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Collaborative challenges in integrated care:

Untangling the preconditions for collaboration and frail older people's participation

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Gothenburg 2018

Cover illustration: Johanna Bångsbo

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ISBN 978-91-7833-189-5
ISBN 978-91-7833-190-1

Printed in Gothenburg, Sweden 2018
Printed by BrandFactory

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ABSTRACT

Introduction: Frail older people often have comprehensive and complex care needs involving different caregivers and professionals. Deficits in integrated caretaking often result in hospital readmission. **Aim:** The aim of this thesis was to describe and analyze preconditions for collaboration and participation in integrated care for frail older people from the professionals' perspective. **Methods:** In study I patient participation was examined with a case study, including face-to-face interviews with health and social care professionals and audio-recordings of discharge planning conferences. Study II explored inter-professional and inter-organizational collaboration using a focus group technique, focusing discharge planning conferences. Study III was quantitative, and described and compared the influence of different factors on the importance of inter-organizational collaboration within the integrated care process program "Continuum of care for frail older people." Study IV quantitatively evaluated the preconditions for implementation of the program. **Results:** Study I showed that frail older people's participation in discharge planning conferences was achieved when the older people took or were supported to be active participants, the professionals had clear roles, authority, they created a structured, calm atmosphere, and older people and professionals were well prepared before discharge planning takes place. Study II demonstrated that conflict in collaboration arose between professionals and organizations, implicating a tacit framework, e.g. who is responsible and has the authority to make decisions and what are the prioritizations in relation to the choice of care actions for older people. In Study III, educational level i.e. post-secondary education, influenced inter-organizational collaboration more than organizational affiliation. Study IV showed that the preconditions for the program implementation were limited with regard to the professionals' understanding and ability to change their work procedure, and their commitment decreased. **Conclusion:** Inter-professional and inter-organizational collaboration need improvements to ensure a continuum of high-quality care and frail older people's participation in the discharge process. Insufficient knowledge among the professionals obstructed collaboration in favor of organizationally related norms and values and professional boundaries. Implementing complex interventions in organizations with high employee turnover and competing projects takes time and dedication.

Keywords: Inter-organizational collaboration, cooperative behavior, patient discharge, frail elderly, interview, health personnel, professionals, cross-sectional study, implementation.

ISBN 978-91-7833-189-5 (PRINT)
ISBN 978-91-7833-190-1 (PDF)

SWEDISH SUMMARY

Introduktion: Sköra äldre människor har ofta omfattande och komplexa vårdbehov med behov av flera vårdgivare och olika professioner. Brister i omhändertagandet kan medföra återinläggning på sjukhus. **Syfte:** Att undersöka och analysera förutsättningar för samverkan och delaktighet i integrerad vård för sköra äldre ur personalens perspektiv. **Metoder:** I studie I undersöktes sköra äldres delaktighet genom en fallstudie som omfattade intervjuer med personal på sjukhus och i kommunal vård och omsorg samt inspelningar av vårdplaneringsmöten. Därefter undersöktes med hjälp av fokusgruppsdiskussioner personalens uppfattningar om samverkan mellan personal och mellan organisationer med fokus på vårdplaneringsmöten (studie II). Studie III var kvantitativ och beskrev och jämförde olika faktorers betydelse för inter-organisatorisk samverkan inom ett integrerat vårdprocessprogram, ”Continuum of care for frail older people”. I studie IV utvärderades förutsättningarna för implementering av vårdprocessprogrammet. **Resultat:** Studie I visade att sköra äldres delaktighet var möjlig under specifika förhållanden, där de genom sitt eget agerande och med hjälp av personalen stöttades till att vara aktiva och delaktiga vid vårdplaneringsmöten. Delaktigheten främjades av att de äldre och personalen var väl förberedda, personalen hade tydliga roller, yrkesmässiga befogenheter samt skapade en strukturerad och trygg atmosfär för den äldre. I studie II framkom att samverkan inom och mellan organisationerna sker inom ett outtalat ramverk med risk för konflikter mellan personal och över organisationsgränser. Det kan exempelvis beröra vem som bär ansvar och har rätt att fatta beslut samt vilka prioriteringar som bör göras i förhållande till val av fortsatta insatser för den äldre. Resultaten i studie III visade att personalens utbildningsnivå hade betydelse för samverkan mellan organisationerna inom ramen för vårdprocessprogrammet. Vid utvärdering av förutsättningarna för implementering av vårdprocessprogrammet framkom att personalen hade kunskap om programmet men begränsade resurser och begränsat stöd från ledningspersoner till att förändra sitt arbetssätt. Deras vilja till att förändra sitt arbetssätt i enlighet med vårdprocessprogrammet minskade över tid (studie IV). **Slutsats:** Samverkan mellan personal och mellan organisationer kräver förbättringar för att garantera en väl koordinerad och integrerad vård samt sköra äldres delaktighet i utskrivningsprocessen. Bristande kunskap hos personalen hindrade samverkan till förmån för organisatoriska normer, värderingar och professionella gränser. Implementering av komplexa interventioner i organisationer med hög personlomsättning och andra konkurrerande projekt tar tid och kräver strategier.

LIST OF PAPERS

This thesis is based on the following studies, referred to in the text by their Roman numerals.

I. Bångsbo A, Dunér A, Lidén E. **Patient participation in discharge planning conference.**
International Journal of Integrated Care 2014; 6.

II. Bångsbo A, Dunér A, Dahlin-Ivanoff S, Lidén E. **Collaboration in discharge planning in relation to an implicit framework**.
Applied Nursing Research 2017; 36: 57-62.

III. Bångsbo A, Dunér A, Dahlin-Ivanoff S, Lidén E**. Inter-organizational collaboration within a comprehensive care process program.**
Manuscript 2018

IV. Bångsbo A, Dunér A, Dahlin-Ivanoff S, Lidén E.
Preconditions to implementation of a comprehensive care process program.
Submitted

CONTENT

LIST OF PAPERS 8
CONTENT 9
ABBREVIATIONS 11
BRIEF DEFINITIONS 12
1 INTRODUCTION 13
1.1 An integrated care approach on health and social care for frail older people 13
1.2 Frail older people 13
1.3 Establishing integrated care for and together with frail older people ... 14
1.4 Frail older people and the need for integrated care 16
1.5 Organization of elderly care in Sweden 16
1.6 Integrated care and hospital discharge 19
1.7 Inter- organizational and inter-professional collaboration 21
1.8 Integrated care process programs 23
1.9 Implementing integrated care process programs 25
1.10 Rationale for this thesis 26
2 AIM 28
3 METHODS 29
4 ETHICAL CONSIDERATIONS 36
5 RESULTS 37
6 DISCUSSION 41
7 CONCLUSION 55
8 FUTURE PERSPECTIVES 57
ACKNOWLEDGEMENTS 59
REFERENCES 61
APPENDIX PAPER I-V

ABBREVIATIONS

ADL	Activities of Daily Living
CGA	Comprehensive Geriatric Assessment
CI	Confidence Interval
DPC	Discharge Planning Conference
ICF	International Classification of Functioning, Disability and Health
OR	Odds Ratio
OT	Occupational Therapist
PH	Physician
PN	Practical Nurse
PT	Physiotherapist
RN	Registered Nurse
SW	Social Worker
VAS	Visual Analogue Scale
WHO	World Health Organization

BRIEF DEFINITIONS

Co-morbidity	Two or more indexed chronic diagnoses in the same individual (Fried et al. 2004).
Disability	An umbrella term that refers to impairment, limitations in activity, and participation restrictions. Impairment is a problem in body function or structure; activity limitation refers to difficulties in executing a task or action; and participation restriction is the individual's experiences of problems in participation in a life situation. Disability reflects the interaction between the body and the society (WHO 2018).
Impairment	Problem in body function or structure in a person (WHO 2018), for example, a problem with balance.
Multi-morbidity	Coexistence of several chronic diseases (Ording & Sørensen 2013).
Team	Refers to "team practice" or "teamwork," professional practice by a group of professionals, including, for example, physicians, nurses, social workers, occupational therapists, and physiotherapists who manage the care of a specified number of patients as a coordinated group (Mosby's dictionary of medical, nursing and allied health 2002).

1 INTRODUCTION

1.1 An integrated care approach on health and social care for frail older people

The comprehensive and complex care needs of frail older people are often overlooked in planning and provision of health and social care, and with insufficient caretaking, hospital readmissions occur too frequently. In this context, integrated care with coordinated actions across care settings as a continuum from hospital to community living is essential to secure care continuity for frail older people with complex needs. Moreover, to enable frail older people to participate in their care and to accomplish person-centered care, inter-professional and inter-organizational collaboration are necessary. In this thesis, participation and collaboration are identified as central phenomena that contribute to establishing integrated care from a person-centered perspective.

Care organizations are usually created to facilitate organizational steering and to clarify the areas of responsibilities. This implies that the patient perspective cannot be neglected. For specific groups, such as frail older people, with need for coordinated and integrated care activities, organizational boundaries are problematic. To meet the increasing demand on collaborative improvements and the demand to support and involve frail older people in their care, there is a need to study the professionals' preconditions to collaboration and how the professionals involved perceive the care integration. This thesis is based on four studies, investigating integrated care for frail older people aged 77 and over. Together, these four studies bring a contribution to our understanding of the preconditions for organizational improvements to secure care continuity and integrated care for frail older people.

1.2 Frail older people

The average life expectancy is increasing, and this is expected to continue. Approximately 18 % of today's population in Sweden is 65 years or older, and it is estimated to be 23% by 2030 and 25% by 2070 (SCB 2018). The same scenario is anticipated to occur in many other low- and middle-income countries (WHO 2015).

Aging is related to underlying physiological changes often with losses in seeing, hearing and moving and an increased risk of developing disease and need of long-term care (WHO 2017). However, older people are healthier than ever before despite living longer, and the population will be very old in the near future (SCB 2018; WHO 2015) with postponed or prolonged multi-morbidity (Crimmins & Beltran Sanchez 2011; Fabbri et al. 2015). With an

increasing average life span, age in itself is the biggest risk factor in developing chronic diseases, such as diabetes, musculoskeletal conditions (back pain, osteoarthritis), stroke, dementia, heart disease, chronic respiratory disorder, all of which result in care dependency (WHO 2017).

Frailty can be described as a biological deterioration of the elderly with reduced reserves and decline in physiological systems leading to an increased vulnerability for adverse health outcomes, such as disability, falls, dependency, long-term care needs and mortality. The most frequently included characteristics are weakness, fatigue, weight loss, low physical activity, poor balance, slow gait speed and impaired cognition (Fried et al. 2004). Due to these risk factors, frail older people are in need of special attention from professionals to meet their comprehensive needs and for them to be able to participate in their own care. In this thesis, frail older people are emphasized as the vulnerable target group in need of integrated care.

1.3 Establishing integrated care for and together with frail older people

In a global context, the World Health Organization (WHO) has drawn attention to fragmented care services and lack of person-centeredness, initiating a global strategy in 2014-2015 to establish integrated health services, focusing on people, rather than organizational structures (WHO 2014). Integrated care is defined as actions across settings to improve care quality, quality of life, satisfaction with care and system efficiency for patients. Integrated care is the result of the efforts to promote integration for the benefit of specific patient groups for example frail older people (Kodner & Spreuweenberg 2002). Different interventions should be coordinated in such a way that independence in daily life is facilitated. To achieve this level of integrated care, communication must be well established in care and treatment with a well-functioning dialogue between the patient and healthcare professionals (National Board of Health and Welfare 2009). However, when organizational support is absent, difficulties in establishing person-centered care arise (Martin & Finn 2011).

The importance of establishing person-centeredness in integrated care has been emphasized to prevent functional decline in older people. Functional ability refers to people's ability to do the tasks that they value and expect to be able to perform (WHO 2017). Person-centered care is an approach establishing therapeutic relations and offering choices as well as supporting negotiation of care (Martin & Finn 2011). The patient should be treated as a person from a holistic perspective, regarding his/her special needs (Morgan & Yoder 2011).

Furthermore, the person is considered an expert on his/her own impairments and should be allowed to be an active participant in partnership with the professionals. For the professionals, it is important to see the person behind the impairment and put a focus on capability and other positive aspects, rather than simply on their illness or diagnosis (Leplège et al. 2007). In this thesis, integrated care from a person-centered perspective is a goal to strive for in the care of frail older people. A report from the National Board of Health and Welfare (2009) in Sweden has emphasized the importance of treating the person as a participating subject, the central figure in his/her own rehabilitation. Healthcare professionals are obliged to focus on the person's needs independent of organizational links where continuity in contact and information should be the ultimate goal.

Older people's participation is included in the concept of person-centeredness, where they should be regarded as active participants in their rehabilitation (Leplège et al. 2007). In this thesis, participation was chosen as a central concept as person-centeredness has a wider definition, including an organizational standpoint, which is outside the scope of this thesis. However, treating the older person as a capable person and an active participant has guided this work.

How the concept of participation is defined depends on the context. According to International Classification of Functioning, Disability and Health (ICF; 2003), participation is defined broadly as "involvement in a life situation." In a concept-analysis by Cahill (1996), the author found three levels of a hierarchical relationship concerning participation in healthcare: at the bottom, patient collaboration or involvement; in the middle, patient participation; and at the top, patient partnership, which was the highest level of participation to strive for, indicating closeness between professionals and patients.

Previous studies have shown that older people experience difficulties in participating actively in decision-making. They use different strategies to establish participation in decision-making or delegated information exchange and care planning with the professionals to their next of kin (Nyborg et al. 2016). Furthermore, studies have shown that older people experience information and participation deficits, but they are modest and grateful for the opportunity to be included (Hvalvik & Dale 2015). The older people look upon the hospital as an institution where they do not expect to be involved or to take active part in the decision-making (Ekdahl, Andersson & Friedrichsen 2010). However, recent studies have shown that there are possibilities to increase older people's participation at hospital discharge. A person-centered program with early discharge planning for patients with chronic heart failure increased patients' participation and decreased hospital length-of-stay (Ulin et al. 2016).

Furthermore, care planning at home may increase the involvement of frail older people, however, it did not obtain real influence concerning help, organization or provision of service and care (Berglund et al. 2012).

