFF stands for Oxman, Fretheim, Flottorp). They were critical of theory use in implementation science, and argued that, ‘We need less rather than more focus on high-level theories, less rather than more jargon, less dogmatism, more common sense, less theoretical work, and more rigorous evaluations that include direct measurement of important outcomes’ (Oxman et al., 2005, p. 115). Still, over time implementation science has increasingly emphasized the importance of establishing the theoretical bases of implementation and strategies to facilitate implementation. In fact, there are now so many theoretical approaches that some researchers have complained about the difficulties of choosing the most appropriate (Cane et al., 2012; Godin et al., 2008; ICEBeRG, 2006; Martinez et al., 2014; Mitchell et al., 2010; Rycroft-Malone and Bucknall, 2010a).

This chapter provides a narrative review of the theories, models and frameworks applied in this research field. The aim is to describe and
analyse how theories, models and frameworks have been applied in implementation science and to propose a taxonomy that distinguishes between different approaches to advance clarity and achieve a common terminology. The ambition is to facilitate appropriate selection and application of relevant approaches in implementation studies and to foster cross-disciplinary dialogue among implementation researchers. The importance of a clarifying taxonomy has evolved during the many discussions on theoretical approaches used within implementation science that the author has had over the past few years with fellow implementation researchers, as well as reflection on the utility of different approaches in various situations.

Six textbooks that provide comprehensive overviews of research regarding implementation science and implementation of EBP were consulted: Rycroft-Malone and Bucknall (2010c), Nutley et al. (2007), Greenhalgh et al. (2005), Grol et al. (2005), Straus et al. (2009) and Brownson et al. (2012). A few papers presenting overviews of theories, models and frameworks used in implementation science were also used: Estabrooks et al. (2006), Sales et al. (2006), Graham and Tetroe (2007), Mitchell et al. (2010), Flottorp et al. (2013), Meyers et al. (2012) and Tabak et al. (2012). In addition, *Implementation Science* was searched using the terms ‘theory’, ‘model’ and ‘framework’ to identify relevant articles. The titles and abstracts of the identified articles were scanned, and those that were relevant to the study aim were read in full.

**THEORIES, MODELS AND FRAMEWORKS IN THE GENERAL LITERATURE AND IN IMPLEMENTATION SCIENCE**

Generally, a theory may be defined as a set of analytical principles or statements designed to structure our observation, understanding and explanation of the world (Carpiano, 2006; Frankfort-Nachmias and Nachmias, 1996; Wacker, 1998). Authors usually point to a theory as being made up of definitions of variables, a domain where the theory applies, a set of relationships between the variables and specific predictions (Bunge, 1967; Dubin, 1969; Hunt, 1991; Reynolds, 1971). A ‘good theory’ provides a clear explanation of how and why specific relationships lead to specific events. Theories can be described on an abstraction continuum. High abstraction level theories (general or grand theories) have an almost unlimited scope, middle abstraction level theories explain limited sets of phenomena, and lower level abstraction theories are empirical generalizations of limited scope and application (Bluedorn and Evered, 1980; Wacker, 1998).
A model typically involves a deliberate simplification of a phenomenon or a specific aspect of a phenomenon. Models need not be completely accurate representations of reality to have value (Carpiano, 2006; Cairney, 2012). Models are closely related to theory and the difference between a theory and a model is not always clear. Models can be described as theories with a more narrowly defined scope of explanation; a model is descriptive, whereas a theory is explanatory as well as descriptive (Frankfort-Nachmias and Nachmias, 1996).

A framework usually denotes a structure, overview, outline, system or plan consisting of various descriptive categories – for example, concepts, constructs or variables – and the relations between them that are presumed to account for a phenomenon (Sabatier, 1999). Frameworks do not provide explanations; they only describe empirical phenomena by fitting them into a set of categories (Frankfort-Nachmias and Nachmias, 1996).

