DESCRIPTION OF THE PRACTICE	
1. Title of the practice	
- 'THE MÖLNDAL MODEL – A CONTINUUM CARE FOR FRAIL OLDER PEOPLE' -	
2. Organisation responsible for the practice	
Mölndal Hospital, Mölndal Municipality and primary health care, Sweden	
3. Contact person(s)	
E-mail	policy@esn-eu.org
4. National/regional/local context of the practice	

The legal foundation for health care in Sweden is the 'Health and Medical Services Act' (1983) which aims to provide equal, needs-based access to health services. The 1982 'Social Services Act' regulates that municipalities have the responsibility to ensure help and support for citizens and emphasises the right of the individual to receive public services and help at all stages of life. The 1992 'Ädel reform' was set out to address regional differences and the health and social divides. Municipalities have become responsible for patients following hospital discharge and are obliged to pay fees if patients stay longer than needed in the hospital.

These laws have created 'frames' that leave flexibility for local authorities. National policy has tried to enforce cooperation between health and social care, especially in care for older people with complex health problems and severe needs. In recent years, this has resulted in several financial incentives by the government to stimulate cooperation. Counties are responsible for health and medical care, including hospital and primary health care, while municipalities are responsible for social care for older people. Support at home includes assistance for daily activities, nursing (medical) care, assistive devices, daycare, and short-term institutional care. Additional services include transportation, foot care, wheel meals, security alarms and housing adaptations.

Developmental projects have been implemented with earmarked resources to develop integrated care models for older people. In addition, health and social care authorities are paid when they include a patient in a relevant register. For instance, authorities are remunerated for every person diagnosed with dementia who registers in the Swedish Dementia Register, for people included in the Senior Alert Register, where data on the prevalence of pressure sores, falls, and malnutrition are noticed, and finally, for people included in the Swedish Register of Palliative Care.

Recently, a performance-related payment system was introduced in the Swedish health and social care system to reduce hospital admissions and readmissions among older people. It provides financial rewards to county councils, regions and municipalities for reducing such admissions. Another type of performance-related payment is tied to the reduction of inappropriate drug use among older people.

5. Summary of the practice

This practice started at Mölndals Hospital. Mölndal is a suburban municipality in Southern Gothenburg. The population is around 62,000 inhabitants, with 16% aged over 65 years and 4.4% over 80 years (2013). The population composition is rather young compared to other Swedish municipalities.

The practice is a care chain involving the hospital, primary health care and the municipality to create a continuum of care from the emergency department, through the hospital ward, to the older person's home. The practice provides a protocol for screening and detecting older people (75+) at risk in the hospital and offers pathways for safe hospital discharge. This practice connects with outpatient healthcare organisations and municipal care services starting at the hospital. A geriatric nurse screen needs a new screening tool. If the patient is ready to go home again from the hospital, the nurse liaises with the case manager in the municipality to coordinate the transfer back home, which involves the development of a care plan together with the older person and the family.

The care model was designed in cooperation with representatives from the care providers and intervention researchers.

Lessons learnt:

- The model has been put into practice and seems to work. The model has been thoroughly researched - a unique situation in Sweden.
- At the beginning of the model (2010- 2011), the project had problems involving primary health care (= physicians). Now (2014-2015), new practices have been taken to establish routines involving primary health care.

6. Staff involved

Research team, hospital nurses, a case manager (municipal nurse), an interprofessional home care team (social worker, occupational therapist, physiotherapist)

7. Target group

Older people over 75 years old

8. Aims of the practice

- Better use of resources by reducing the number of inadequate hospital admissions
- Enhance safety through the development of a protocol between professionals and a care plan for older people following hospital discharge

9. Issues for social services

Service Integration/ Cooperation across services	X	**Service Planning**		**Contracting**	

Technology		**Skills development (of the workforce)**		**Quality of services**	

ANALYSIS OF THE PRACTICE	
10. Status	
Pilot project (ongoing)	
Pilot project (terminated)	
Project (ongoing)	
Project (terminated)	
Implemented practice (restricted areas)	X
Widely spread practice/rolled out	

11. Scope of the practice

Describe the setting of the practice, considering the following criteria:

- *Micro-level practice: a* practice that involves individuals at the local level
- *Meso-level practice: a* practice that involves organisations or communities
- *Macro level practice: a* practice that involves large population groups

Meso level integration

12. Leadership and management of the practice

Describe the leadership of the practice, considering the following criteria:

- *Collaborative management*: shared between large partnerships, often of central, regional, and local representation
- *Organisational management*: by one organisation
- *Professional management*: managed by a single person
- *Shared management*: shared with no defined leadership

Professional management: the geriatric nurse at the hospital and the nurse (case manager) in the municipality manage and coordinate future care services at home.