1.4 Frail older people and the need for integrated care

Being frail implies a need for health and social care from several different caregivers at different care levels and with different competences, such as gerontology, geriatrics, rehabilitation, nursing and social care (Martin-Sanchez et al. 2016; Tinetti, Fried & Boyd 2012). This indicates that the care needs for frail older people are complex, and demand integration and coordination of care interventions (Clarfield, Bergman & Kane 2001). It also implies that communication is important, inter-professionally and inter-organizationally, to secure care continuity. To support frail older people, the importance of integration and collaboration between different organizations has been emphasized in many contexts, especially in evaluations done by supervisory authorities (National Board of Health and Welfare 2017; SOU 2016:2). There are national intentions from the authorities to establish integrated care for frail older people (National Board of Health and Welfare 2014, 2015), to secure and improve care quality approved consistent across all county councils (SOSFS 2011:9).

The main areas in the care of frail older people are to solve problems and coordinate and evaluate different care interventions (National Board of Health and Welfare 2013b, 2017). It is also encouraged that various rehabilitation interventions are integrated by means of inter-organizational collaboration (National Board of Health and Welfare 2008). However, the recommended guidelines must be considered in relation to the specific preconditions of frail older people, for example, co-morbidities and disabilities with needs from different caregivers and professionals (National Board of Health and Welfare 2016). Increasing specialization with more professional groups and more care providers, facilitates fragmentation of care while simultaneously increasing the needs for collaboration between care organizations (Axelsson & Bihari Axelsson 2006).

1.5 Organization of elderly care in Sweden

The care for frail older people involves different care levels and settings, ranging from hospital, primary care and municipal health and social care. Elderly care in Sweden is regulated by the Health and Medical Services act (Hälso- och sjukvårdslag SFS 2017:30) and the Social Services Act (Socialtjänstlagen SFS 2001:453). These two acts regulate medical healthcare through the county councils, and social and nursing care within the municipalities. The Health and Medical services act (SFS 2017:30) stipulates

that the health- and social care system must establish good care, for example to supply the patient's need for safety, continuity and security. It also describes that the municipal health and social care may offer home nursing for those who have their own housing within the community. Moreover, the Social Services Act (SFS 2001:453) specifies the society's responsibility for people's social security and people's active participation in social life. Both the Health and Medical Services Act (SFS 2017:30) and the Social Services Act (SFS 2001:453) describe the demand for inter-organizational collaboration. In addition, patient participation in their own care is regulated by the Patient Act (Patientlag SFS 2014:821). This act strengthens and clarifies the patients' position within healthcare and related activities to support the patient's confidence, integrity and involvement.

The healthcare system in Sweden has changed rapidly over the past few decades where more older people continue to live in their own housing in their community. Living in nursing homes is restricted only to those with the greatest needs (National Board of Health and Welfare 2017). The amount of older people >65 years living in nursing homes, has decreased from 115 500 to 81 400 people from 2002-2018 (National Board of Health and Welfare 2018). Moreover, the Freedom of Choice System Act (Lag om valfrihetssystem SFS 2008:962) has increased the number of actors involved in home and primary care.

In addition, the length of stays at hospitals has shortened and is more often followed by home care by the municipal authorities, such as social workers in elderly care (National Board of Health and Welfare 2018). The number of community living older people with support from municipal health and social care have increased (National Board of Health and Welfare 2017). Community living older people living in their own housing use three times as much primary and secondary care (hospital care) than frail older people in nursing homes (National Board of Health and Welfare 2013a). Moreover, their care needs may be comprehensive, which demand inter-professional and inter-organizational collaboration, making it more complex to provide the needed care (National Board of Health and Welfare 2017).

In 1992, the Elderly Care Reform act was introduced (ÄDEL-reformen) to improve integration and cost-effectiveness in care for the elderly. The healthcare service responsibilities were moved from the county councils to the municipalities, changing the municipal payment responsibility from day six for patients at the hospital ready for discharge (Government Bill 1990/91:14). However, this act has been replaced by tighter rules, Act on Collaboration at Hospital Discharge (Lag om samverkan vid utskrivning från sjukhus SFS 2017:612), where the payment responsibility has been shortened to after three

days. The goal of this act was to strengthen safe and efficient hospital discharge for patients whose needs could be dealt with at the primary care and municipal health and social care level.

A frail older person with integrated care needs often moves within and between different care settings, which creates a complex care situation. To illustrate this complex context, an overview of the possible care organizations and professionals involved in the provision of health and social care for frail older people is presented in Figure 1.

Care transitions across settings is a particularly critical issue for target groups with comprehensive and complex care needs (Coleman & Boult 2003; Naylor & Keating 2008). For frail older people, critical points in integrated care are, for example, at the discharge planning conferences and hospital discharge. The discharge planning is a central issue when care responsibility is transferred from the hospital to primary care and municipal health and social care (Lin et al. 2012). A community living frail older person with their own housing is admitted to hospital and transferred to care unit one and then possibly transferred further to other care units. According to the regulations, planning for discharge should be initiated at admission (SFS 2017:612). If the hospital physician feels the frail older person at admission will need further care from primary care financed by the county council or from municipal health and social care, a notice of registration (inskrivningsmeddelande) is to be sent to primary care.

A discharge planning conference takes place either at the hospital or in the older people's own dwelling, with or without a specialized discharge planning unit or team, the older person and next of kin. The purpose of the conference is to establish a coordinated individualized care plan (SFS 2017:612). This plan should include what kind of activities that are needed, division of responsibility and overall implementation and result of the plan (SFS 2009:981; SFS 2017:30). The older person is discharged to primary care and is often in need of services from municipal health and social care. In these complex contexts, each care unit, team and organization include multiple professionals. To secure care continuity at the transitions, care must be well coordinated and integrated, or there may be a risk of hospital readmission (Kessler et al. 2013; Scott 2010).

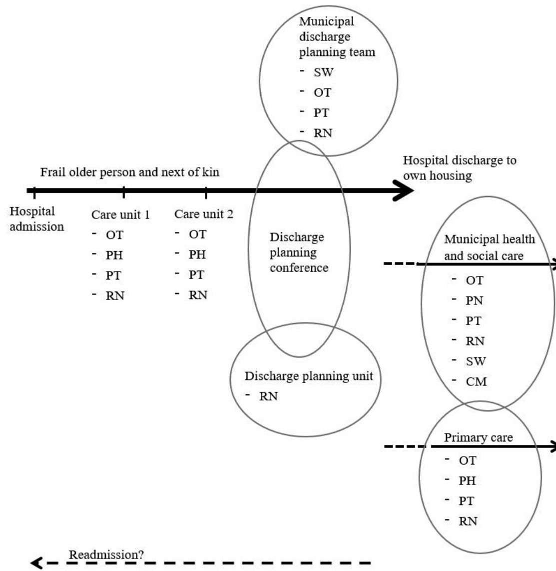

Figure 1. Overview of those involved in health and social care settings

1.6 Integrated care and hospital discharge

At hospital discharge, there are different methods to measure and achieve the organizational goals to secure patient transitions—effects on mortality, hospital length of stay—and different quantitative measures to hospital readmissions, for instance, after 30 days or three months (LeBerre et al. 2018; Oo et al. 2013). Deficits at care transitions are associated with risks of adverse outcomes and readmissions within 30 days, thus evaluating these indictors can provide insight on the success of the integrated care (Kessler et al. 2013; Scott 2010).

Fragmentary care services and being frail increases vulnerability and thus puts frail older people further at risk for poor quality of care (Coleman 2003; Fried et al. 2004; Song, Mitnitski & Rockwood 2010). Studies have shown deficient caretaking and an increased risk for adverse events in frail older people at hospital discharge (Hvalvik & Dale 2015; Mandl et al. 2018). Frequent hospitalizations and unplanned readmissions are seen as indicators of insufficient care quality of older people, and readmissions are a risk factor associated with frailty and poorer health (Bernabeu-Mora et al. 2017; Ma, Yu

& Woo 2013). Hence, there are goals and demands on improvements from the individual, organizational and societal perspectives.

Studies have shown that older people have expressed feelings of being disregarded and powerless in discharge planning conferences (Efraimsson et al. 2004; Hvalvik & Dale 2015). Frail older people need to be more participative in their care and in the context of transitions at hospital discharge and discharge planning (Ekdahl, Andersson & Friedrichsen 2010; Hvalvik & Dale 2015; Nyborg et al. 2016). Being frail with multiple diseases affecting biological, psychological and social functioning indicates complex and comprehensive care needs (Fried et al. 2004). These specific circumstances must be considered in relation to participation. The important issue is to support frail older people to become active, engaged in the situation and able to participate in assessing their own care needs. Furthermore, older people should be encouraged to participate in the discharge process from hospital to living in the community in their own housing in order to secure the care they feel they need and decrease the risk of hospital admission.

Frail older people with comprehensive care needs require care from multiple professionals in different organizations (Nolte & McKee 2008). Teamwork is an essential part of integrated care process programs, which are supposed to organize care into more effective work methods. It involves different professionals working in a cooperative manner to reach mutual goals with a focus on good dialogue (Carlström, Kvarnström & Sandberg 2013; Martin & Finn 2011). The multidisciplinary teamwork, as a method, has been operationalized in a concept analysis as a dynamic process involving two or more professionals collaborating to assess, plan or evaluate patient care (Xyrichis & Ream 2008). Multidisciplinary teams support professionals to make well-grounded decisions where the professional responsibilities overlap and complement each other (Lundgren 2009). The term multidisciplinary implies that teamwork is accomplished in a coordinated but more independent manner than in inter-disciplinary teams, which presupposes a higher degree of integrated work (D'Amour et al. 2005). In this thesis, inter-professional collaboration is explored in the team setting, including professionals, frail older people and next of kin, using negotiation and interaction to achieve shared decision-making. However, where the team-discourse is central, there can be a risk of unwanted effects like professional boundaries or barriers that also exclude other professionals or patients (Finn, Learmonth & Ready 2010; Martin & Finn 2011; Mitchell et al. 2014). The team-discourse has been criticized as an approach that supports existing power hierarchies that create significant obstacles to inter-disciplinary collaboration (Oborn & Dawson 2010). However, effective communication and teamwork are essential for care

security and continuity, as communication deficits can cause patients harm in complex healthcare situations (Leonard, Graham & Bonacum 2004).

A review over discharge planning interventions by Gonçalves-Bradley et al. (2016) and a meta-analysis by Preyde, Macaulay and Dingwall (2009) for people over 65 with a medical condition showed moderate effects on readmission rates at three-month follow-ups, hospital length of stay and older people's quality of life. They found there may be an increase in older people's and professionals' care satisfaction as well (Preyde, Macaulay & Dingwall 2009; Gonçalves-Bradley et al. 2016). The multidisciplinary team approach has reported positive outcomes in reduced length of hospital stay and costs (Blewett et al. 2010). Other studies have found that early discharge planning may reduce readmissions and lengths of hospital stay, but the results are not clear with frail older people (Bowles et al. 2014; Fox et al. 2013). A review by Zurlo and Zuliani (2018) demonstrated that a lack of proper discharge planning increased the risk for hospital readmission for frail older people.

There are studies indicating hospital readmissions can be avoided if the discharge planning starts early, already at hospital admission and including home follow-ups (Dainty & Elizabeth 2009). Moreover, research reviews have showed that discharge planning interventions can be improved if older people and next of kin participate and get information, education and support after discharge and the intervention address interprofessional communication (Bauer & Fitzgerald 2010; Carroll & Dowling 2007). Interactions with older people and next of kin are beneficial to improve person-centered teamwork, coordination of care activities and information exchange during care transitions, leading to better medical outcomes (Toles et al. 2012). Hence, the purpose of this thesis is to help fill the knowledge gap of how collaboration and frail older people's participation can be accomplished in discharge planning conferences.

1.7 Inter- organizational and inter-professional collaboration

Integrated care is meant to bridge care services to prevent the fragmentation of care. Inter-professional and inter-organizational collaboration are vital parts of integrated care in order to ensure care continuity (Hartgerink et al. 2013). Moreover, communicative deficits and missing information between care providers highlights problems with care continuity at care transitions (Toscan et al. 2012; Waring, Bishop & Marshall 2016). A "chain of care" is a metaphor for an integrated care process program highlighting that care is supposed to function as a complete and unbroken continuum or collaborative chain between different caregivers to build a link to one another (Ahgren 2003). However, despite the collaborative intentions, collaboration is obstructed by

organizational problems like differing goals (Dunér, Blomberg & Hasson 2011). Furthermore, specialized professionals and regional managers who protect their own organizations obstruct collaboration and is a symptom of fragmentary organization. Hence, leadership and a professional approach characterized by altruism requires a will to sacrifice some of the organizational structure and boundaries and for the professionals to sacrifice some of their own professional interests for inter-professional collaboration to be strengthened (Bihari Axelsson & Axelsson 2009).

Differing definitions of inter-organizational and inter-professional collaboration exists, and the following explanations can be representative in the integrated care setting. Inter-organizational collaboration can be defined as different processes involving multiple professionals from different organizations working interdependently on patient care (Keyton, Ford & Smith 2008). Inter-professional collaboration focuses on the process where health and social care professionals work together toward mutual goals in patients' care. Hence, inter-professional collaboration implies regular interaction and negotiation between professionals to accomplish shared decision-making and provide the best possible care for the patients (Reeves et al. 2011). Despite their frailty and subsequent limitations, frail older people should be considered as participating actors in their care as previously explained in sections 1.1 and 1.3 (Dury et al. 2018; Leplège et al. 2007; SFS 2014:821). In this thesis, frail older people are incorporated as a part of inter-professional collaboration in the team setting.

According to theory from a public health perspective, inter-organizational integration can take different forms between different degrees of management hierarchy and market competition. Management hierarchy refers to top-down organizational steering, and market competition is related to developing contracts with private sector actors. Moreover, there is a somewhat voluntary network, which is accomplished through cooperation or collaboration, between organizations that is not part of either a management hierarchy or common market (Axelsson & Bihari Axelsson 2006). However, integrated care includes management hierarchies, private actors and networks through collaboration or cooperation. Unlike the public health perspective, the integrated care networks are not voluntary.

