### DESCRIPTION OF THE PRACTICE

<table>
<thead>
<tr>
<th>1. Title of the practice</th>
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<tbody>
<tr>
<td>The Mölndal model – a continuum of care for frail older people</td>
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<table>
<thead>
<tr>
<th>2. Organisation responsible for the practice</th>
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<tbody>
<tr>
<td>Mölndal hospital, Mölndal municipality and primary health care in Mölndal, Sweden</td>
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<tr>
<th>3. Contact person(s)</th>
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<tbody>
<tr>
<td>Name / E-mail</td>
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<th>4. National/regional/local context of practice</th>
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<tr>
<td>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 ‘Social Services Act’ 1982 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 life stages. National policy has put an emphasis on the cooperation between health and social care, especially in care of older people with complex health problems and severe needs. The ‘Ädel reform’ of 1992 was set out to address regional differences and the health and social divide. Municipalities became responsible for patients ready to leave the hospital and obliged to pay fees if a patient stays longer than needed in hospital. These laws have created ‘frames’ that leave flexibility for local authorities. The national policy has tried to enforce cooperation between health and social care, especially in care of older people with complex health problems and severe needs. In recent years, this has resulted in a number of different financial incentives by the government to stimulate cooperation. Sweden’s counties are responsible for health and medical care which includes hospital care and primary health care. Municipalities are responsible for social care for older people. Support at home includes: help with activities of daily living, personal care, nursing (medical) care, assistive devices, day care and short-term institutional care. Additional</td>
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services include transportation, foot care, meals on wheels, security alarms and housing adaptations.

In recent years, there have been a number of different financial incentives by the government to stimulate cooperation. Developmental projects have been implemented with earmarked resources to develop models of integrated care for older people. In addition, health and social care authorities are paid when they include a patient in a relevant register; e.g., the authorities are remunerated for every person diagnosed with dementia who is registered 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 registered, and finally for people included in the Swedish Register of Palliative Care (payment for registration).

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 provided 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 initiative started at Mölndals hospital. Mölndal is a suburban municipality south of Gothenburg. Mölndal municipality has around 62,000 inhabitants and 16 percent are 65 years and older and 4, 4 percent are 80 years and older (2013). This is a younger population compared to other municipalities in Sweden.

The initiative is a care chain that involves 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 own home. The initiative provides a protocol for screening and detecting older people (75+) at risk in the hospital and offers pathways for safe hospital discharge. Starting at the hospital, this initiative connects with the out–patient health care organisations and the municipal care services. A geriatric nurse screens needs with new screening tool. If the patient is ready to go home again from the hospital, the nurse connects with the case manager in the municipality in order to coordinate the transfer back home that involves the development of a care plan together with the older person and the family.

The care model was designed in cooperation between representatives from the care providers and intervention-researchers.
Lessons learnt:

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

6. Staff involved

Research team, hospital nurses, 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 initiative

The aim is to use resources better by the reduction of “unnecessary” admittances to hospital and to enhance safety by the provision of a protocol between professionals and a care plan for older people to return home safely after a hospital stay.

9. Issues for social services

<table>
<thead>
<tr>
<th>Service Integration/Cooperation across services</th>
<th>Service Planning</th>
<th>Contracting</th>
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<tbody>
<tr>
<td>Technology</td>
<td>Skills development (of the workforce)</td>
<td>Quality of services</td>
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ANALYSIS OF THE PRACTICE

10. Status

Pilot project (ongoing)
Pilot project (terminated)
Project (ongoing)
Project (terminated)
11. Scope of the initiative

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

- **Micro level initiatives**: initiatives that involve individuals at local level
- **Meso level initiatives**: initiatives that involve organisations or communities
- **Macro level initiatives**: initiatives that involve large population groups

**Meso level integration**

12. Leadership and management of the initiative

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 project

Describe the engagement of stakeholders, considering the following criteria:

- **Individual initiative**: Individuals have sought practice change
- **Network approach**: one or more organisation(s) develop a network
- **Collaborative approach**: large collaboration with relevant stakeholders

This initiative describes how new roles for new integrated care pathways had 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, together with an inter-professional team (a social worker, an occupational therapist and/or a physiotherapist), plan the care programme and rehabilitation in the older
person’s home after discharge from hospital. The case manager is the hub, managing the services in cooperation with the multi-professional team and following-up 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 project team
- Consultative: A consultative body of users was set up for an on-going dialogue and feedback
- Involvement in care: person-centred approaches to care/support

Involvement in care: the initiative 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 home and strives to promote 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 geriatric nurse at the hospital and the nurse (case-manager) in the municipality.

### 16. Evaluation approaches

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

- **Multi-method**: use of both a qualitative and quantitative approach,
- **Single method**: qualitative or quantitative approach
- **Audit**: looks at data sources such as existing medical records, and 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 initiative and what it has achieved

<table>
<thead>
<tr>
<th>Service users</th>
<th>Formal care givers</th>
<th>Informal carers</th>
<th>Organisations</th>
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## 18. Anticipated or 'aspirational' effects of the initiative 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.*

<table>
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<tr>
<td>The model offers frail older people a safe pathway back from hospital and provide tailored support to maximise the person’s possibilities to age in place</td>
<td>Increased job satisfaction</td>
<td>The carers are relieved from their traditional role of having to coordinate service and care.</td>
<td>The municipality reported less costs for medical treated patients. Moreover, the hospital reported less costs due to less admittances and bed days in hospital. The initiative creates a structure with clear roles and at the same time promotes professional collaboration, which is based on shared values of the importance to “work together”. The model has achieved to create sustainable routines for collaboration between health care and social services.</td>
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## 19. How the initiative has changed the way care/support is provided

Care pathway: the initiative established 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:** practices were newly started or are on-going/not yet mainstreamed. How could the initiatives be sustained (in terms of resources)?
- **Organic sustainability:** service users have been empowered to take the initiative forward
- **Established:** the project has been operational for several years

**Established:** this initiative had been mainstreamed as it is included in the ordinary services in Mölndal municipality.

### 21. Transferability of the initiative

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 initiative have been taken up and used elsewhere; material for transferability (for ex. training material) has been developed

**Potential for transferability:** Elements of the initiative had been taken up and used elsewhere, such as the screening tool and the role of the geriatric nurse.

The screening tool is now being introduced at other hospitals in the Gothenburg area. The function of the geriatric nurse is now been introduced at every hospital in the Gothenburg area. A further development of the initiative is the establishment of a “mobile assessment team” that is piloted in the Gothenburg area. The aim is to assess of the health status at home (after having being called by e.g. the ambulance), and to provide necessary emergency care at home, instead of transporting the person to the emergency department.