Coordinating care of the multimorbid elderly in Sweden – lessons learned from practice and research

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Summary

Coordinating care for older patients is important both for quality and efficiency

Many older patients suffer from chronic diseases, as well as needing social care This means that multiple care providers, such as inpatient care, primary care, municipal home care, and social services, must collaborate to meet their care needs. Care coordination refers to coordinated action from multiple entities with the aim to achieve a common goal – in this case the patient's health. Deficiencies in coordination can lead to stress and concern among patients or lead to medical interventions being delayed, omitted, or performed at the wrong level in the system. Medical risks due to deficient coordination are particularly salient for older patients, as they generally have a lower ability to compensate for such deficiencies by acting as information carriers themselves. Deficient coordination around multimorbid elderly patients is also an economic problem, as this can result in unnecessary or avoidable care interventions.

Collaboration deficiencies are currently too common

In Sweden, there are clear signs that coordination around older patients is often deficient, despite many years of trying to improve the situation. Deficient collaboration is seen for instance in increasing numbers of unplanned readmissions of multimorbid older patients to

hospitals, and that so-called coordinated individual plans (*samordnad invididuell plan*, SIP) are not created, even though this is required by law. The report provides an overview of the different types of reforms that have been initiated in Sweden over the past decades to improve care coordination. Based on evaluations and experiences of these reforms, explanations are sought as to why the problems appear largely to remain. The report focuses on the group of multimorbid elderly e living in their own homes, which is the largest group. Aside from the Swedish experiences, the report also describes international research on care coordination around the multimorbid elderly. The report's concluding chapter highlights several challenges that hinder coordination between regions and municipalities in providing care for the multimorbid elderly.

Care coordination is hindered by responsibilities being divided between municipalities and regions

The attempts to achieve better coordination in care of the multimorbid elderly in Sweden is conditioned by a division of responsibilities between regions and municipalities, with regions being responsibility for medical care in primary and specialist care, whereas municipalities (usually) are responsible for social interventions and primary care in patient homes up to the nursing level. This division of responsibilities, which resulted from a reform (*Ädelreformen*) in 1992, raises a risk of creating situations where no one takes full responsibility for the patient's health and where physicians' participation in home-based healthcare becomes sporadic. The boundaries between regions and municipalities in Sweden are both geographical, legal, organizational, and professional.

Many local experiments, but systematic evaluation is lacking

The large number of organizational changes that have been initiated within regions and municipalities in order to improve coordination around the multimorbid elderly in the latest decades makes it hard to get an overview of coordination practices at the organizational level today. It is also hard to get an overview of how different aspects of re-

forms interact and in which combination they occur locally. Further, there is often a lack of systematic evaluations of the organizational changes undertaken locally. When it comes to national reforms, such as the adoption of the Act on Coordination in Hospital Discharges (2017), there is a need for more stringent follow-up of the effects. A lack of clear evidence on which coordination forms are most effective makes knowledge dissemination in the field more difficult.

Deficient agreements between regions and municipalities on physician participation

To get access to physician consultations for the multimorbid elderly with municipal primary care in their own homes, the municipality must enter into an agreement with the region. Several studies over the past years have indicated that the agreements concluded are not fit for purpose and work poorly as steering instruments. The agreements are also too rarely followed up. Consequences of such failures can be deficiencies in availability and continuity of care and worsened conditions for close collaboration between regional physicians and municipal nurses, which is a prerequisite for qualitative care of multimorbid older patients treated in their homes.

International research does not give a clear indication of what works

The research review presented in the report shows that positive effects can be achieved through care coordination reforms, in particular when it comes to patient satisfaction and access to care. Regarding effects related to care consumption, such as hospital days and hospital re-admissions, the results are weaker and more inconclusive. Most studies investigate organizational interventions such as multi-professional teams, care coordinators, and geriatric evaluations of patients' health status and functional abilities. The main limitation of the studies is that there is often a lack of information on the context, or care setting, for instance regarding legislation, reimbursement systems, or how care is financed in the countries where the studies have been performed. In the USA, it is more common than in Europe to use financial incentives

such as financial penalties for hospitals in case of unplanned re-admissions of older patients.

Government steering toward effective forms of care coordination must be stronger

National steering of how health and social care providers should coordinate their activities must be made more explicit. The existing legislation in the form of the Healthcare Act, the Social Services Act, and the Act on Coordination in Hospital Discharges prescribe that principals must collaborate, for instance by concluding joint agreements, but not how they should do so, or what the agreements should contain. Instead, large scope is given for local practice and innovation. Such openness and flexibility are valuable, but if the local experiences are not systematically documented and disseminated, there is a risk of increasing geographical differences and poor learning in the system as a whole. Currently, much of the follow-up and knowledge dissemination from national authorities and other organizations is based on 'good examples', which is an vague form of steering. More precise guidelines on how coordination in the care of multimorbid elderly should be achieved are thus needed.

The capacity of the primary care sector must be strengthened if it is to serve as a main coordinator

Primary care centers have been given a key role in coordinating care around the multimorbid elderly, both in connection to hospital discharge and municipal home–based health care. One finding in the report is that the primary care sector is having difficulty performing this coordinating role due to lack of resources and staff. The "Close Care" (*Nära vård*) reform initiated in 2018 aims to shift resources from inpatient care to regional primary care and thereby create better conditions for coordination with municipalities for multimorbid elderly patients, but this shift appears not to have been achieved yet.

Staff shortages one of the main obstacles to care coordination

Increasing physicians' presence in municipal home-based healthcare is probably one of the most important factors to achieve improved coordination in the care of the multimorbid elderly in Sweden. It is therefore problematic that many regions still have a lack of general practitioners. Strengthening physician participation in municipal health care must also be created through increased collaboration with the municipalities. The different local models developed for this, for instance co-localization of regional and municipal care facilities, should be evaluated more systematically. Another solution, suggested by the Coronavirus Commission (*Coronakommissionen*), is that the municipalities are given the possibility to employ physicians directly within home healthcare. There is also a lack of nurses and other medical staff within municipal health and social care. Current municipal care and healthcare services is in this regard poorly adapted to higher and more complex care needs of older patients treated in own home today. The medical competence of home-based social care staff is also an important factor for improving coordination with the regions, as they are the ones meeting with patients most regularly and thus often the first ones to observe altered care needs. Such information being passed on without delay is crucial in order for health care interventions to be implemented at the right level and in a timely manner if unnecessary hospital admission is to be avoided.

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