With regard to implementation science, the terms ‘theories’, ‘models’ and ‘frameworks’ are often used interchangeably (Estabrooks et al., 2006; Kitson et al., 2008; Rycroft-Malone and Bucknall, 2010a). A theory in this field usually implies some predictive capacity (for example, to what extent do health care practitioners’ attitudes and beliefs concerning a clinical guideline predict their adherence to this guideline in clinical practice?) and attempts to explain the causal mechanisms of implementation. Models in implementation science are commonly used to describe and/or guide the process of translating research into practice (that is, ‘implementation practice’) rather than to predict or analyse what factors influence implementation outcomes (that is, ‘implementation research’). Frameworks in implementation science often have a descriptive purpose by pointing to factors believed or found to influence implementation outcomes (for example, health care practitioners’ adoption of an evidence-based patient intervention). Neither models nor frameworks specify the mechanisms of change; they are typically more like checklists of factors relevant to various aspects of implementation.

It is possible to identify three overarching aims of the use of theories, models and frameworks in implementation science:

- describing and/or guiding the process of translating research into practice;
- understanding and/or explaining what influences implementation outcomes;
- evaluating implementation.

Based on descriptions of their origins, how they were developed, what knowledge sources they drew on, stated aims and applications in
Overview of theories, models and frameworks

Theoretical approaches used in implementation science

Describing and/or guiding the process of translating research into practice

Understanding and/or explaining what influences implementation outcomes

Evaluating implementation

Process models
Determinant frameworks
Classic theories
Implementation theories
Evaluation frameworks

Figure 1.1 Three aims of the use of theoretical approaches in implementation science and the five categories of theories, models and frameworks

Implementation science, theoretical approaches that aim at understanding and/or explaining influences on implementation outcomes (that is, the second aim) can be further broken down into:

- determinant frameworks;
- classic theories;
- implementation theories.

Thus, five categories of theoretical approaches used in implementation science can be delineated, as shown in Figure 1.1. Table 1.1 summarizes the five categories and provides examples of approaches in each category.

PROCESS MODELS

Process models are used to describe and/or guide the process of translating research into practice. Models by Huberman (1994), Landry et al. (2001), the CIHR (Canadian Institutes of Health Research, 2014), the Knowledge Model of Knowledge Translation, Davis et al. (2007), Majdzadeh et al. (2008) and the K2A (Knowledge-to-Action) Framework, Wilson et al. (2011) outline phases or stages of the research-to-practice process, from discovery and production of research-based knowledge to implementation and use of research in various settings.
Table 1.1  Five categories of theories, models and frameworks used in implementation science

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<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Examples</th>
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<tr>
<td>Process models</td>
<td>Specify steps (stages, phases) in the process of translating research into practice, including the implementation and use of research. The aim of process models is to describe and/or guide the process of translating research into practice. An action model is a type of process model that provides practical guidance in the planning and execution of implementation endeavours and/or implementation strategies to facilitate implementation. Note that the terms ‘model’ and ‘framework’ are both used, but the former appears to be the most common.</td>
<td>Model by Huberman (1994), model by Landry et al. (2001), model by Davis et al. (2007), model by Majdzadeh et al. (2008), the CIHR Model of Knowledge Translation (Canadian Institutes of Health Research, 2014), the K2A Framework (Wilson et al., 2011), the Stetler Model (Stetler, 2010), the ACE Star Model of Knowledge Transformation (Stevens, 2013), the Knowledge-to-Action Model (Graham et al., 2006), the Iowa Model (Titler et al., 1994; Titler et al., 2001), the Ottawa Model (Logan and Graham, 1998, 2010), model by Grol and Wensing (2004), model by Pronovost et al. (2008), the Quality Implementation Framework (Meyers et al., 2012)</td>
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<tr>
<td>Determinant frameworks</td>
<td>Specify types (also known as classes or domains) of determinants and individual determinants, which act as barriers and enablers (independent variables) that influence implementation outcomes (dependent variables). Some frameworks also specify relationships between some types of determinants. The overarching aim is to understand and/or explain influences on implementation outcomes, e.g., predicting outcomes or interpreting outcomes retrospectively.</td>
<td>i-PARIHS (Harvey and Kitson, 2016), PARIHS (Kitson et al., 1998; Rycroft-Malone, 2010), Active Implementation Frameworks (Blasé et al., 2012; Holmes et al., 2012), Understanding-User-Context Framework (Jacobson et al., 2003), Conceptual Model (Greenhalgh et al., 2005), framework by Grol et al. (2005), framework by Cochrane et al. (2007), framework by Nutley et al. (2007), Ecological Framework by Durlak and DuPre (2008), CFIR (Damschroder et al., 2009), framework by Gurses et al. (2010), framework by Ferlie and Shortell (2001), Theoretical Domains Framework (Michie et al., 2014)</td>
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Early research-to-practice (or knowledge-to-action) models tended to depict rational, linear processes in which research was simply transferred from producers to users. However, subsequent models have highlighted the importance of facilitation to support the process and placed more emphasis on the contexts in which research is implemented and used. Thus, the attention has shifted from a focus on production, diffusion and dissemination of research to various implementation aspects (Nutley et al., 2007).