This inter-organizational integration can be more horizontal or vertical. Horizontal integration is accomplished through collaboration or cooperation, while vertical integration is accomplished with top-down steering, established with acts and regulations from those in senior positions (Axelsson & Bihari Axelsson 2006). Horizontally organized integration is managed between organizations on the same hierarchical level and status, for example, hospital,

municipal health and social care. Vertical integration takes place between organizations on different hierarchical levels, and this is regulated by national acts and guidelines that must be implemented by the organizations. Horizontal and vertical integration often co-exist, which leads to four different forms: contracting, coordination, cooperation and collaboration, each emphasizing different degrees of horizontal and/or vertical integration (Axelsson & Bihari Axelsson 2006). Contracting represents a low degree of integration and is used in competing market situations, for example, when people are considering various private home care providers. Furthermore, the integration is accomplished through contractual relationships with very little influence on vertical hierarchical control or horizontal voluntary integration. Contracting implies that private home care providers follow the same regulations as the public home care providers do. Coordination has a high degree of vertical, but a low degree of horizontal, integration, where integration is achieved through a common vertical management structure. Cooperation is defined as concrete tasks that are conducted together, thus having a high degree of both horizontal and vertical integration. Collaboration results in a high degree of horizontal, but low degree of vertical, integration (Axelsson & Bihari Axelsson 2006). Collaboration implies that integration is organized across institutional boundaries, for instance, between authorities, professions and different care units (Carlström, Kvarnström & Sandberg 2013; Martin & Finn 2011). Collaboration is, in this thesis, defined as a means to establish integrated care (Axelsson & Bihari Axelsson 2009).

In this thesis, there are public and private primary care units represented, and public and private sector providers of home care services in municipal health and social care. When the model is practiced in elderly care, it can be exemplified as follows. The inter-organizational setting in healthcare and municipal health and social care is thus differentiated by autonomous organizations (Axelsson & Bihari Axelsson 2006). With several involved actors, including private ones, there is no common hierarchy or structure for decision-making, which makes providing care more challenging, especially for frail older people. Hence, collaboration or cooperation between professionals needs to be established to provide the best care possible for a vulnerable part of the population.

1.8 Integrated care process programs

Integrated care involves different care levels and settings (e.g., hospital units, primary care and municipal health and social care). Therefore, improvements to integrated care involves complex interventions with several units and professionals. Integrated care process programs have proved to be beneficial, safer and more secure for frail older people with complex care needs. Post-

discharge programs for frail older people have shown positive results on collaboration among professionals, older people's satisfaction with care, functional outcomes (Orvik 2016), and readmission reductions (DiPollina et al. 2017; Tinetti et al. 2012).

An integrated care process program for older people over 65 with social workers as case managers showed decreased readmissions and increased satisfaction and quality of life for the target group (Watkins, Hall & Kring 2012). An integrated care process program for people 65 and older with hip-fractures, including person-centered care, was found to be cost-effective and showed improved rehabilitation outcomes (Olsson et al. 2009). In addition, an integrated care program for frail older people showed improved satisfaction with quality of life at three-month follow-ups, but there were no significant changes in health or use of care (Looman, Fabbricotti & Huijsman 2014). A comprehensive geriatric intervention program, including inter-professional teamwork, case management and care planning in older people's homes, has shown positive results in improving care quality for frail older people. In several studies, the older people were more satisfied with the discharge planning and post-discharge contact with municipal health and social care (Berglund et al. 2013); they rated their health and functional ability higher than the participants in the control group (Berglund et al. 2015), their symptoms had improved (Ebrahimi et al. 2017), they had maintained their self-determination (Ekelund & Eklund 2015), and the program intervention had reduced the frail older people's dependence on ADL (Eklund et al. 2013).

While there have been many studies highlighting the benefits of integrated care for older people, there are some obstacles that prevent integrated care from being easily implemented. Several studies have shown that nurses in hospitals lack knowledge about home nursing and related resources, which complicates the possibilities of collaboration between the organizations (Cumbler, Carter & Kutner 2008; Popejoy, Moylan & Galambos 2009). However, studies have indicated that more carefully made discharge plans and changed attitudes can be reached when healthcare professionals from primary and secondary care get to know each other's organizations better, as found in a review by Bauer and Fitzgerald (2010) and a study by Robinson and Street (2004). Furthermore, integrated care process programs based on inter-professional collaboration are enhanced when the different professionals' perspectives and attitudes are well integrated, resulting in a more supportive manner toward frail older people (Hartgerink et al. 2013). Hospitalized frail older people are vulnerable and at risk for adverse events at discharge from hospital to community living. A comprehensive, hospital-based multidisciplinary intervention could reduce readmission and increase the older adults' satisfaction in regard to care (Dedhia et al. 2009), and an integrated care program in primary care has the potential

to improve the caretaking of frail older people from the professionals' perspective (Vestjens, Cramm & Nieboer 2018).

Targeted interventions may be beneficial to integrate care actions for frail older people and are often a part of integrated care process programs. Having a nurse as case manager has shown contradictive results on how beneficial it is to readmissions, but positive to patient satisfaction according to a systematic review (Chiu & Newcomer 2007) and a meta-analysis (Preyde, Macaulay & Dingwall 2009). Access to advanced registered nurses and having telephone follow-ups were advantageous for frail older people in the discharge process (Wong, Montoya & Quinlan 2018), and Comprehensive Geriatric Assessments in acute geriatric settings were beneficial for planning multidisciplinary interventions (Oo et al. 2013). Integrated care process programs have proved to be beneficial, safer and more successful in meeting the complex care needs of frail older people. Therefore, in terms of this thesis, it was necessary to study the preconditions for collaboration and the preconditions to the implementation of such an integrated care process program.

1.9 Implementing integrated care process programs

Implementing organizational changes (e.g., implementation of integrated care process programs) suggests that organizational changes can be adopted differently by different organizations, broadly or by only a few people in the organization (Greenhalgh 2017). Furthermore, if patients are excluded from the implementation process of the organizational changes in healthcare, there is a risk of the process being more oriented toward the innovation rather than prioritizing the actual benefits for the patients (Rogers 2003). Therefore, implementation of organizational changes in healthcare needs to include both patients and professionals.

Before implementation, there is a need for knowledge about organizational preconditions at the managerial level (Alharbi et al. 2006) to have engagement from groups of healthcare professionals within the organizations and confidence toward the professionals working with implementing a care process program (Dunér, Blomberg & Hasson 2011). However, how organizational changes are adopted may be influenced by psychological aspects within the individual professional, such as their previous experiences, values and knowledge, learning style, goals and motivations (Greenhalgh 2008).

Factors related to adaptations to the local context, high professional responsiveness, other concurrent projects, fluctuating team members in the discharge planning team and the amount of staff education before and during the implementation of the program impact the implementation of an integrated

and comprehensive care process program (Hasson 2012). Moreover, studies have shown that implementing comprehensive and integrated care process programs for older people requires a multidisciplinary approach with training for the professionals, engagement on different levels within the organizations and from different perspectives, such as geriatrics and nursing (de Vos et al. 2017).

Studies have shown that implementing an integrated care program in geriatric rehabilitation for older people with complex needs improved inter-organizational collaboration (Everink et al. 2017). However, for the implementation to become sustainable, strategies involving professionals (e.g., maintaining behavioral change) and organizations (e.g., dedication to delivering the program and producing benefits) are required (Moore et al. 2017).

1.10 Rationale for this thesis

Within health and social care organizations, there are needs for constant improvements and for up-to-date research to support organizational development. In Sweden and other countries, there are an increasing number of very old frail people with multi-morbidities in need of different caregivers and integrated care. Despite acts and guidelines urging collaboration and integrated care and patient participation, there are deficits in the caretaking of frail older people (SFS 2017:612; WHO 2017). It is challenging for all the involved organizations and professionals (e.g., primary care, municipal healthcare and social care) to integrate care and transfer frail older people safely between care settings from hospital to community living because the care is often fragmentary. In addition, the transfer process is further complicated by increases in professional specializations, shorter care periods with a need for timely coordinated care actions and economic demands for efficiency.

Previous research has shown that fragmentary care services are problematic for frail older people. There is some evidence on the benefits of integrated care for frail older people, and previous studies have shown the importance of collaboration and communication during transfers from the hospital (Everink et al. 2017; Gaboury et al. 2009). In addition, deficient caretaking during transitions increases the risks of adverse outcomes and readmissions (Kessler et al. 2013; Scott 2010). Furthermore, there are difficulties, such as perceptions and expectations of older people's involvement of themselves and professionals in getting frail older people to participate in their care at the hospital (Hvalvik & Dale 2015; Nyborg et al. 2016). Despite laws, guidelines and research evidence, there are challenges in accomplishing integrated care

through collaboration and communication involving frail older people. Therefore, it is of the utmost importance to highlight how collaboration, inter-organizationally and inter-professionally, and also involving patient participation, is accomplished in clinical praxis from the professionals' perspective.

2 AIM

The aim of this thesis was to describe and analyze preconditions for collaboration and participation in integrated care for frail older people from the professionals' perspective.

Specific objectives for the included studies:

- To elucidate the variation of frail older persons' positioning in discharge planning conferences, and to elucidate professionals' opinions on the preconditions for frail older persons' participation in these conferences.
- To explore healthcare and social care professionals' experiences of preconditions to inter-organizational and inter-professional collaboration to support frail older peoples' participation in discharge planning conferences.
- To describe professionals' views of the influence of different factors on the importance of inter-organizational collaboration and to compare the outcomes between inpatient and outpatient professionals with regard to organizational affiliation and educational level when starting up the implementation of a comprehensive care process program.
- To investigate the preconditions for implementation of a care process program by comparing the professionals' understanding, commitment and ability to change their work procedure over time within and between organizations.

3 METHODS

Study design

In this thesis, inter-professional and inter-organizational collaboration in integrated care has been investigated from the professionals' perspective. Frail older people's participation is a part of that collaboration. Both qualitative and quantitative methods were deemed valuable in order to understand the preconditions for collaboration and participation in discharge planning conferences and in an integrated care process program. An overview of studies I-IV methods are presented in Table I.

Table I. Overview of the included studies in the thesis, informants or population and data collection.

	Study informants or population	Study design	Data collection
Study I	Discharge planning conferences (DPCs) with frail older persons (>77 years) at hospital and in municipal health- and social care (N = 10) Occupational therapists, OTs, (n = 6), Physiotherapists, PTs, (n = 4), Nurses, RNs from hospital and municipal health- and social care (n = 20), Social workers, SWs (n = 10) (N = 40)	Case study	Interaction data from DPCs Individual interviews
Study II	OTs, PTs, RNs from hospital, primary care and municipal health and social care, SWs (N = 30)	Focus group	Focus group discussions
Study III	OTs, PHs, PTs, RNs, PNs, SWs from hospital, primary care, and municipal health and social care (N = 208)	Cross-sectional study	Questionnaire
Study IV	OTs, PTs, PNs, RNs, SWs from hospital and municipal health and social care (N = 191)	Repeated cross-sectional study	Questionnaire

Study I and II

Methodological framework

The methodological framing of this thesis is partly based on a social constructionist perspective (Gergen 2009). The social constructionist perspective concerns how the social context and different phenomenon, such as knowledge, norms and values are constructed through communication in

social relationships within a specific context. The socially constructed knowledge, norms and values have an impact on how people choose to act in different situations and how they interpret their surrounding world (Gergen 2009). The first two studies (I and II) are thus focusing on social interactions (Goffman 1959) and institutional discussions (Sarangi & Roberts 1999) in the context of discharge planning.

Institutional talks were investigated and discussed from how they influence societal structures, organizations and inter-professional relations (Sarangi & Roberts 1999). Institutional talks were run by professionals and nonprofessionals (e.g., patients and next of kin) and differed from ordinary talks in that there were specific aims and rules (Linell 1990). For example, the institutional talks aimed to plan frail older people's discharge at a discharge planning conference, which is governed by acts and regulations from health and social care.

There are institutional talks at work, held either "front stage," "back stage" or "off-stage." "Front stage" refers to talks between professionals and nonprofessionals, whereas "back stage" talks are institutional talks with professionals only (Goffman 1959; Sarangi & Roberts 1999). "Off-stage" talks refer to when individuals meet the patient with the team (Goffman 1959). Discharge planning conferences are examples of institutional talks being held front stage, but they are influenced by back stage inter-professional talks. Due to the use of terminology and jargon, healthcare professionals are in a power position at discharge planning conferences. Therefore, there is a need for reflection over how communication is being used on all stages to level the playing field so to speak (Dunér & Nordström 2006.

Positioning takes place between individuals and describes how people act in relation to others (Hollway 1989). The concept of positioning describes which positions people take or are given at institutional talks (Harré & van Langenhove 1999). Positioning or positioning theory can be understood as a way of creating discourses from narratives, making it comprehensible and reflecting upon how the participants take many different positions during talks. Taking a position causes positioning. Positioning is the social interaction that occurs in relation to others (Harré & van Langenhove 1999). Positioning is used as a more dynamic concept than the concept of roles; positioning has its focus on talking and social actions and presupposes ongoing social interaction. Positioning is created from a communicative interaction between people (Davies & Harré 1990). Furthermore, it represents three kinds of processes or discursive practices: conversation, which is the most fundamental, institutional practice and the use of social rhetoric (Harré & van Langenhove 1991).

The social constructionist approach and our focus on institutional talk was seen as crucial for studying collaboration in discharge planning conferences. In study I, this was conducted by investigating how interactions between the participants were shaped and the implications this would have for the participants' view on collaboration. In this context, discharge planning conferences represented an institutional talk that could be analytically analyzed. Furthermore, the social constructionist approach was seen as a valuable analytical tool to study interaction data from focus groups (study II). In this study, the interactions in focus groups were used to explore preconditions to inter-organizational and inter-professional collaboration at hospital discharge.

The method chosen for study I was a multiple case study (Stake 2000) with the discharge planning conference as "the case." Audio-recordings from multidisciplinary discharge planning conferences and interviews were conducted and analyzed with qualitative content analysis (Hsieh & Shannon 2005) and discourse analysis (Roberts & Sarangi 2005) in order to elicit frail older people's participation in these conferences. The older people's participation in the discharge planning conference was highlighted from positioning theory perspective. In this context, collaboration was explored from the professionals' perspective. Whereas in study II, collaboration was studied from the professionals' perspective, and how their behavior could support or obstruct frail older people's participation. The focus group method was chosen to allow the professionals to express their experiences of daily discharge decisions and to obtain a collective understanding among the participants (Dahlin Ivanoff & Holmgren 2017; Krueger & Casey 2009).