13. Engaging stakeholders in the practice

Describe the engagement of stakeholders, considering the following criteria:

- *Individual practice*: individuals have sought practice change
- *Network approach*: one or more organisations develop a network
- *Collaborative approach*: large collaboration with relevant stakeholders

This practice describes how new roles for new integrated care pathways have been established. The professionals create a care pathway for older people from hospital to home involving a care chain and creating clear lines of responsibility and a continuum of care from the emergency department through the hospital ward to the older person's own home. Care coordinators (registered nurses) perform a geriatric assessment in the hospital emergency ward. A case manager (nurse) in the municipality is informed and plans home care. The case manager and a multi-professional team (a social worker, an occupational therapist and/or a physiotherapist) plan the care programme and rehabilitation in the older person's home following discharge from the hospital. The case manager is the hub, managing the services in cooperation with the multi-professional team and following up on the situation.

14. Involvement of service users and their families

Describe the involvement of service users, considering the following criteria:

- *Team involvement: service users and carers were part of the practice team*
- *Consultative: a consultative body of users was set up for an ongoing dialogue and feedback* *Involvement in care: person-centred approaches to care/support*

Involvement in care: the practice has a person-centred approach to care which is seen as a key success factor in involving people in their care. The care planning is performed in the older people's homes and strives to encourage the older person to make choices and to involve the family. One important aim is to offer enablement–oriented services to improve the older person's ability to manage everyday life on his or her own.

15. Costs and resources needed for implementation

Describe how the practice is financed, considering the following criteria:

- *Within existing resources:* staff time and other resources are provided 'in-house'
- *Staffing costs:* costs for staff investment
- *Joint/Pooled budgets:* two or more agencies pool budgets to fund services *Funded project:* external investment

Staffing costs: The hospital's geriatric nurse and the municipality's nurse (case-manager).

16. Evaluation approaches

Describe the evaluation method of the practice, considering the following criteria:

- *Multi-method:* use of both a qualitative and a quantitative approach
- *Single method: a* qualitative or quantitative approach
- *Audit:* looks at data sources such as existing medical records and/or other routinely collected service data.
- *Informal:* refers to in-house service evaluation using locally designed tools and/or collecting opportunistic feedback
- *No evaluation*
- *An evaluation is planned*

n.a.

17. Measurable effects of the practice and what it has achieved

Service users	
Formal care givers	

Informal carers	
Organisations	
18. Anticipated or 'aspirational 'effects of the practice and what it has achieved *This category can include outcomes which are not documented, quantified, or properly evaluated. They can include such elements as improved knowledge, quality, workforce, etc.*	
Service users	The model offers frail older people a safe pathway back from the hospital and provides tailored support to maximise the person's possibilities to age in place
Formal caregivers	Increased job satisfaction
Informal carers	The carers are relieved from their traditional role of coordinating service and care.
Organisations	The municipality reported fewer costs for medically treated patients. Moreover, the hospital reported fewer costs due to fewer admittances and bed days in the hospital. The practice creates a structure with clear roles and, at the same time, promotes professional collaboration, which is based on shared values of the importance of "working together". The model successfully created sustainable routines for collaboration between health care and social services.
19. How has the practice changed the way the service is provided	
Care pathway: the practice establishes a new care pathway that provides safe transitions from hospital to home care.	
20. Sustainability of the practice *Describe if the practice is sustainable, considering the following criteria:* • *Potential for sustainability:* practice was newly started or is ongoing/not yet mainstreamed. How could the practice be sustained (in terms of resources)? • *Organic sustainability:* service users have been empowered to take the practice forward *Established:* the project has been operational for several years	
Established: this practice is now part of the traditional services in Mölndal Municipality.	
21. Transferability of the practice *Describe if the practice has been transferred, considering the following criteria:* • *Transferred:* transfer to other regions, countries, service user groups, etc. • *Potential for transferability:* there is interest from the outside; elements of the practice have been taken up and used elsewhere; material for transferability (for ex. training material) has been developed	

Potential for transferability: some elements of the practice were transferred, such as the screening tool and the role of the geriatric nurse.

The screening tool has been recently introduced in other hospitals in the Gothenburg area. The role of the geriatric nurse has been introduced in every hospital in the Gothenburg area. A new development of the practice is establishing a “mobile assessment team” piloted in the Gothenburg area. The aim is to assess the health status at home (after a call to emergency services, e.g. the ambulance) and to provide necessary emergency care at home instead of transporting the person to the emergency department.