So-called action (or planned action) models are process models that facilitate implementation by offering practical guidance in the planning

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<td>Classic theories</td>
<td>Theories that originate from fields external to implementation science, e.g., psychology, sociology and organizational theory, which can be applied to provide understanding and/or explanation of aspects of implementation.</td>
<td>Theory of Diffusion (Rogers, 2003), social cognitive theories, theories concerning cognitive processes and decision-making, social networks theories, social capital theories, communities of practice, professional theories, organizational theories</td>
</tr>
<tr>
<td>Implementation theories</td>
<td>Theories that have been developed by implementation researchers (from scratch or by adapting existing theories and concepts) to provide understanding and/or explanation of aspects of implementation.</td>
<td>Implementation Climate (Klein and Sorra, 1996), Absorptive Capacity (Zahra and George, 2002), Organizational Readiness (Weiner, 2009), COM-B (Michie et al., 2011), Normalization Process Theory (May and Finch, 2009)</td>
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<tr>
<td>Evaluation frameworks</td>
<td>Specify aspects of implementation that could be evaluated to determine implementation success.</td>
<td>RE-AIM (Glasgow et al., 1999); PRECEDE-PROCEED (Green et al., 2005); framework by Proctor et al. (2010)</td>
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Notes: ACE, Academic Center for Evidence-Based Practice; CFIR, Consolidated Framework for Implementation Research; CIHR, Canadian Institutes of Health Research Knowledge; COM-B, Capacity, Opportunities, Motivation, Behaviour; Conceptual Model, Conceptual Model for Considering the Determinants of Diffusion, Dissemination, and Implementation of Innovations in Health Service Delivery and Organization (full title); K2A, Knowledge-to-Action; (i)-PARIHS, (Integrated)-Promoting Action on Research Implementation in Health Services; PRECEDE-PROCEED, Predisposing, Reinforcing and Enabling Constructs in Educational Diagnosis and Evaluation – Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development; RE-AIM, Reach, Effectiveness, Adoption, Implementation, Maintenance.
and execution of implementation endeavours and/or implementation strategies. Action models elucidate important aspects that need to be considered in implementation practice and usually prescribe a number of stages or steps that should be followed in the process of translating research into practice. Action models have been described as active by Graham et al. (2009, p.185) because they are used ‘to guide or cause change’. However, the terminology is not fully consistent, because some of these models are referred to as frameworks; for example, the Knowledge-to-Action Framework (Rycroft-Malone and Bucknall, 2010b).

Many of the action models originate from the nursing-led field of research use or utilization; well-known examples include the Stetler Model (Stetler, 2010), the ACE (Academic Center for Evidence-Based Practice) Star Model of Knowledge Transformation (Stevens, 2013), the Knowledge-to-Action Framework (Graham et al., 2006), the Iowa Model (Titler et al., 1994; Titler et al., 2001) and the Ottawa Model (Logan and Graham, 1998, 2010). There are also numerous examples of similar ‘how-to-implement’ models that have emerged from other fields, including models developed by Grol and Wensing (2004) and Pronovost et al. (2008), and the Quality Implementation Framework (Meyers et al., 2012), all of which are intended to provide support for planning and managing implementation endeavours.

The how-to-implement models typically emphasize the importance of careful, deliberate planning, especially in the early stages of implementation endeavours. In many ways, they present an ideal view of implementation practice as a process that proceeds stepwise, in an orderly, linear fashion. Still, authors behind most models emphasize that the actual process is not necessarily sequential. Many of the action models mentioned here have been subjected to testing or evaluation, and some have been widely applied in empirical research, underscoring their usefulness (Field et al., 2014; Rycroft-Malone and Bucknall, 2010a).