Data collection

In study I and II, the professional participants were chosen with purposive sampling from their experiences in the discharge process of frail older people. The data collection took place in different settings, where the discharge planning conferences (study I) took place in the older people's home, in hospital or municipal health and social care settings. Interviews with the professionals primarily took place at the employee workplace (study I) or at the university (study I and II). The focus groups in study II consisted of eight participants who were recruited to represent the different geographical and professional perspectives of the conferences (Table 1). Each group conducted two focus group sessions, which were audio-recorded. One group had one missing recording as they decided saturation was reached after the first discussion. Seven discussions were audio-recorded for approximately two hours each.

Data analysis

Study I consisted of two data sets where the analysis had two focuses. The first data set was analyzed for how the older people's positions varied in interactions with the professionals and next of kin during discharge planning conferences inspired by discourse analysis (Harré & van Langenhove 1999; Roberts & Sarangi 2005). In the analysis of the second data set, the interviews, a qualitative content analysis with a deductive approach was conducted. The analysis was based on the results from the discourse analysis of the professionals' opinions on the frail older person's participation in discharge planning conferences. In study II, the analysis was conducted to identify and categorize a variety of preconditions to inter-professional and inter-organizational collaboration. The analysis was conducted with inspiration from Krueger & Casey (2008) and Rabiee (2004).

Study III and IV

In these two quantitative studies, a cross-sectional study (study III) and a repeated cross-sectional study (study IV) were conducted. The design was chosen in order to describe and compare the professionals' views at one time in study III. In study IV, instead of only measuring at one time, the professionals were asked at three time points throughout the implementation process. The three cross-sections were independently administered from the other cross-sections. This study evaluated the professionals' views from an organizational perspective later in the process than has been previously done to investigate the preconditions of the implementation in an ecologically valid manner. These studies were conducted within a larger project, "From intervention to trial (RCT) to full-scale implementation research."

Within the larger project, "From intervention to trial (RCT) to full-scale implementation research," an integrated care process program "Continuum of care for frail older people" came about as policy (Sabatier 1981; Wilhelmsson et al. 2011). The intent was to reach mutual goals in the care of frail older people 75 years or older and to improve integrated care for that target group. Moreover, the mutual goals aimed to accomplish integrated health and social care and rehabilitation in the municipality in order to reduce emergency hospital care visits. The program comprised a care continuum, a "chain of care," from hospital to community living for frail older people across organizational borders. The care continuum comprised a comprehensive geriatric assessment (CGA) in emergency care, a case manager (CM) and an inter-professional team in the municipality. The program was tested as a two-armed intervention where the implementation was studied in parallel (Dunér, Blomberg & Hasson 2011; Wilhelmsson et al. 2011).

Before the start of the program in 2008, the staff received information and training about program organization, CGAs and laws and regulations. Furthermore, the professionals exchanged knowledge about the different units involved and the work procedures to understand the content of the care process program. The results from the intervention study formed the basis for a joint care process program, where the program has been accepted as the regular way to work.

In this thesis, the professionals' views on inter-organizational collaboration were described and compared by studying the influence of different factors of importance to inter-organizational collaboration at the start of the implementation of the integrated care process program (study III). In study IV, the preconditions for the implementation of a care process program were investigated by comparing the professionals' understanding ("I understand"), commitment ("I will"), and ability ("I can") to change their work procedure over time within and between the organizations.

Questionnaire operationalization and pilot testing

The questionnaire used in study III and IV aimed to assess the views of the operative professionals and have been developed and tested in several steps. A questionnaire used in a similar study of the implementation of an intervention in child protection (Johansson 2013) formed the basis of our questionnaire. In the first step, the questionnaire was slightly adapted to fit the context of the present study (i.e., elderly care). In the next step, it was revised according to the results from the qualitative study of the process of implementing a new continuum of care model in a complex organizational context (Dunér, Blomberg & Hasson 2011). Finally, the questionnaire was tested within the organizations by managerial and operative professionals.

The questionnaire and the previous qualitative study of the implementation process were based on a theoretical model developed by Lundquist (1987). According to this model, the involved professionals' understanding, commitment and ability to change their work procedure according to the care process program shaped the implementation process. The "understanding" indicates the professionals' knowledge of the care process program and their comprehension. "Commitment" was their intentions to support and work in accordance to the program and their "ability" was to work in line with the care process program when it came to decision-making and the setting of the scene and if the professionals required resources. The questionnaire comprised 20 questions on a four- or five-point Likert type scale with a "do not know"

alternative that the informants were asked to consider. The same questionnaire has been used to describe and compare inter-organizational collaboration from the professionals' perspective at one time at the start of the implementation of the program (study III), and at three cross-sections to evaluate the preconditions to the implementation of the care process program over time and between the organizations (study IV).

Data collection and participants

In study III and IV, data were collected from professionals who were directly or indirectly involved in the integrated care process program "Continuum of care for frail older people." Study III included care units in a municipal area in Western Sweden, including public and private units within primary and secondary care and municipal health and social care (n = 32). In study IV, primary care was excluded (n = 24). The units were strategically and randomly sampled (Altman 1991). The units were strategically sampled in order to include units from all organizations that were involved in the integrated care of frail older people. Within each organization, the units were randomly sampled. Before the baseline study, there were units who refused to participate due to organizational changes, an expired contract with a home care provider or were unreachable. Eighteen units agreed to participate in study III and 15 in study IV. Among the professionals, a majority were women and practical nurses from home care services. Moreover, registered nurses, occupational therapists, physiotherapists, social workers and physicians were included. In study III, 208 questionnaires were collected. At the baseline of study IV, 191 questionnaires were collected; 135 at the six-month follow-up; and 96 at the 12-month follow-up.

Procedures

In these studies, questionnaires were used to evaluate the professionals' views at baseline (study III), and for study IV, at baseline and six and 12 months (study IV). Managers from the care units were contacted and gave informed consent or declined to participate. Professionals from the sampled units completed the questionnaire at a staff meeting, mainly handled by the researchers, but a minority were distributed and collected by managers. There were a few dropouts (n = 2) because of language barriers or administrative tasks. There were 8 - 45 employees in each unit.

Data analysis

The data were entered into IBM SPSS 23 statistical program before analysis by descriptive and analytical methods. To analyze group comparisons, Chi-square test (study III and IV) and Fisher's exact test (study IV) were used

(Altman 1991). Moreover, in study IV, change over time was determined and a logistic regression was used to analyze the impact time and organization had on the professionals' perspectives.

4 ETHICAL CONSIDERATIONS

Ethical approvals were obtained when appropriate from the Regional Ethical Review Board in Gothenburg for studies I-IV. In study I, the audio-recordings of the discharge planning conferences were approved 2009-01-22 (Dnr: 816-08). In study I and II, there was no need for ethical approval according to the Swedish law concerning the individual and the focus group interviews involving professionals (SFS 2008:192). Ethical guidelines were followed as recommended concerning information, consent, confidentiality and access rights, however. The participants gave informed consent. Ahead of study I, the participants received information at a staff meeting. In study I and II, an oral agreement concerning confidentiality was made between the researcher and the informants.

Regarding study III and IV, ethical approvals were obtained. Initially ethical approval was granted to the main study ("Vårdkedja: från akutmottagning till eget boende – implementering och utvärdering av en intervention för sårbara äldre") 2008-08-12 (Dnr 413-08), but this approval was complemented with an additional application and approval for the evaluation of the full-scale implementation "From intervention to trial (RCT) to full-scale implementation research" ("Från akutmottagning till eget boende- implementering och utvärdering av en intervention för sårbara äldre") 2012-02-28 (T 140-12). However, concerning the interviews with the professionals, there was no need for ethical approval according to the Swedish law (SFS 2008:192). In study III and IV, the participants were given oral and written information about the studies and that participation was voluntary. All study data were handled confidentially, and only the researchers had access to them.

5 RESULTS

The results are presented in detail in each separate paper (studies I-IV). In this section, the results are briefly introduced and summarized for the four studies.

The results show that the professionals were aware of the importance of preparing their older patients to the discharge process. Both the professionals and the frail older people themselves contributed in the discharge planning conferences (study I). Moreover, the professionals had a certain awareness and agreed about how older people could become more participative (study II). The professionals were committed to changing their work procedures according to the care process program at baseline and were familiar with the care process program over time (study IV). However, our findings reveal some problematic issues. The professionals' awareness of the importance of older people's preparations in the discharge process was excluded from the regular work procedures and was, thus, sometimes overlooked. The institutional setting dominated and was prioritized over the older people's participation (study I). A false sense of participation was created toward the frail older people, as the outcome of the discharge planning conferences was planned by the professional's beforehand "back-stage," therefore, the conferences became merely formalities. Furthermore, the professionals did not agree on who should be responsible for the division of care activities or how the participation of frail older people could be accomplished in the discharge process (study II). In these studies, it became evident that there was insufficient knowledge of each other's working circumstances, diverging perceptions of division and transfer of care responsibilities, insufficient experiences in collaboration and psychosocial factors that were obstructing collaboration (study II-III). In this context, the professionals' commitment to changing their work procedures according to the new work procedure decreased over time. Their abilities to change their work procedures according to the care process program and their understanding of the division of responsibilities were limited and remained unchanged (study IV).

Promotive and obstructive factors for frail older people's participation in discharge planning conferences

The first study (study I) showed that frail older people's participation in discharge planning conferences was possible under certain circumstances. During these conferences, older people's care and rehabilitation needs were negotiated, and their participation was communicatively shaped by their own or the professionals' approach. Their positions varied and were categorized from being an active person to a passive patient. The analysis revealed that someone who was categorized as an "active person" was actively taking part

in the situation and reflecting upon their whole life more holistically. On the contrary, someone categorized as a "passive patient" was passive in relation to participation in the discharge planning conference and a "patient" when not including their whole life situation. Their positions varied dynamically between the four different categories from being (1) an active person, (2) passive person, (3) active patient or (4) a passive patient. All professionals being well prepared and having structured meetings were seen as promotive factors to older people's participation and a patient centered approach. Obstructive factors occurred when the professionals used "over the head" talk, the older people or the professionals were not prepared for the discharge planning conference and when the professionals did not collaborate inter-organizationally due to insufficient knowledge about which other organizations were involved.

Collaboration within an implicit framework in discharge planning conferences prioritized over frail older people's participation

The analysis of study II explored what preconditions and obstacles to frail older people's participation were evident on both the professional and organizational levels. Furthermore, these preconditions implicated an unspoken framework to collaboration where the discussions revealed underlying norms and values that influenced the outcome of the discharge planning conferences. The unspoken framework of collaboration was interpreted as different perceptions of prioritizing the older people's involvement in practice, choice of method for information transferal affecting collaboration, the limited timeframe affecting assessments and choice of actions, and underlying professional hierarchies. The results showed the preconditions to inter-organizational and inter-professional collaboration were related to timing, "back-stage" pre-meetings (förmöten), specializations, the want to remain within professional boundaries, the composition of the discharge planning conference (mötets sammansättning), the institutional conversation/order (samtalsstruktur) and IT-systems. The discharge planning conferences appeared to be an arena for a professional exchange of ideas more than a dialogue with frail older people.

Different factors influencing inter-organizational collaboration

A majority of the professionals in inpatient care had a post-secondary education, in this context, referred to as an academic education (registered nurses, occupational therapists, physiotherapists, social workers and physicians), while a minority in outpatient care were academically educated, most had a secondary-level education (study III) referred to as non-academic

in this paper. Insufficient knowledge of each other's working circumstances was the factor that was scored as the greatest difficulty to inter-organizational collaboration by the professionals (n = 132, 63%), followed by insufficient experience of inter-organizational collaboration (n = 99, 48%), and psychosocial factors, for example, interpersonal chemistry and insufficient psychosocial working climate (n = 91, 44%). In study III, the factors that were scored as presenting the least difficulties were the influence of different professions (n = 27, 13%) and professional power and status among the staff at the care units (n = 49, 24%). Non-academic professionals responded in greater proportion (24-56%) than academic staff (4-37%) that they did not know how the different factors influenced collaboration. No statistically significant differences occurred when comparing potential difficulties to inter-organizational collaboration between inpatient and outpatient care respondents.

When comparing differences in views between professionals with or without an academic education, significant differences occurred on all collaboration factors. The academically educated professionals scored difficulties to inter-organizational collaboration higher than non-academic professionals did on the influence of different laws and regulations ($p = 0.02$), the influence of insufficient knowledge about each other's working circumstances ($p = 0.001$), and the influence of insufficient experiences of inter-organizational collaboration ($p = 0.002$). A higher proportion of the non-academic professionals scored the influence of long distances ($p = 0.02$), different professions ($p < 0.0001$), professional power and status ($p = 0.02$) and psychosocial factors (insufficient psychosocial working climate, interpersonal chemistry) ($p = 0.01$) as difficulties to inter-organizational collaboration.

Limited preconditions to implement an integrated care process program

At the baseline survey (study IV), the majority of the respondents (n = 144, 75%) agreed that they were familiar with the care process program. However, a minority (n = 41, 21%) of the respondents agreed that it was obvious, according to the program, which unit was responsible for different actions, for example, in nursing, care and rehabilitation. A minority (n = 51, 27%) of the respondents believed in their abilities to change their work procedures according to the care process program or found that management prioritized and promoted the program's adoption at baseline. The results showed no statistically significant changes or differences in the views between hospital and municipal healthcare professionals, and the professionals' understanding and ability to change their work procedures remained unchanged over time.

However, the professionals were committed to give their support to most of the statements (80-93%) at baseline, and the majority of the respondents (n = 111, 58%) agreed on the program's relevance to offer a better integrated care structure and support for frail older people. There were statistically significant changes over time within the organizations and in comparison between the organizations according to their commitment. The professionals' commitment decreased on the importance of frail older people being offered a permanent municipal contact. Their commitment decreased over time from 12-month follow-up compared to baseline ($p = 0.02$, OR = 0.39, CI = 0.17-0.87), and from 12-month follow-up compared to six-month follow-up ($p = 0.05$, OR = 0.41, CI = 0.17-0.99). Furthermore, the professionals' commitment changed and decreased over time in relation to the importance of information transfer from the emergency department to the municipal health and social care at 12-month follow-up compared to six-month follow-up ($p = 0.04$, OR = 0.2, CI = 0.18-0.98). The professionals changed their views regarding the importance of discharge planning in the hospital setting and their commitment decreased over time at 12-month compared to six-month follow-up ($p = 0.04$, OR = 0.51, CI = 0.27-0.98). Moreover, the professionals' commitment to discharge planning at home decreased over time, and they were least committed at the six-month follow-up compared to baseline ($p = 0.04$, OR = 0.57, CI = 0.33-0.98).

