DESCRIPTION OF THE PRACTICE	
1. Title of the practice	
- 'MULTI 7 – SAFE AND SECURE AT HOME SICHARGE FROM HOSPITAL' -	
2. Organisation responsible for the practice	
Umeå Municipality, in cooperation with the County Council of Västerbotten, Sweden	
3. Contact person(s)	
E-mail	policy@esn-eu.org
4. National/regional/local context of 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 'Social Services Act' of 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 stages of life. 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 were obliged to pay fees if a patient stayed longer than needed in the 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 the care of older people with complex health problems and severe needs. In recent years, this has resulted in several 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, daycare, and short-term institutional care. Additional services include transportation, foot care, meals on wheels, security alarms and housing adaptations. The national level provides funding for local initiatives that aim at the collaboration between health and social care.	
5. Summary of the practice	
The national initiative "Better Life for older people" aims to develop health and social care based on a holistic view of the situation of the older person and his or her needs. However, there is still a lack of cooperation between caregivers and individuals who are not sufficiently involved. Information and communication gaps between the actors involved are also a problem.	

Umeå Municipality, in cooperation with the County Council of Västerbotten, started the project Multi7 to address these problems. The goal of Multi7's approach is to achieve the following:

- Well-informed older people and relatives/carers,
- Good quality of health care interventions for older people,
- Efficient coordination among health care providers.

At the start of the project, they identified seven focus areas for improvement that could be pursued to achieve increased quality and efficiency. With time, they have pinpointed two basic working processes:

- Safe and secure at home, and
- Secure and safe discharge from the hospital

One district in the city of Umeå has been used as a testing ground for Multi7's pilot project, where employees from the health centre and the municipal home care services jointly produced the Multi7 model. It started in November 2011, and in September 2013, 80 people (with an average age of 84 years) participated in the project, all with a healthcare contact and at risk of falling.

The project stakeholders agree that Multi7 has led to several positive changes for both the older person and their family members/relatives as for the staff involved in primary care, home care and inpatient care. The effects of the project indicate that the frailest older persons often need extensive, holistic health care and clear information about health care interventions.

Lessons learnt:

- Workforce planning must take into account increases in workload to prevent burnout and that the demand for the approach does not outweigh capacity and resources
- Good forward planning is needed to ensure attendance at joint meetings

6. Staff involved

Older people and their informal carers

7. Target group

Discharge nurses, hospital nurses, health, and social home care providers

8. Aims of the initiative

Improve the quality of care, Improve coordination and continuity of health and social care, Improve access to information and services

9. Issues for social services

Service Integration/ Cooperation across Services		Service Planning	X	Contracting	

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

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

11. Scope of the initiative

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

- *Micro-level initiatives:* initiatives that involve individuals at the 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

Organisational management: Umeå Municipality, in cooperation with the County Council of Västerbotten, started the project Multi7 in 2011. These stakeholders took the initiative and were also responsible for the evaluation after the pilot study.

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

Pathways facilitating exchange: Two examples here focus on how new or improved pathways of integrated care in themselves have acted as a catalyst for increased knowledge exchange. The exchange between healthcare providers at a meso level project concerned with the safe discharge has increased, resulting in more joint home visits and regular meetings between staff.

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 ongoing dialogue and feedback*
- *Involvement in care: person-centred approaches to care/support*

n.a.

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

Within existing resources: four examples at the micro and meso levels of integration highlighted that staff time, such as a full-time discharge nurse (SE2)

Staffing costs: in three examples, again at the micro and meso levels, costs for staff investment were described. This included a 0.25 FTE pharmacist (BE2), an increase in physiotherapists and occupational therapists through the municipality (SE1), and a further initiative that witnessed a staff budget increase of 2 million SKR overall for the initiative (SE2).

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: a 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*

Multi-method: focus groups with staff, documentary review and structured interviews with 80 users/carers

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

Service users	• **Improved quality of care** Multi7 is, in its nature, “prevention”. By increasing the use of quality registers, the project has seen an increased focus on other early detection of medical conditions occurring. With more structured reviews of medication should, medication use decreased in general (so far with an average of 2.53 drugs per patient) and for those with many drugs in particular. It should also lead to drug-related medical injuries is reduced and thus creates greater patient quality. All that has been identified and accepted (80 individuals) to participate in Multi7 and with contributions from both municipal and county have received a coordinated individual plan, which means that the prescribing of different means to users has improved. • **Access to services** There are several signs that users, patients, and family/relatives are more well-informed. Senior Alert* and drug utilisation reviews have become so famous that they are now in demand by older people and family/relatives. Another measure that increased information in the older people and their family/relatives was the introduction of discharge letters, medicines stories and medication lists when the patient was discharged from the hospital". When the “discharge-nurse” will phone the older people at home within 72 hours after discharge, both parties get good information on current health status and any possible outstanding needs can be referred to the appropriate level of care (hospital, primary care, or home care). Older people have also become increasingly aware of their contact with in-home care and the coordinated individual plan of care and attention.
Formal caregivers	**Workforce improvements**

	The staff believes they have received greater insight and knowledge of older people's health. The exchange between healthcare providers has increased, which has resulted in joint home visits and regular meetings between home care and home health care. The division of responsibilities has become clearer. The project has introduced quality registers as an everyday living tool to convey adequate health and social care. There is a consensus between the different personnel groups that the “discharge letter” makes the elderly feel safe and cared for. Rapid action and the right help for the elderly have also been facilitated. Understanding each other's work has increased, and the work environment has become more instructive. Home help staff believes that it is stimulating to work with the district nurse, which means that they also increase their knowledge in the medical field. This also provides better conditions for a holistic perspective in the elderly.
Informal carers	
Organisations	Better use of resources/cost reduction
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.*	
Service users	
Formal caregivers	
Informal carers	
Organisations	
19. How has the initiative changed the way care/support is provided	
20. Sustainability of the practice *Describe if the practice is sustainable, considering the following criteria:* - *Potential for sustainability:* practices were newly started or are ongoing/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	

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: this practice describes some conditions to think about before transferring practice.

Aspects need to be considered for transferability of the safe discharge initiative – instigation of an implementation team with seminars to familiarise people, temporary increase in resources, space to develop a learning culture with joint learning, mutual staff development plans, and creation of a joint management team to foster a positive climate for collaboration.