The process models vary with regard to how they were developed. Models such as the Stetler Model (Stetler, 1994, 2010) and the Iowa Model (Titler et al., 1994; Titler et al., 2001) were based on the originators’ own experiences of implementing new practices in various settings (although they were also informed by research and expert opinion). In contrast, models such as the Knowledge-to-Action Framework (Graham et al., 2009) and the Quality Implementation Framework (Meyers et al., 2012) have relied on literature reviews of theories, models, frameworks and individual studies to identify key features of successful implementation endeavours.
DETERMINANT FRAMEWORKS

Determinant frameworks describe general types (also referred to as classes or domains) of determinants that are hypothesized or have been found to influence implementation outcomes, for example, health care professionals’ behaviour change or adherence to a clinical guideline. Each type of determinant typically comprises a number of individual barriers (hindrances, impediments) and/or enablers (facilitators), which are seen as independent variables that have an impact on implementation outcomes, that is, the dependent variable. Some frameworks also hypothesize relationships between these determinants (e.g., Durlak and DuPre, 2008; Greenhalgh et al., 2005; Gurses et al., 2010), whereas others recognize such relationships without clarifying them (e.g., Cochrane et al., 2007; Damschroder et al., 2009). Information about what influences implementation outcomes is potentially useful for designing and executing implementation strategies that aim to change relevant determinants.

The determinant frameworks do not address how change takes place or any causal mechanisms, underscoring that they should not be considered theories. Many frameworks are multi-level, identifying determinants at different levels, from the individual user or adopter (for example, health care practitioners) to the organization and beyond. Hence, these integrative frameworks recognize that implementation is a multidimensional phenomenon, with multiple interacting influences.

The determinant frameworks were developed in different ways. Many frameworks (e.g., Cochrane et al., 2007; Durlak and DuPre, 2008; Ferlie and Shortell, 2001; Greenhalgh et al., 2005; Grol et al., 2005; Nutley et al., 2007) were developed by synthesizing results from empirical studies of barriers and enablers for implementation success. Other frameworks have relied on existing determinant frameworks and relevant theories in various disciplines, for example, the frameworks by Gurses et al. (2010) and the CFIR (Consolidated Framework for Implementation Research) (Damschroder et al., 2009).

Several frameworks have drawn extensively on the originator’s own experiences of implementing new practices. For instance, the Understanding-User-Context Framework (Jacobson et al., 2003) and Active Implementation Frameworks (Blasé et al., 2012) were both based on a combination of literature reviews and the originators’ implementation experiences. Meanwhile, PARIHS (Promoting Action on Research Implementation in Health Services) (Kitson et al., 1998; Rycroft-Malone, 2010) emerged from the observation that successful implementation in health care might be premised on three key determinants (characteristics of the evidence, context and facilitation), a proposition that was then
analysed in four empirical case studies; PARIHS has subsequently under- 
gone substantial research and development work (Rycroft-Malone, 2010) 
and has been widely applied (Helfrich et al., 2010).

The Theoretical Domains Framework represents another approach 
to developing determinant frameworks. It was constructed on the basis 
of a synthesis of 128 constructs related to behaviour change found in 
33 behaviour change theories, including many social cognitive theories 
(Cane et al., 2012). The constructs are sorted into 14 theoretical domains 
(originally 12 domains): for example, knowledge, skills, intentions, goals, 
social influences and beliefs about capabilities (Michie et al., 2014). The 
Theoretical Domains Framework does not specify the causal mechanisms 
found in the original theories, thus sharing many characteristics with 
determinant frameworks.

The frameworks are superficially quite disparate, with a broad range of 
terms, concepts and constructs as well as different outcomes, yet they are 
quite similar with regard to the general types of determinants they account 
for. Hence, implementation researchers agree to a large extent on what the 
main influences on implementation outcomes are, albeit to a lesser extent 
on which terms that are best used to describe these determinants. Many 
determinant frameworks account for five types of determinants, as shown 
in Figure 1.2:

- characteristics of the implementation object;
- influences at the individual health care professional level;
- patient influences;
- collective-level influences;
- effectiveness of implementation strategies used to support 
  implementation.