In comparison between hospital and municipal professionals, the hospital professionals were more committed than professionals from municipal health and social care to the importance of information transfer from the emergency department ($p = 0.01$, OR = 2.88, CI = 1.30-6.42) and to discharge planning at frail older people's homes after discharge ($p = 0.03$, OR = 1.79, CI = 1.05-3.06).

6 DISCUSSION

The main findings in this thesis reveal that frail older people's participation is possible, but it is the professionals' needs that are prioritized over the needs of the older people (study I and II). Collaboration has been studied as a phenomenon, where patients' participation and influence are an important part in the context of integrated care (study I-IV). The results reveal that frail older people's participation in integrated care is possible, but often it is obstructed by the organizations' structure. The professionals are cognizant of, to some extent, how to support frail older people in the discharge process, but their awareness is based solely on the institutional and governmental policies. The professionals have an awareness of the need for collaboration between the organizations to support frail older people but not who is responsible or how it should be accomplished. Hence, collaboration is inconsistently achieved (study I and II). Moreover, the professionals' educational level influenced inter-organizational collaboration more than their organizational affiliation on all variables, such as, the influence of laws and regulations and insufficient knowledge about each other's working circumstances (study III). The professionals have an understanding of the importance of a care process program to support frail older people in the discharge process, but their preconditions to change their work procedures according to the program was limited. Their abilities in this regard were limited due to a lack of management prioritization of the program and resources. Hence, their commitment to the program decreased over time (study IV).

Discussion of the findings

The organizational setting obstructing frail older people's participation

In study I, the institutional context obstructed the participation of frail older people from being active participants in the discharge conferences. A false type of participation was created for frail older people where the outcome of the discharge process was more or less decided beforehand, making the conference a formality rather than a truly collaborative process involving the patients. Previous studies have shown that a possible reason for this can be the institutional processing of people. Older people are categorized as patients to fit into what the organization can offer, for example, different home care services (Hasenfeld 2010; Olaison & Cedersund 2006) rather than adjusting the organization to fit their needs. Furthermore, studies have shown that participation of older people and their next of kin are overlooked by the professionals who do not properly include patient needs and capabilities (Nyborg, Danbolt & Kirkevold 2017). Studies have shown the older people's room for participation was small and their possibilities to take part in the

negotiations and decision-making of their care was limited (Efraimsson et al. 2004). Moreover, in this study, we discovered routines for preparing the older people for the discharge process was missing. This means, that besides shorter care periods at hospitals, professional pre-meetings before the discharge planning conference were conducted in the absence of the older person and/or their next of kin. This fact has been emphasized in previous studies were organizational routines were prioritized before the older people's participation (Efraimsson et al. 2006; Mabire 2015). However, the results of study I showed frail older people's participation was not to be taken for granted and possible under certain conditions.

The results in study I revealed that the participation of frail older people in the discharge process was possible, however, under certain conditions. Having frail older people participate as an "active person" was possible when the older people were prepared, made themselves participate, when the professionals communicated with them or their next of kin and had a supportive approach. However, previous studies have shown that professionals' views on older people's participation in hospital care diverged between the organizational and professional domains and the older people and their satisfaction with care. How participation was accomplished depended on the care (e.g., treatment and medical examinations) and the available hospital resources (e.g., beds and staff) (Dyrstad, Testad & Storm 2015). Moreover, in study I, the frail older people's health and their own approach to discharge conference participation, support and demands from the next of kin, and the professionals' will to include a holistic approach to the entire care situation of the patients affected participation. This emphasizes the importance of organizational support, professional approach and inter-professional collaboration to enhance frail older people's participation and engagement in their care, as defined in ICF (2003). Organizational routines that safeguard, initiate, and integrate care are necessary for person-centered care to be established. Furthermore, the person's own narrative, shared decision-making and related documentation were found to be important cornerstones to establish person-centered care (Ekman et al. 2015). Person-centered care is an approach to support people to become active participants rather than being considered as care objects (Leplège et al. 2007). To establish integrated care from a person-centered perspective, these conditions are essential and need to be established in healthcare and municipal health and social care settings.

The results in study I revealed that the professionals were aware, to some extent, of how the older people's participation should be accomplished, but the organizational settings obstructed this. Inter-professional collaboration in the discharge process was mainly seen as the professionals' arena where older people's participation was considered to be minor. When older people were categorized and reduced to "passive patients," there was a lack of a holistic view with regard to the older people's life situation and both the older people and the professionals identified the needs before abilities (study I). As previous studies have shown this issue can be understood as having a lack of a person-centered perspective, which focuses on capabilities and is based on information from the older person and/or the next of kin to facilitate older people's empowerment and participation (Leplège et al. 2007; Morgan & Yoder 2011). The results in study I revealed that when older people were categorized as "passive patients," there was a lack of focus on the older people's own goals during hospitalization and post discharge. However, other studies have shown community-dwelling frail older people can be effectively supported to participate more actively in the decision-making concerning their care and treatment (Robben et al. 2015). Older people can be supported in setting realistic goals and providing insight into what they would like prioritized most in their care and treatment (Robben et al. 2015). On the contrary, the results from a study of person-centered goal-setting in geriatric rehabilitation showed that the professionals felt that the older people were unable to formulate or set realistic goals during hospitalization (Seben, Smorenburg & Buurman 2018). However, the older people themselves viewed their goals during hospitalization as crucial to becoming independent in self-care activities, return home, be able to perform activities and regain full independence (Seben, Smorenburg & Buurman 2018). Therefore, to establish integrated care from a person-centered perspective, it is essential for the professionals to include the older person in the discharge process and encourage the frail older people to take an active role in their care and in setting goals.

Collaboration with inconsistent approaches

The results revealed that collaboration in the discharge process was inconsistently conducted where it was unclear to the professionals who was responsible in the discharge planning conference or how good integrated care should be accomplished (study II). The professionals collaborated within an unspoken, tacit framework, which was interpreted differently based on different perceptions of priorities for the older people's involvement, methods of information transferal, the limited timeframe affecting assessments and decisions, and underlying professional hierarchies.

This study (study II) revealed that underlying professional hierarchies were significant barriers to collaboration. The problematic issue of professional hierarchies has been highlighted in previous studies, where collaboration was hampered by formal and informal divisions among care workers. However, having formal guidelines and managerial strategies to support collaboration across these hierarchies was beneficial (Jakobsen et al. 2018). The results in our study revealed that it was unclear to the professionals who were responsible in the discharge process and how it should be conducted. Previous studies have shown that power-hierarchies between different professions served as barriers to collaboration (Miller & Ashcroft 2016). Hence, communication to clarify professional responsibilities, decision-making in team discussions, collaborative culture, roles and professional self-identity served as facilitators to collaboration and they helped prevent the development of power hierarchies. In addition, an organizational culture that values, supports and encourages collaboration is beneficial (Miller & Ashcroft 2016). Hence, developing inter-professional communication and establishing organizational development to improve inter-organizational collaboration is beneficial to overcome these obstacles.

The results show that the professionals' objective to be time efficient meant that the discharge planning conferences were mainly the professionals' arena. Assessments and choice of actions were affected by shorter care periods where the assessments were conducted at an earlier stage, and the choice of actions before the forthcoming discharge were determined from an early assessment. The professionals' opinions were inconsistent with regard to choice of actions for the older people. Moreover, the frail older people's participation was limited. In the professionals' pursuit to be time efficient, unethical presentation of the older people's lack of abilities and talking over their heads were evident. These findings are in line with previous research that found that diverging organizational structures with different timetables and decision-making structures may have hindered collaboration (Auschra 2018). It was also found that a limited timeframe and lack of accountability created different barriers to care integration. In times of shorter care periods, mutual organizational strategies have to be established in order to balance inconsistent approaches between professionals and for person-centered care to be achieved.

This study showed the choice of method for information transferal affected collaboration between the organizations (study II). The professionals' views were inconsistent and varied with regard to how information should be transferred and documented. However, the results are in line with previous studies that have indicated that the organizational structure obstructs collaboration (SOU 2016:2). Fragmentary organization, where each unit has its own goals and results to achieve and professionals that are more specialized, suggests difficulties in meeting the complex care needs of frail older people (Simonet 2015; SOU 2016:2). These findings reveal that there may be a lack of mutual agreement regarding information transferal, negatively influencing collaboration in this study.

In these studies, the findings revealed that the organization may be problematic for both the older people and professionals, as there were a lack of venues to meet and develop mutual knowledge of inter-organizational collaboration. According to Axelsson and Bihari Axelsson (2006), horizontal integration supports collaboration with mutual agreements between units on the same level. The results in this study (study II) revealed there were limiting factors to inter-organizational collaboration in the discharge process influenced by either vertical integration or a combination of horizontal and vertical integration. Moreover, the Freedom of Choice Act (SFS 2008:962) means there are more actors within home and primary care, which may contribute to the difficulty with collaboration. Integration is accomplished with contracting that has little influence on vertical hierarchical control or horizontal voluntary integration despite the fact that private care providers follow the same regulations as public care providers (Axelsson & Bihari Axelsson 2006).

Education level influencing professionals' views on inter-organizational collaboration

Study III's results showed the professionals' educational level influenced collaboration. However, the organizational affiliation did not influence collaboration significantly. Professionals with an academic education scored difficulties related to the organizational setting higher than the non-academic professionals. The non-academic professionals scored the influence of psychosocial aspects as difficulties to inter-organizational collaboration higher than advanced academic professionals. These findings may be explained by a lack of inter-professional education as has been demonstrated in previous studies (Gjessing et al. 2014). In this study, the professionals got information and training before the start of the implementation of the care process program. It is possible the education and training for different professional groups differed slightly, depending on how the education and training was planned. Previous studies have suggested that improved inter-professional collaboration

enhanced professional practice and outcomes, as shown in a review by Zwarenstein, Goldman and Reeves (2009). Despite the demand for inter-professional collaboration in an integrated care process program, the lack of inter-professional education may have negatively influenced the professionals' views in this study. This fact may have had a negative influence on the preconditions to implement the care process program.

Moreover, the results revealed that the participating professionals viewed collaboration as obstructed due to a lack of knowledge about the circumstances in the other organizations. According to the participants, the lack of knowledge was communicated through unrealistic expectations toward the other organizations and was viewed as an obstacle to collaboration. For integrated care improvements, there is a need for increased knowledge among the staff. Previous studies have indicated that an educational program for professionals about integrated care had the potential to improve patient safety culture, for example, the transferring of patient care information (Storm, Schulz & Aase 2018). However, these studies revealed that there were knowledge deficits among the professionals about the circumstances in the other organizations, which may have influenced integrated care and patient safety negatively. In this thesis, the participants were aware that different professional affiliations may obstruct inter-professional collaboration. This was obvious when the professionals strived to remain within their own professional framework. This result is supported by previous studies showing that professional identity and professionalization may be threatened by collaboration, making professionals more hesitant to adapt to the new process (Axelsson & Bihari Axelsson 2009).

Limited preconditions to work according to an integrated care process program

The professionals had an understanding of the importance of a care process program to support frail older people in the discharge process, but their preconditions to change their work procedures according to the program was limited (study IV). Their abilities were limited because management did not prioritize the program and resources were not plentiful. Hence, their commitment to the new program decreased over time.

In this study (study IV), the preconditions to the implementation of a comprehensive and complex integrated care process program were evaluated. Previous studies have shown that organizational changes with less complexity and more local compatibility were more advantageous and easier to implement for organizations (Greenhalgh et al. 2004, Greenhalgh 2017; Rogers 2003). Hence, implementation and evaluation of complex interventions need specific strategies and phases: development, feasibility, implementation and evaluation

(Craig et al. 2008). However, in organizations with heavy workloads and extensive professional turnover, evaluation of complex interventions may be particularly challenging as the same professionals are not necessarily involved over time. To be implemented in the long-term, new work procedures must become routine to the professionals (Greenhalgh 2008).

In this study (study IV), the professionals' commitment decreased in their view of the importance of a permanent municipal contact, the municipality receiving information from the emergency department, and discharge planning at the hospital and at home. This result shows the preconditions for the implementation was limited over time in the organizations. However, previous studies have shown that implementation was facilitated by trust between the participating organizations and authorities (Ahgren 2007). In addition, there needs to be mutual organizational benefits for the involved organizations and units; otherwise, the programs may be less well implemented (Ahgren 2012). This study revealed (study IV), the professionals from the hospital were the most committed and agreed to the preconditions to the implementation to a greater extent. To strengthen the preconditions for implementation, a decentralized and flat management structure would be beneficial where the workers have the freedom to cross professional boundaries to ensure collaborative efforts (Axelsson & Axelsson 2006; Greenhalgh 2017). These studies revealed that the professionals were committed to changing their work procedures at baseline despite the limited ability to control their work procedures. Hence, the professionals may have limited room for action. These results are in line with previous studies, where implementations of new interventions benefited from an approach where professionals with a driving spirit were encouraged by management, and there was room for local initiatives among the professionals. This study showed (study IV), the driving professionals may not have been thoroughly encouraged by the management. In addition, the preconditions to the implementation may have been limited as a consequence of high professional turnover where the professionals driving the program left, especially with municipal professionals. As previous studies have shown, implementing integrated care is obstucted by a top-down approach, and any new program must be complemented with a bottom-up approach (Ahgren 2007). Moreover, previous research has shown that management needs to prioritize the program and resources are important factors to implementation (Greenhalgh et al. 2004; Greenhalgh 2017).