The arrow in Figure 1.2 represents the implementation outcomes that 
result from the five types of determinants. The links between the nodes 
depict the interdependency between the different types of determinants 
to underscore that they should ideally be assessed holistically, that is, not 
in isolation of each other. There could be synergistic effects such that two 
seemingly minor barriers constitute an important obstacle to successful 
outcomes if they interact or potentially strong facilitators may combine to 
generate weak effects.

The frameworks describe implementation ‘objects’ in terms of research, 
guidelines, interventions, innovations and evidence (that is, research-based 
knowledge in a broad sense). Outcomes differ correspondingly, from 
adherence to guidelines and research use, to successful implementation 
of interventions, innovations, evidence, and so on (that is, the application
Overview of theories, models and frameworks

of research-based knowledge in practice). The relevance of the end users (for example, patients, consumers or community populations) of the implemented object is not explicitly addressed in some frameworks (e.g., Fixsen et al., 2005; Greenhalgh et al., 2005; Nutley et al., 2007), suggesting that this is an area where further research is needed for better analysis of how various end users may influence implementation outcomes.

Determinant frameworks imply a systems approach to implementation because they point to multiple levels of influence and acknowledge that there are relationships within and across the levels and different types of determinants. A system can be understood only as an integrated whole, because it is composed of not only the sum of its components but also the relationships among those components (Holmes et al., 2012). However, determinants are often assessed individually in implementation studies (e.g., Broyles et al., 2012; Légaré et al., 2008; Johnson et al., 2010; Verweij et al., 2012), (implicitly) assuming a linear relationship between the determinants and the outcomes and ignoring that individual barriers and enablers may interact in various ways that can be difficult to predict.

Figure 1.2  Illustrating the interdependent determinants of implementation success

![Illustration of determinants and outcomes in implementation success](image-url)
Another issue is whether all relevant barriers and enablers are examined in these studies, which are often based on survey questionnaires, and are thus biased by the researcher’s selection of determinants. Surveying the perceived importance of a finite set of predetermined barriers can yield insights into the relative importance of these particular barriers but may overlook factors that independently affect implementation outcomes. Furthermore, there is the issue of whether the barriers and enablers are the actual determinants (that is, whether they have actually been experienced or encountered), and the extent to which they are perceived to exist (that is, they are more hypothetical barriers and enablers). The perceived importance of particular factors may not always correspond with the actual importance.

The context is an integral part of all the determinant frameworks. Described as ‘an important but poorly understood mediator of change and innovation in health care organizations’ (Dopson and Fitzgerald, 2005, p. 79), the context lacks a unifying definition in implementation science (and related fields such as organizational behaviour and quality improvement). Still, context is generally understood as the conditions or surroundings in which something exists or occurs, typically referring to an analytical unit that is higher than the phenomena directly under investigation. The role afforded the context varies from studies (e.g., Ashton et al., 2007; Mohr et al., 2008; Scott et al., 2008; Zardo and Collie, 2014) that essentially view the context in terms of a physical ‘environment or setting in which the proposed change is to be implemented’ (Kitson et al., 1998, p. 150), to studies (e.g., Ashton et al., 2007; Gabbay, 2004; Nutley et al., 2007) that assume that the context is something more active and dynamic that greatly affects the implementation process and outcomes. Hence, although implementation science researchers agree that the context is a critically important concept for understanding and explaining implementation, there is a lack of consensus regarding how this concept should be interpreted, in what ways the context is manifested, and the means by which contextual influences might be captured in research.

The different types of determinants specified in determinant frameworks can be linked to classic theories. Thus, psychological theories that delineate factors influencing individual behaviour change are relevant for analysing how user or adopter characteristics affect implementation outcomes; whereas organizational theories concerning organizational climate, culture and leadership are more applicable for addressing the influence of the context on implementation outcomes.
CLASSIC THEORIES

Implementation researchers are also wont to apply theories from other fields such as psychology, sociology and organizational theory. These theories have been referred to as classic (or classic change) theories, to distinguish them from research-to-practice models (Graham et al., 2009). They might be considered passive in relation to action models because they describe change mechanisms and explain how change occurs without ambitions to actually bring about change.

Psychological behaviour change theories such as the Theory of Reasoned Action (Fishbein and Ajzen, 1975), the Social Cognitive Theory (Bandura, 1977, 1986), the Theory of Interpersonal Behaviour (Triandis, 1980) and the Theory of Planned Behaviour (Ajzen, 2005) have all been widely used in implementation science to study determinants of ‘clinical behaviour’ change (Nilsen et al., 2012). Theories such as the Cognitive Continuum Theory (Hammond, 1981), the Novice–Expert Theory (Benner, 1984), the Cognitive–Experiential Self-Theory (Epstein, 1994) and habit theories (e.g., Ouellette and Wood, 1998; Verplanken and Aarts, 1999) may also be applicable for analysing cognitive processes involved in clinical decision-making and implementing EBP, but they are not as extensively used as the behaviour change theories.

Theories regarding the collective level (such as health care teams) or other aggregate levels are relevant in implementation science; for example, theories concerning professions and communities of practice, as well as theories concerning the relationships between individuals, such as social networks and social capital (Cunningham et al., 2011; Eccles et al., 2009; Estabrooks et al., 2006; Grol and Wensing, 2004; Parchman et al., 2011; Mascia and Cicchetti, 2011). However, their use is not as prevalent as the individual-level theories.

There is increasing interest among implementation researchers in using theories concerning the organizational level because the context of implementation is becoming more widely acknowledged as an important influence on implementation outcomes.

Theories concerning organizational culture, organizational climate, leadership and organizational learning are relevant for understanding and explaining organizational influences on implementation processes (Chaudoir et al., 2013; Durlak and DuPre, 2008; French et al., 2009; Gifford et al., 2007; Grol and Wensing, 2004; Nutley et al., 2007; Meijers et al., 2006; Parmelli et al., 2011; Wallin et al., 2006; Wensing et al., 2006; Yano, 2008). Several organization-level theories might have relevance for implementation science. For instance, Estabrooks et al. (2006) have proposed the use of the Situated Change Theory (Orlikowski, 1996) and the
Institutional Theory (DiMaggio and Powell, 1991; Scott, 1995), whereas Plsek and Greenhalgh (2001) have suggested the use of complexity science (Waldrop, 1992) for better understanding of organizations. Meanwhile, Grol et al. (2005) have highlighted the relevance of economic theories and theories of innovative organizations. However, despite increased interest in organizational theories, their actual use in empirical implementation studies thus far is relatively limited.

The Theory of Diffusion, as popularized through Rogers’s work on the spread of innovations, has also influenced implementation science. The theory’s notion of innovation attributes – that is, relative advantage, compatibility, complexity, trialability and observability (Rogers, 2003) – has been widely applied in implementation science, both in individual studies (e.g., Aubert and Hamel, 2001; Foy et al., 2002; Völlink et al., 2002) and in determinant frameworks (e.g., Damschroder et al., 2009; Greenhalgh et al., 2005; Gurses et al., 2010), to assess the extent to which the characteristics of the implementation object (for example, a clinical guideline) affect implementation outcomes. Furthermore, the Theory of Diffusion highlights the importance of intermediary actors (opinion leaders, change agents and gatekeepers) for successful adoption and implementation (Rogers, 2003), which is reflected in roles described in numerous implementation determinant frameworks (e.g., Blasé et al., 2012; Rycroft-Malone, 2010) and implementation strategy taxonomies (e.g., Grimshaw et al., 2003; Leeman et al., 2007; Oxman et al., 1995; Walter et al., 2003). The Theory of Diffusion is considered the single most influential theory in the broader field of knowledge utilization of which implementation science is a part (Estabrooks et al., 2008).