Methodological considerations

As the author of this thesis, I have a certain preunderstanding of the context. I had experience in this area from a clinical perspective as an occupational therapist where I participated in the discharge process with frail older people and was a coordinator in a research and development unit. Working as a coordinator meant I had the opportunity to work with issues related to care development from an organizational standpoint for the benefit of the users, clients or frail older people. These experiences have given me first-hand insight into the problems that occur regarding the collaboration between professionals and between care organizations. Therefore, writing this thesis is my contribution to gain an understanding of the complex nature of integrated care for frail older people.

In order to fulfil the overall aim of this thesis, both qualitative and quantitative methods were chosen. Theoretically, the methods ranged from the medical positivistic paradigm to the holistic perspective from human sciences. The methods were chosen to represent diverging perspectives in order to understand different aspects of how collaboration and participation are achieved in an integrated care context. The mixed methods in this thesis enables us to find an understanding of diverging methods but may hamper more in-depth knowledge of each specific method (Patton 2015; Polit & Beck 2012).

Limitations

Being frail includes fatigue, weakness and cognitive deficits among the older participants, where even a minor increase in stress can further reduce their capacity significantly (Bergman et al. 2007). These conditions may have been a reason why there were problems in recruiting older participants for study I. The recruitment problems may also have had an organizational origin. Nurses and social workers asked frail older people within the inclusion criteria (aged 77 years or older with at least two health-related problems, with the ability to communicate, without cognitive and hearing deficits) at the hospital or within municipal health and social care to participate. During the data collection, there may have been some discharge planning conferences that we did not get access to due to staff circumstances, heavy workload and stressed personnel. Due to some absences, the composition of the focus groups was slightly uneven, for example, in one of the focus groups the majority of the participants were occupational therapists. This uneven group composition in study II influenced the heterogeneity and may have influenced the discussions, reducing the possibilities to identify more perspectives (Kitzinger 1995).

The care process program was revised to suit the local context to better fit their own local needs and preconditions. This may be beneficial for program adoption in the local units (Rogers 1995). Due to this, there is som uncertainty where the units changed the program. The researchers have not investigated these interpretations or revisions of the program (study IV). There may also have been other competing projects interfering with the implementation. It is not known what particular implementation efforts were performed in each unit (study III and IV). Accordingly, there may be some uncertainty where the researchers were unaware of what happened in terms of other projects. Hence, the professionals' interpretation of the implementation could have changed over time due to external variables that were not measured in our studies (study IV).

Trustworthiness in qualitative studies

In order to understand the discharge process as a phenomenon, we chose to study the discharge planning conference, utilizing different methodologies (study I). The qualitative methods were chosen to shed light on the social interactions (Goffman 1959) and positioning (Harré & van Langenhove 1999) that occur in discharge planning conferences, a kind of institutional talk (Sarangi & Roberts 1999), and its meaning for the participants' opinions of collaboration (study I). Using a case study method meant that frail older people's participation could be elicited from different perspectives (Stake 2000). A mixed method study design to study older people's participation in discharge planning was an alternative, but presupposing another design including a mix of qualitative and quantitative methods (Hanisko et al. 2016). Studying discharge planning conferences as a case meant a large amount of study data to collect and analyze. However, the choice of methods offered the opportunity to study discharge planning conferences and participation more in depth.

Knowledge is created during social interactions, and this reflects how people understand their surrounding worlds (Gergen 2009). Therefore, social constructionism was a valuable approach to explore how the professionals communicated and shared their experiences of collaboration (study II). To be able to explore health and social care professionals' experiences of inter-professional and inter-organizational collaboration, we chose to conduct focus groups in study II (Dahlin Ivanoff & Holmgren 2017; Krueger & Casey 2009). There are other methods available, for example, individual interviews (Kvale 1996). However, to allow the participants to share their experiences of collaboration in the discharge process and to obtain a collective understanding, the focus group method was chosen. The focus groups were conducted by the

same moderator, a researcher. A certain awareness from the group leader is needed without any demand on being an expert on the study's focus in order to moderate the discussions. This awareness is needed to prevent some people from dominating the discussions or potential conflicts, especially if the participants know each other beforehand (Patton 2015).

To ensure the credibility in the qualitative studies, triangulation was used during data collection and analysis (Miles & Huberman 1994). In study I, data were collected from different sources where participants from different professions were interviewed, and two of the researchers representing different professions (registered nurse, occupational therapist) conducted the interviews with the professionals. Moreover, data from the audio-recorded discharge planning conferences were theoretically triangulated using discourse analysis to study how they communicated, and power asymmetries were studied with support from positioning theory by Harré and van Langenhove (1999). In study II, the data were triangulated during analysis by two of the researchers, representing different professional backgrounds (Miles & Huberman 1994).

Two of the researchers took turns making the audio recordings in the case study (study I). The researchers had no intention of interfering during the discharge planning conferences. There was a risk that the participants would pay attention to the attendance of the researcher and the audio recorder and alter their behavior, but most likely they were occupied with the conference proceedings (Miles & Huberman 1994). During data analysis of the case study (study I), a certain structure was identified, eliciting possibilities and obstacles to patients' participation in discharge planning conferences. Regarding the external validity of the findings, the older people's positioning is not transferable to other settings. However, the positioning model, active person versus passive patient, is transferable to other discharge planning conferences and target groups. This model can help develop and improve inter-professional collaboration and other frail target groups' participation in discharge planning conferences (Miles & Huberman 1994).

In order to ensure the confirmability, data collection in the interviews in the case study (study I) were accomplished by an interviewer with a different profession to the informant and the focus groups sessions were moderated by a researcher (study II) (Miles & Huberman 1994). Furthermore, the data were handled systematically where each step in the data analysis was described in the papers. For a more thorough description of the data analyses, see papers I and II.

The studies benefit from having the same project leader across all of the studies (study I and II). In addition, both professionals and health organization

managers contributed to data validation through inquiry audit in oral and written presentations during the study (study I) (Patton 2015). In these studies, a variation of organizations, units and professionals from healthcare and municipal health and social care were represented and sufficiently related to the study methods (study II). The participants were heterogeneous, representing different geographical, professional and organizational groups, while they were still homogeneous in that they all had experience in discharge planning—a knowledge that they agreed to share and discuss in study II (Patton, 2015). The focus group sessions were initiated by having participants read a vignette in order to engage them and initiate the discussions (Miles & Huberman 1994). There is a possibility that its illustration of discharge planning conferences may have influenced the outcome of the focus groups discussions. The study dependability has been carefully described in the methodological sections in the papers (I and II).

Validity and reliability in quantitative studies

At the start of the implementation of the integrated care process program "Continuum of care for frail older people," the professionals' views were measured quantitatively in a cross-sectional study on the factors of importance to inter-organizational collaboration (study III). Furthermore, the preconditions for the implementation of the care process program were evaluated from the professionals' views with three independent cross-sectional studies. The included organizations had heavy workloads and extensive turnovers of professionals. Therefore, to be able to get access to the units and to study this complex organizational setting in real-life, a cross-sectional study design was chosen. While a longitudinal study could have been conducted, as that would require following the same individuals over time, it would have proven problematic due to the extensive staff turnover (Altman 1991).

The studies were conducted with a questionnaire to study the influence of different factors to collaboration (study III) and to evaluate the professionals' views of the preconditions to implement an integrated care process program (study IV). The first part of the questionnaire (questions 1-17, study IV) was inspired by Lundquist's (1987) model to investigate the professionals' understanding, commitment and ability, and the latter part investigated the important factors for collaboration (questions 18-19, study III). Lundquist's model was deemed relevant to evaluate the professionals' views of the preconditions to implement a policy, such as the integrated care process program. At the end of the questionnaire, there was an open comment section for personal considerations.
The professionals were studied as groups from an organizational view and not as individuals or professions. A quantitative design with questionnaires was

more advantageous compared to interviews, for areas such as cost, anonymity and limiting interviewer bias (Polit & Beck 2012). However, interviewing tended to produce higher response rates. In these studies (study III and IV), the questionnaires were distributed personally in order to increase the response rates while simultaneously retaining the advantages of viewing the professionals as groups (Polit & Beck 2012).

Before the baseline study (study III and IV), the professionals received information and training about the content of the care process program (e.g., laws, regulations and CGAs). Policy implementation presupposes education and training of the professionals. However, if in-service training at the workplace does not follow the education, the intended effects of the implementation are diminished (Fixsen et al. 2005). Thus, professionals from the units, which were directly involved in all three organizations, received information and training regarding the implementation. As we even included those who were indirectly involved, this may have affected their understanding of the care process program.

The questionnaire in study III and IV has been used in a similar context to measure collaboration within child protection (Johansson 2013). In order to evaluate the preconditions to the implementation of an integrated care process program (Continuum of care for frail older people), the questionnaire was modified to fit the target group and the complex organizational context of the care process program (study IV). The questionnaire was revised according to the results from a qualitative study in a complex organzational context of the implementation process of Continuum of Care for Frail Older People (Dunér et al. 2011). In addition, the questionnaire was piloted by professionals and managers within the organizations, and finally it was revised and tested one last time in order to ensure stability and validity. These questionnaire revisions toward the target group and healthcare context were carefully conducted to increase validity. As designing questionnaires is demanding and needs to be developed carefully and pretested (Polit & Beck 2012), it was piloted for these studies. In order to be clear, the questions and response alternatives were written as statements instead of in the form of questions (study IV). This may imply an uncertainty concerning the reliability of the instrument; therefore, the questionnaire was tested, revised and piloted again (Polit & Beck 2012).

The questionnaire in study III and IV has been used in a similar context to measure collaboration within child protection (Johansson 2013). In order to evaluate the preconditions to the implementation of an integrated care process program (Continuum of care for frail older people), it was modified in order to fit the target group and the complex organizational context of the care process program (study IV). In addition, the questionnaire was piloted by professionals and managers within the organisations. These questionnaire revisions towards the target group and healthcare context were carefully accomplished to consider face validity. However, designing questionnaires is demanding and needs to be developed carefully, and pretested (Polit & Beck 2012). Hence, a pretest has been accomplished in these studies. Furthermore, the questionnaire that was used in these studies included questions. In order to clarify, the questions have been entitled as statements instead of questions in the paper (study IV). However, the response alternatives are formulated as statements (study IV). This may imply, an uncertainty concerning the reliability of the instrument. However, since the questionnaire was modified, in order to ensure the questionnaire stability the questionnaire was tested, revised and tested one last time (Polit & Beck 2012).

To measure the preconditions to the implementation from the professionals' views, the respondents were asked to respond to statements on Likert scales with four or five response alternatives (study IV). Choosing an odd number of items gave the opportunity for the respondents to respond neutrally (Polit & Beck 2012). In study IV, the statements were measured on a four-point or five-point Likert scale. There is a chance that using the same number of response alternatives on the Likert scales may have produced a more similar dichotomization of the responses. Dichotomization allowed us to study those who agreed (including those who slightly agreed and strongly agreed) on their understanding, commitment and ability to change their work procedures according to the care process program (study IV). Dichotomizing the ordinal data into two categories simplified the analysis but increased the risk of information loss (Altman 1991).

These studies (study III and IV) were conducted in an average sized municipality for Sweden and included local units in hospital and municipal health and social care settings (study III and study IV) and primary care (study III). These were the units available in this particular area that were possible to include in the studies. Before the baseline study, there were managers at the units who declined to participate, were unreachable or had an expired contract as a home care provider. Among those units who agreed to participate (in study III, N = 18, in study IV, N = 15), all included organizations and units were represented. As we studied the units at three cross-sections and not the professionals as individuals, the units that agreed to participate were included

even if not all of the respondents participated in all three cross-sections. At baseline, a majority of the respondents were practical nurses (n = 94), but at the 12-month follow-up, they were a minority (n = 9). This fact may be caused by organizational changes and new managers in the home care services to whom the integrated care process program was unknown. The practical nurses in home care services were those who were least involved in the care process program since discharge planning conferences were moved from the hospital to the older people's own home according to the program's intention. Internal attrition was low, there was at most six (study III) or five (study IV) missing values on each question. Possibly, the study data may represent this and other complex organizational settings, as different units were represented, and it is the units that have been studied not the professionals as individuals.

In study III, the analysis investigated the influence of difficulties. In the evaluation of the implementation (study IV), we choose to study the preconditions for the implementation. In order to be able to analyze more data, the choice was to describe and compare those who responded to the difficulties of collaboration factors to inter-organizational collaboration. The results were estimated to be representative for all operative professionals directly or indirectly involved in the care process program. In this complex organizational context, it is important to study collaboration in "real life" to increase our understanding of the influence of different collaboration factors and the preconditions to implementation. Therefore, we surmise this knowledge may be transferable to other complex organizational settings (study III and IV).

The researchers had control over the questionnaire collection when they participated. However, some of the managers preferred to distribute and collect the questionnaires, indicating that the researchers had less control on the procedure. Different people responded to the three surveys due to the turnover. High turnover of employees meant new professionals, sometimes with limited work experience in units characterized by a heavy workload, were included in the studies. These factors highlight the challenges to the implementation of organizational changes and conducting research studies in organizations with high professional turnover and heavy workload. These difficulties make it particularly complicated to conduct longitudinal research and long-term implementations. For researchers, these organizational conditions complicate designing and analyzing data. However, these are the real-life preconditions in which implementations take place, thus offering a more realistic interpretation (Hasson, Blomberg & Dunér 2012).

7 CONCLUSION

During the last decade, new models for the discharge process have been developed in order to ensure care continuity. Moreover, the complex and comprehensive care needs of frail older people have been emphasized with a person-centered approach and their participation are important parts. Integrated care has become more of a matter concerning primary care and a focus on person-centered care has contributed to organizational changes. However, it is reasonable to assume that the development and implementation of efficient and sustainable methods to ensure person-centered care would have made more progress in a decade.

This thesis reveals that frail older people's participation is possible but is currently insufficient in integrated care because the process favors the professionals and their opinions. Discharge preparations are not yet routinized and need to be included in the regular work procedures and preparations with frail older people and their next of kin. Frail older people must be supported to participate actively and be better prepared for discharge conferences to ensure the professionals have a focus on each individual's needs.

Furthermore, there is a lack of knowledge among the professionals on the division and transfer of care responsibilities and who should be responsible for delegating care activities. In addition, insufficient knowledge of each professional's working circumstances in the different organizations, insufficient collaboration experience and psychosocial factors obstruct collaboration. Therefore, developing integrated care needs specialized knowledge and education among the professionals. In addition, to improve integrated care for frail older people, there needs to be avenues to develop mutual knowledge between the organizations.