IMPLEMENTATION THEORIES

There are also numerous theories that have been developed or adapted by researchers for potential use in implementation science to achieve enhanced understanding and explanation of certain aspects of implementation. Some of these have been developed by modifying certain features of existing theories or concepts; for example, concerning organizational climate and culture. Examples include theories such as Implementation Climate (Klein and Sorra, 1996), Absorptive Capacity (Zahra and George, 2002) and Organizational Readiness (Weiner, 2009). The adaptation allows researchers to prioritize aspects considered to be most critical to analyse issues related to the how and why of implementation, thus improving the relevance and appropriateness to the particular circumstances at hand.
COM-B (Capability, Opportunity, Motivation, Behaviour) represents another approach to developing theories that might be applicable in implementation science. This theory began by identifying motivation as a process that energizes and directs behaviour. Capability and opportunity were added as necessary conditions for a volitional behaviour to occur, given sufficient motivation, on the basis of a United States (US) consensus meeting of behavioural theorists and a principle of US criminal law (which considers prerequisites for performance of specified volitional behaviours) (Michie et al., 2011). COM-B posits that capability, opportunity and motivation generate behaviour, which in turn influences the three components. Opportunity and capability can influence motivation, and enacting a behaviour can alter capability, motivation and opportunity (Michie et al., 2014).

Another theory used in implementation science, the Normalization Process Theory (May and Finch, 2009), began life as a model, constructed on the basis of empirical studies of the implementation of new technologies (May et al., 2007). The model was subsequently expanded and developed into a theory as change mechanisms and interrelations between various constructs were delineated (Finch et al., 2013). The theory identifies four determinants of embedding (that is, normalizing) complex interventions in practice – coherence or sense-making, cognitive participation or engagement, collective action and reflexive monitoring – and the relationships between these determinants (Murray et al., 2010).

EVALUATION FRAMEWORKS

There is a category of frameworks that provides a structure for evaluating implementation endeavours. Two common frameworks that originated in public health are RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) (Glasgow et al., 1999) and PRECEDE-PROCEED (Predisposing, Reinforcing and Enabling Constructs in Educational Diagnosis and Evaluation – Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development) (Green et al., 2005). Both frameworks specify implementation aspects that should be evaluated as part of intervention studies.

Proctor et al. (2010) have developed a framework of implementation outcomes that can be applied to evaluate implementation endeavours. On the basis of a narrative literature review, they propose eight conceptually distinct outcomes for potential evaluation: acceptability, adoption (also referred to as uptake), appropriateness, costs, feasibility, fidelity, penetration (integration of a practice within a specific setting) and sustainability (also referred to as maintenance or institutionalization).
Although evaluation frameworks may be considered in a category of their own, theories, models and frameworks from the other four categories can also be applied for evaluation purposes because they specify concepts and constructs that may be operationalized and measured. For instance, the Theoretical Domains Framework (e.g., Fleming et al., 2014; Phillips et al., 2015), Normalization Process Theory (McEvoy et al., 2014) and COM-B (e.g., Connell et al., 2015; Praveen et al., 2014) have all been widely used as evaluation frameworks. Furthermore, many theories, models and frameworks have spawned instruments that serve evaluation purposes; for example, tools linked to PARIHS (Estabrooks et al., 2009; McCormack et al., 2009), CFIR (Damschroder and Lowery, 2013) and the Theoretical Domains Framework (Dyson et al., 2013). Other examples include the EBP Implementation Scale, to measure the extent to which EBP is implemented (Melnyk et al., 2008) and the BARRIERS Scale to identify barriers to research use (Kajermo et al., 2010), as well as instruments to operationalize theories such as Implementation Climate (Jacobs et al., 2014) and Organizational Readiness (Gagnon et al., 2011).

CONCLUDING REMARKS

This chapter proposes a taxonomy of five categories of theories, models and frameworks used in implementation science. These categories are not always recognized as separate types of approaches in the literature. For instance, systematic reviews and overviews by Graham and Tetroe (2007), Mitchell et al. (2010), Flottorp et al. (2013), Meyers et al. (2012) and Tabak et al. (2012) have not distinguished between process models, determinant frameworks or classic theories because they all deal with factors believed or found to have an impact on implementation processes and outcomes. However, what matters most is not how an individual approach is labelled; it is important to recognize that these theories, models and frameworks differ in terms of their assumptions, aims and other characteristics, which have implications for their use.

There is considerable overlap between some of the categories. Thus, determinant frameworks, classic theories and implementation theories can also help to guide implementation practice (that is, functioning as action models), because they identify potential barriers and enablers that might be important to address when undertaking an implementation endeavour. They can also be used for evaluation because they describe aspects that might be important to evaluate. A framework such as the Active Implementation Frameworks (Holmes et al., 2012) appears to have...
a dual aim of providing hands-on support to implement something and identifying determinants of this implementation that should be analysed. Somewhat similarly, PARIHS (Kitson et al., 1998) can be used by ‘anyone either attempting to get evidence into practice, or anyone who is researching or trying to better understand implementation processes and influences’ (Rycroft-Malone, 2010, p. 120), suggesting that it has ambitions that go beyond its primary function as a determinant framework.

Despite the overlap between different theories, models and frameworks used in implementation science, knowledge about the three overarching aims and five categories of theoretical approaches is important to identify and select relevant approaches in various situations. Most determinant frameworks provide limited ‘how-to’ support for carrying out implementation endeavours, because the determinants may be too generic to provide sufficient detail for guiding users through an implementation process. Although the relevance of addressing barriers and enablers to translating research into practice is mentioned in many process models, these models do not identify or systematically structure specific determinants associated with implementation success. Another key difference is that process models recognize a temporal sequence of implementation endeavours, whereas determinant frameworks do not explicitly take a process perspective of implementation because the determinants typically relate to implementation as a whole.

Selecting an appropriate theory, model or framework often represents a considerable challenge for implementation researchers. Choosing one approach means placing weight on some aspects (for example, certain causal factors) at the expense of others, thus offering only partial understanding. Combining the merits of multiple theoretical approaches may offer more complete understanding and explanation, yet such combinations may mask contrasting assumptions regarding key issues. For instance, are people driven primarily by their individual beliefs and motivation, or does a pervasive organizational culture impose norms and values that regulate how people behave and make individual characteristics relatively unimportant? Is a particular behaviour primarily influenced by reflective thought processes, or is it an automatically enacted habit? Furthermore, different approaches may require different methods based on different epistemological and ontological assumptions.

Although the use of theories, models and frameworks has many advocates in implementation science, there have also been critics (Bhattacharyya et al., 2006; Oxman et al., 2005), who have argued that theory is not necessarily better than common sense for guiding implementation. Common sense has been defined as a group’s shared tacit knowledge concerning
a phenomenon (Fletcher, 1984). One could argue that common sense about how or why something works (or does not) also constitutes a theory, albeit an informal and non-codified one. In either case, empirical research is needed to study how and the extent to which the use of implementation theories, models and frameworks contributes to more effective implementation and under what contextual conditions or circumstances they apply (and do not apply). It is also important to explore how the current theoretical approaches can be further developed to better address implementation challenges. Hence, both inductive construction of theory and deductive application of theory are needed.

The use of theory does not necessarily yield more effective implementation than using common sense, yet there are certain advantages to applying formal theory over common sense (that is, informal theory). Theories are explicit and open to question and examination; common sense usually consists of implicit assumptions, beliefs and ways of thinking and is therefore more difficult to challenge. If deductions from a theory are incorrect, the theory can be adapted, extended or abandoned. Theories are more consistent with existing facts than common sense, which typically means that a hypothesis based on an established theory is a more educated guess than one based on common sense. Furthermore, theories give individual facts a meaningful context and contribute towards building an integrated body of knowledge, whereas common sense is more likely to produce isolated facts (Cacioppo, 2004; Fletcher, 1984).

On the other hand, theory may serve as blinkers, as suggested by Kuhn (1970) and Greenwald et al. (1986), causing us to ignore problems that do not fit into existing theories, models and frameworks or hindering us from seeing known problems in new ways. Theorizing about implementation should therefore not be an abstract academic exercise unconnected with the real world of implementation practice. In the words of Immanuel Kant, ‘Experience without theory is blind, but theory without experience is mere intellectual play.’

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REFERENCES


(2009) Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science* 4, 50.


Overview of theories, models and frameworks

Frameworks and taxonomies of factors that prevent or enable improvements in healthcare professional practice. *Implementation Science* 8, 35.


A critical synthesis of literature on the promoting action on research implementation in health services (PARIHS) framework. Implementation Science 5, 82.


May, C., Finch, T., Mair, F., Ballini, L., Dowrick, C., et al. (2007) Understanding the
implementation of complex interventions in health care: the normalization process model. 

*BMC Health Services Research* 7, 148.


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