The findings reveal that despite the intentions to defragment care services and establish an integrated care process for frail older people, the professionals preconditions caused limitations. The professionals had an understanding of the program, but their abilities, such as having enough resources and support from the management, were overestimated. Therefore, the professionals' commitment to work according to the program decreased over time. To develop health and social care and implement organizational changes, it is essential to work toward long-term goals with certain strategies targeting professionals at different levels. The professionals need to have enough resources and support from the management in the long term for the organizational development to be implemented in real life. Moreover, these

professionals must be encouraged to develop local initiatives in a bottom-up way as well.

Lastly, in these studies, the integrated care models that were studied were complex and collaboration was prevented by organizational and professional boundaries. Older people's needs are becoming more complex and professionals are becoming more specialized to provide care actions to meet these needs. Not only does having fragmentary services increase the risk of having deficits in the care, but it also highlights a risk of establishing integrated care programs with limited preconditions for the organizations.

8 FUTURE PERSPECTIVES

Integrated care may benefit from further development. From these studies, some areas to improve the preconditions to collaboration in integrated care have been identified. Explicit guidelines need to be established on how to inform older people about the need to be prepared for the discharge process. Furthermore, structural barriers need to be identified in order to facilitate older people's participation in health and social care. Regarding collaboration, there is a need to develop collaborative avenues to develop knowledge about discharge planning, regulations, ethical considerations, teamwork and participation and support of frail older people.

Research on integrated care is ongoing. However, there is a need for further studies on the implementation of complex interventions in health and social care with particular focus on investigating the preconditions to implementation in real-life targeting frail older people. Conducting research studies under real-life circumstances is challenging for researchers, but nevertheless they are important to achieve an understanding of how organizational development can be accomplished in healthcare and municipal health and social care. In addition, further studies may be beneficial to gain an understanding on how developing integrated care is planned and implemented in municipal care settings and understanding the impact educational level may have when implementing such organizational changes.

The new tighter rules on collaboration at discharge, Collaboration at Hospital Discharge Act (Lag om samverkan vid utskrivning från sjukhus SFS, 2017:612), where the financial responsibility has changed, implies changes including different organizational levels and toward older people and their next of kin. This act will have an impact on integrated care, where it is reasonable to assume that integrated care process programs will have an increased significance for primary care and municipal health and social care. It is necessary to investigate the significance of this act from different perspectives to understand its impact on the organizations, professionals and older people and their next of kin.

Finally, further studies of integrated care must inevitably include frail older people. In this context, developing and establishing person-centered care for the older people they and their next of kin must be encouraged to take an active role in any development.

ACKNOWLEDGEMENTS

The writing of this thesis has come to an end as well as the days as a doctoral student. It has been a bit of a journey that has been accompanied by different people in various settings, under the guidance of three tutors. This long journey would not have been possible without the support and encouragement that I have benefited from you all. I would like to thank all the older people who have kindly shared their experiences, and all the staff within hospitals, primary care and municipal health and social care who have participated and contributed their knowledge to this thesis.

I wish to express my warmest gratitude and appreciation to all who have contributed to make this work possible:

My supervisor, associate professor **Eva Lidén**, for the excellent support during my studies. Your scientific guidance, always being positive and finding new possibilities, and your willingness to discuss problems whenever I needed. Professor **Synneve Dahlin-Ivanoff**, co-supervisor, for always being positive, your encouragement and guidance especially in quantitative analysis, and rapid feedback. Professor **Anna Dunér**, co-supervisor, for your skillful guidance and for sharing your deep knowledge of elderly care and implementation.

For organizing the doctoral course, "From Master in Physio/Occupational Therapy to Doctor in Medical Sciences," **Gunilla Gosman-Hedström**, Associate Professor; **Jane Carlsson**, Professor; **Synneve Dahlin-Ivanoff**, Professor, and **Kristina Holmgren**, Professor. This course was instructive, provided interesting discussions and was an important part of being a doctoral student. To all the doctoral students at the Institution for reading my papers and for inspiring interesting discussions.

Emmelie Barenfeld and **Helene Berglund**, for your careful scrutiny, followed by both critical and constructive discussions at the pre-defence.

My colleagues, researchers and managers at FoU Sjuhärad Välfärd, former managers **Per-Åke Karlsson**, and **Margareta Lundberg Rodin**, and the present manager **Ylva Mühlenbock**, for all your support, advice and discussions. **Göran Jutengren**, for helping me to sort out statistical queries.

To my manager at the occupational therapy department, **Britt-Louise Olsson**, Södra Älvsborgs sjukhus, for being so positive and encouraging and letting me off work to follow my goals.

Anneli Schwarz and **Marie Rusner**, research managers at R & D department (FoU-enheten) at Södra Älvsborgs sjukhus, for interesting discussions, support and coffee breaks.

The **doctoral students** who have been my colleagues at University of Borås, for our discussions and social occasions. **Marie Engwall**, for our discussions and your positive encouragement.

To **Christie Tetreault**, **Eva Medin** and **Gabrielle Mackay Thomsson**, I am grateful for the invaluable help that I have received in editing the English manuscripts and letters.

Staff members at Akademistatistik/Health Metrics at Univerity of Gothenburg and **at the library at University of Borås** for fast and excellent service.

The organizations who have supported the studies in this thesis with grants; **Carin Mannheimers foundation**, **Agneta Prytz-Folkes and Gösta Folkes foundation**, the **Felix Neubergh foundation**, the **Research and Development Council of Södra Älvsborg, Södra Älvsborgs sjukhus,** the **Swedish Research Council for Health, Working Life and Welfare (AGECAP**), **Vinnvård,** and **R & D Center FoU Sjuhärad Välfärd**.

Christina Blomdahl, **Lena Nässén**, **Lisbeth Mensas** and **Eva Höglund**, for support, discussions and friendship. My friends, colleagues, and family have supported me greatly during this work. My mum, **Ylva**, for always listening and being so encouraging.

Finally, I would like to thank my own family: **Magnus**, my husband, for your love and humor and patience. **Johanna** and **Erik**, for your great support and loving devotion, and patience with mummy's dream to complete this thesis.

REFERENCES

Alharbi, TSJ, Ekman, I, Olsson, L, Dudas, K & Carlström, E 2012, "Organizational culture and the implementation of person centered care: Results from a change process in Swedish hospital care", *Health Policy,* vol. 108, no. 2, pp. 294-301.

Altman, DG 1991, *Practical statistics for medical research*, 1st ed, Chapman and Hall, London; New York;.

Ahgren, B 2003, "Chain of care development in Sweden: results of a national study", *International Journal of Integrated Care,* vol. 3, no. 4.

Ahgren, B 2007, "Creating integrated healthcare", Nordic School of Public Health Gothenburg University, Gothenburg Sweden.

Ahgren, B 2012, "The Art of Integrating Care: Theories Revisited"*, The Open Public Health Journal,* vol. 5*,* no. 1, pp. 36-39.

Anderson, DM, Keith, J, Novak, PD & Elliot, MA 2002, *Mosby's medical, nursing, & allied health dictionary,* 6th ed., Mosby, St. Louis.

Auschra, C 2018, "Barriers to the Integration of Care in Inter-Organizational Settings: A Literature Review", *International Journal of Integrated Care*, vol. 18, no. 1, pp. 5.

Axelsson, R & Bihari Axelsson, S 2006, "Integration and collaboration in public health: A conceptual framework", *International Journal of Health Planning and Management,* vol. 21*,* no. 1, pp. 75-88.

Axelsson, SB & Axelsson, R 2009, "From territoriality to altruism in interprofessional collaboration and leadership", *Journal of Interprofessional Care,* vol. 23, no. 4, pp. 320-330.

Bauer, M & Fitzgerald, L 2010, "Response to commentary by Manthorpe J (2009) Commentary on Bauer M, Fitzgerald L, Haesler E & Manfrin M (2009) Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence. Journal Clinical Nursing 18, 2539-2546", *Journal of clinical nursing,* vol. 19, no. 7-8, pp. 1173.

Berglund H, Dunér A, Blomberg S & Kjellgren K 2012, "Care planning at home: a way to increase the influence of older people?", *International Journal of Integrated Care,* vol. 12*,* no. 5.

Berglund, H, Wilhelmson, K, Blomberg, S, Dunér, A, Kjellgren, K & Hasson, H 2013, "Older people's views of quality of care: a randomised controlled study of continuum of care", *Journal of Clinical Nursing,* vol. 22, no. 19-20, pp. 2934-2944.

Berglund, H, Hasson, H, Kjellgren, K & Wilhelmsson K 2015, "Effects of a continuum of care intervention on frail older persons' life satisfaction: A randomized controlled study", *Journal of Clinical Nursing,* vol. 24, no. 7-8, pp. 1079-90.

Bergman, H, Ferrucci, L, Guralnik, J, Hogan, DB, Hummel, S, Karunananthan, S & Wolfson, C 2007, "Frailty: an emerging research and clinical paradigm-issues and controversies", *The journals of gerontology. Series A, Biological sciences and medical sciences,* vol. 62, no. 7, pp. 731-737.

Bernabeu-Mora, R, García-Guillamón, G, Valera-Novella, E, Giménez-Giménez, LM, Escolar-Reina, P & Medina-Mirapeix, F 2017, "Frailty is a predictive factor of readmission within 90 days of hospitalization for acute exacerbations of chronic obstructive pulmonary disease: a longitudinal study", *Therapeutic Advances in Respiratory Disease,* vol. 11, no. 10, pp. 383-392.

Blewett, LA, Johnson, K, McCarthy, T, Lackner, T & Brandt, B 2010, "Improving geriatric transitional care through inter-professional care teams", *Journal of Evaluation in Clinical Practice,* vol. 16, no. 1, pp. 57-63.

Bowles, KH, Hanlon, A, Holland, D, Potashnik, SL & Topaz, M 2014, "Impact of Discharge Planning Decision Support on Time to Readmission Among Older Adult Medical Patients", *Professional Case Management,* vol. 19, no. 1, pp. 29-38.

Cahill, J 1996, "Patient participation: a concept analysis", *Journal of advanced nursing,* vol. 24, no. 3, pp. 561-571.

Carlström, E, Kvarnström, S & Sandberg, H 2013, *Samverkan i team*. In:, Edberg, A, Ehrenberg, A, Friberg, F, Wallin, L, Wijk, H, Öhlén, J (eds.), *Teamwork in care [Teamarbete i vården],* Lund: Studentlitteratur.

Carroll, Á & Dowling, M 2007, "Discharge planning: communication, education and patient participation", *British Journal of Nursing,* vol. 16, no. 14, pp. 882-886.

Chiu, WK & Newcomer, R 2007, "A systematic review of nurse-assisted case-management to improve hospital discharge transition outcomes for the elderly", *Professional case management,* vol. 12, no. 6, pp. 330-336.

Clarfield, AM, Bergman, H & Kane, R 2001, "Fragmentation of Care for Frail Older People- an International Problem. Experience from Three Countries: Israel, Canada, and the United States", *Journal of the American Geriatrics Society,* vol. 49, no. 12, pp. 1714-1721.

Coleman, EA 2003, "Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs", *Journal of the American Geriatrics Society,* vol. 51, no. 4, pp. 549–55.

Coleman, EA & Boult, C 2003, "Improving the quality of transitional care for persons with complex care needs", *Journal of the American Geriatrics Society,* vol. 51, no. 4, pp. 556-557.

Craig, P, Dieppe, P, Macintyre, S, Michie, S, Nazareth, I & Petticrew, M 2008, "Developing and evaluating complex interventions: the new Medical Research Council guidance", *BMJ,* vol. 337, no. 7676, pp. 979-983.

Crimmins, E.M & Beltrán-Sánchez, H 2011, "Mortality and morbidity trends: is there compression of morbidity?", *The journals of gerontology. Series B, Psychological sciences and social sciences,* vol. 66, no. 1, pp. 75-86.

Cumbler, E, Carter, J & Kutner, J 2008, "Failure at the transition of care: Challenges in the discharge of the vulnerable elderly patient", *Journal of Hospital Medicine,* vol. 3, no. 4, pp. 349-352.

Dahlin Ivanoff, S & Holmgren, K 2017, *Fokusgrupper,* Studentlitteratur: Lund.

D'Amour, D, Ferrada-Videla, M, San Martin-Rodriguez, L & Beaulieu, M 2005, "The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks", *Journal of Interprofessional Care,* vol. 19, no. S1, pp. 116-131.

Dainty, P & Elizabeth, J 2009, “Timely discharge of older patients from hospital: improving the process”, *Clinical Medicine, Journal of the Royal College of Physicians,* vol. 9, no. 4, pp. 311-314.

Davies, B & Harré, R 1990, “Positioning: The Discursive Production of Selves”, *Journal for the Theory of Social Behaviour,* vol. 20, no. 1, pp. 43-63.

Dedhia, P, Kravet, S, Bulger, J, Hinson, T, Sridharan, A, Kolodner, K, Wright, S & Howell, E 2009, “A quality improvement intervention to facilitate the transition of older adults from three hospitals back to their homes”, *Journal of American Geriatrics Society*, vol. 57, no. 9, pp. 1540–1546.

Department of Population and Welfare, Statistics Sweden, Demographic reports 2018:1, *The future population of Sweden 2018–2070*, viewed 6 October 2018, https://www.scb.se/hitta-statistik/statistik-efter-amne/befolkning/befolkningsframskrivningar/befolkningsframskrivningar/pong/publikationer/sveriges-framtida-befolkning-20182070/

Di Pollina, L, Guessous, I, Petoud, V, Combescure, C, Buchs, B, Schaller, P, Kossovsky, M & Gaspoz, J 2017, “Integrated care at home reduces unnecessary hospitalizations of community-dwelling frail older adults: a prospective controlled trial”, *BMC geriatrics,* vol. 17, no. 1, pp. 53.

Dunér, A, Blomberg, S & Hasson, H 2011, “Implementing a continuum of care model for older people- results from a Swedish case study”, *International Journal of Integrated Care,* vol. 11, no. 4.

Dury, S, Dierckx, E, van der Vorst, A, Van der Elst, M, Fret, B, Duppen, D, Hoeyberghs, L, De Roeck, E, Lambotte, D, Smetcoren, A, Schols, J, Kempen, G, Zijlstra, GAR, De Lepeleire, J, Schoenmakers, B, Verté, D, De Witte, N, Kardol, T, De Deyn, PP, Engelborghs, S & De Donder, L 2018, “Detecting frail, older adults and identifying their strengths: results of a mixed-methods study”, *BMC Public Health,* vol. 18, no. 1.

Dyrstad, DN, Testad, I & Storm, M 2015, “Older patients' participation in hospital admissions through the emergency department: an interview study of healthcare professionals”, *BMC health services research,* vol. 15, no. 1, pp. 475.

Ebrahimi, Z, Eklund, K, Ivanoff, SD, Jakobsson, A & Wilhelmsson, K 2017, "Effects of a continuum of care intervention on frail elders' self-rated health, experiences of security/safety and symptoms: A randomized controlled trial", *Nordic Journal of Nursing Research*, vol. 37, no. 1, pp. 33-43.

Efraimsson, E, Sandman, P, Hydén, L & Rasmussen, BH 2004, "Discharge planning: 'fooling ourselves?'– patient participation in conferences", *Journal of Clinical Nursing,* vol. 13, no. 5, pp. 562-570.

Ekdahl, AW, Andersson, L & Friedrichsen, M 2010, "They do what they think is best for me". Frail elderly patients' preferences for participation in their care during hospitalization", *Patient education and counseling*, vol. 80, no. 2, pp. 233-240.

Ekelund, C & Eklund, K 2015, "Longitudinal effects on self-determination in the RCT Continuum of care for frail elderly people", *Quality in Ageing and Older Adults*, vol. 16, no. 3, pp. 165-176.

Eklund, K, Wilhelmsson, K, Gustafsson, H, Landahl, S & Dahlin-Ivanoff, S 2013, "One-year outcome of frailty indicators and activities of daily living following the randomized controlled trial; "Continuum of care for frail older people", *BMC geriatrics*, vol. 13, no. 76, pp. 1-10.

Ekman, I, Swedberg, K, Taft, C, Lindseth A, Norberg, A, Brink, E, Carlsson, J, Dahlin-Ivanoff, S, Johansson, IL, Kjellgren, K, Lidén, E, Öhlén, J, Olsson, LE, Rosén, H, Rydmark, M & Sunnerhagen, KS 2011, "Person-centered care- ready for prime time", *European Journal of Cardiovascular Nursing*, vol. 10, no. 4, pp. 248-51.

Everink, IH, van Haastregt, JC, Maessen, JM, Schols, JM & Kempen, GI 2017, "Process evaluation of an integrated care pathway in geriatric rehabilitation for people with complex health problems", *BMC Health Services,* vol. 17, no. 34.

Fabbri, E, Zoli, M, Gonzalez-Freire, M, Salive, ME, Studenski, SA & Ferrucci L 2015, "Aging and multimorbidity: new tasks, priorities and frontiers for integrated gerontological and clinical research", *Journal of the American Medical Directors Association*, vol. 16, no. 8, pp. 640–647.

Finn, R, Learmonth, M & Ready, P 2010, "Some unintended effects of teamwork in healthcare", *Social Science & Medicine,* vol. 70, no. 8, 1148-1154.

Fixsen, DL, Naoom, SF, Blase, KA, Friedman, RM & Wallace, F 2005, *Implementation research: a synthesis of the literature*. Tampa: University of South Florida.

Fox, MT, Persaud, M, Maimets, I, Brooks, D, O´Brien, K & Tregunno, D 2013, “Effectiveness of early discharge planning in acutely ill or injured hospitalized older adults: a systematic review and meta-analysis”, *BMC geriatrics,* vol. 13, no. 70.

Fried, LP, Ferrucci, L, Darer, J, Williamson, JD & Anderson, G 2004, “Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care”, *The Journals of Gerontology. Series A, Biological sciences and Medical sciences,* vol. 59, no. 3, pp. 255-263.

Gaboury, I, Bujold, M, Boon, H & Moher, D 2009, “Inter-professional collaboration within Canadian integrative healthcare clinics: key components, *Social Science and Medicine*, vol. 69, no. 5, pp. 707-15.

Gergen, KJ 2009, *An invitation to social construction*, 2nd ed., SAGE, Los Angeles.

Gjessing, K, Torge, CJ, Hammar, M, Dahlberg, J & Faresjö, T 2014, “Improvement of quality and safety in healthcare as a new interprofessional learning module – evaluation from students”, *Journal of Multidisciplinary Healthcare* , vol. 5, no. 7, pp. 341-347.

Goffman, E 1959, *The presentation of self in everyday life,* Doubleday, Garden City, N.Y.

Gonçalves-Bradley, DC, Lannin, NA, Clemson, LM, Cameron, ID & Shepperd, S 2016, “Discharge planning from hospital”, *The Cochrane database of systematic reviews*, no. 1, pp. CD000313.

Government Bill 1990/91:14 (1990), *Regeringens proposition 1990/91:14 om ansvaret för service och vård till äldre och handikappade m. m.* [Government proposition 1990/91:14 on responsibility for service and care of folder and handicapped persons, etc.], Government of Sweden, Stockholm.

Greenhalgh, T 2008, “Role of routines in collaborative work in healthcare organisations”, *BMJ,* vol. 337, no. 7681, pp. 1269-1271.

Greenhalgh, T 2017, *How to implement evidence-based healthcare*, Oxford: Wiley & Sons.

Greenhalgh, T, Robert, G, Macfarlane, F, Bate, P & Kyriakidou, O 2004, “Diffusion of innovations in service organizations: systematic review and recommendations”, *The Milbank quarterly*, vol. 82, no. 4, pp. 581-629.

Chiang-Hanisko, L, Newman, D, Dyess, S, Piyakong, D & Liehr, P 2016, "Guidance for using mixed methods design in nursing practice research", *Applied Nursing Research,* vol. 31, pp. 1-5.

Harré, R & Langenhove, Lv 1991, “Varieties of Positioning”, *Journal for the Theory of Social Behaviour,* vol. 21, no. 4, pp. 393-407.

Harré, R & van Langenhove, L eds., 1999, *Positioning Theory*, Oxfordshire: Marston Lindsay Ross.

Hartgerink, JM, Cramm, JM, van Wijngaarden, Jeroen D H, Bakker, Ton J E M, Mackenbach, JP & Nieboer, AP 2013, “A framework for understanding outcomes of integrated care programs for the hospitalised elderly”, *International Journal of Integrated Care,* vol. 13, pp. e047.

Hasenfeld, Y 2010, *Human services as complex organisations*, SAGE, Thousand Oaks, California.

Hasson, H 2010, “Systematic evaluation of implementation fidelity of complex interventions in health and social care”, *Implementation Science,* vol. 5, no. 67.

Hasson, H, Blomberg, S & Dunér, A 2012, ”Fidelity and moderating factors in complex interventions: A case study of a continuum of care program for frail elderly people in health and social care”, *Implementation Science*, vol. 7, no. 23, pp. 1-11.

Hollway, W 1989, *Subjectivity and method in psychology: gender, meaning and science,* SAGE, London.

Hsieh, HF & Shannon, SE 2005, “Three approaches to qualitative content analysis”, *Qualitative Health Research*, vol. 15, no. 9, pp. 1277–88.

Hvalvik, S & Dale, B 2015, “The transition from hospital to home: older people’s experiences”, *Open Journal of Nursing*, vol. 5, no. 7, pp. 622-631.

ICF 2003, *International Classification of Functioning, Disability and Health.* Stockholm: National Board on Health and Welfare [Socialstyrelsen].

Jakobsen, LM, Albertsen, K, Jorgensen, AF, Greiner, BA & Rugulies, R 2018, "Collaboration among eldercare workers: barriers, facilitators and supporting processes", *Scandinavian Journal of Caring Sciences*, vol. 32, no. 3, pp. 1127-1137.

Johansson, S 2013, "The chain is never stronger than its weakest link: Implementing a model of collaboration among agencies serving vulnerable children and adolescents", *China Journal of Social Work*, vol. 6, no. 3, pp. 276-291.

Kessler, C, Williams, MC, Moustoukas, JN & Pappas C 2013, "Transitions of care for the geriatric patient in the emergency department", *Clinical Geriatric Medicine,* vol. 29, no. 1, 49-69.

Keyton, J, Ford, DJ & Smith, FI 2008, "A mesolevel communicative model of collaboration", *Communication Theory*, vol. 18, no. 3, 376-406.

Kitzinger, J 1995, "Qualitative research. Introducing focus groups", *British Medical Journal,* vol. 7, no. 311, pp. 299–302.

Kodner, DL & Spreeuwenberg, C 2002, "Integrated care: meaning, logic, applications, and implications – a discussion paper", *International Journal of Integrated Care,* vol. 2, no. 4.

Krueger, RA & Casey, MA 2009, *Focus groups: a practical guide for applied research*, 4th edn, SAGE, Thousand Oaks, California.

Kvale, S 1996, *Interviews: an introduction to qualitative research interviewing*, SAGE, Thousand Oaks, California.

LeBerre, M, Maimon, G, Sourial, N, Guériton, M & Vedel, I 2017, "Impact of transitional care services for chronically ill older patients: A systematic evidence review", *Journal of American Geriatrics Society,* vol. 65, no. 7, pp. 1597-1608.

Leonard, M, Graham, S & Bonacum, D 2004, "The human factor: the critical importance of effective teamwork and communication in providing safe care", *Quality and Safety in Health Care*, vol. 13, no. 1, pp. 85-90.

Leplége, A, Gzil, F, Camellia, M, Lefeve, C, Pachoud, B & Ville I 2007, "Person-centredness: Conceptual and historical perspectives", *Disability & Rehabilitation,* vol. 29, no. 20-21, pp. 1555-1565.

Lin, CJ, Cheng, SJ, Shih, SC, Chu, CH & Tjung JJ 2012, "Discharge planning", *International Journal of Gerontology,* vol. 6, no. 4, 237-240.

Linell, P 1990, "The elementary forms of institutionalized talk: about meetings between professionals and laymen", [De institutionaliserade samtalens elementära former: om samtal mellan professionella och lekmän], *Forskning om utbildning,* vol. 17, no. 4, pp. 18-35.

Looman, WM, Fabbricotti, IN & Huijsman, R 2014, "The short-term effects of an integrated care model for the frail elderly on health, quality of life, health care use and satisfaction with care", *International Journal of Integrated Care*, vol. 14, no. 4, pp. e034.

Lundgren, C 2009, Team Talk : Collaboration through Communication in Meetings of a Multiprofessional Pain Rehabiliation Care Team, University of Linköping, Linköping, Sweden, viewed 6 October 2018, http://liu.diva-portal.org/smash/record.jsf?pid=diva2%3A224065&dswid=9682.

Lundquist, L 1987, *Implementation steering. An actor-structure approach,* Lund: Studentlitteratur.

Ma, HM, Yu, RH & Woo, J 2013, "Recurrent hospitalization with pneumonia is associated with higher 1-year mortality in frail older people", *Internal Medicine Journal*, vol. 43, no. 11, pp. 1210-1215.

Mabire, C, Büla, C, Morin, D & Goulet, C 2015, "Nursing discharge planning for older medical inpatients in Switzerland: A cross-sectional study", *Geriatric Nursing,* vol. 36, no 6, pp. 451-457.

Mandl, LA, Schmucker, AM, Hupert, N, Sasaki, M, Do, J, Cornell, CN, Cross, MB, Gonzalez Della Valle, A, Figgie, MP, Jerabek, SA, Szymonifka, J & Magid, SK 2018, "Is frailty associated with adverse events after total joint arthroplasty?", *Osteoarthritis and Cartilage,* vol. 26, pp. S232-S232.

Martin, GP & Finn R 2011, "Patients as team members: opportunities, challenges and paradoxes of including patients in multi-professional healthcare teams", *Sociology of Health & Illness,* vol. 33, no. 7, pp. 1050-1065.

Martín-Sánchez, FJ, Christ, M, Miró, Ò, Peacock, WF, McMurray, JJ, Bueno, H, Maisel, AS, Cullen, L, Cowie, MR, Di Somma, S, Platz, E, Masip, J, Zeymer, U, Vrints, C, Price, S & Mueller, C 2016, "Practical approach on frail older patients attended for acute heart failure", *International Journal of Cardiology,* vol. 222, pp. 62-71.

Miles, MB & Huberman, AM 1994, *Qualitative data analysis: an expanded sourcebook*, 2 edn, SAGE, Thousand Oaks, California.

Miller, WA & Ashcroft, R 2016, "Challenges faced by social workers as members of interprofessional collaborative health care teams", *Health & Social Work*, vol. 41, no. 2, pp. 101–109.

Ministry of Health and Social Affairs 2013, *Godkännande av en överenskommelse om en sammanhållen vård och omsorg om de mest sjuka äldre 2014 [Approval of an agreement on unified health and social care of the frailest older people 2014].* Stockholm Sweden, viewed 30 September 2018, https://www.regeringen.se/overenskommelser-och-avtal/2013/12/s20138803fst/.

Mitchell, R, Parker, V, Giles, M & Boyle B 2014, "The ABC of health care team dynamics: Understanding complex affective, behavioral, and cognitive dynamics in inter-professional teams", *Health care management review,* vol. 39, no. 1, pp. 1-9.

Moore, JE, Mascarenhas, A, Bain, J & Straus, SE 2017, "Developing a comprehensive definition of sustainability", *Implementation science : IS,* vol. 12, no. 1, pp. 110-8.

Morgan, S & Yoder, LH 2012, "A Concept Analysis of Person-Centered Care", *Journal of Holistic Nursing,* vol. 30, no. 1, pp. 6-15.

National Board of Health and Welfare 2008, *Samverkan i re/habilitering – en vägledning [Collaboration in re/habilitation- a guidance]*, viewed 30 September 2018, http://www.socialstyrelsen.se/publikationer2008/2008-126-4-2009 .

National Board of Health and Welfare 2009, *Nationella indikatorer för God vård [National indicators for good care]*, viewed 30 September 2018, https://www.socialstyrelsen.se/publikationer2009/nationellaindikatorerforgodvard.

National Board of Health and Welfare 2013a, *De mest sjuka äldre – lägesrapport [The chronically ill older people- progress report]*, viewed 30 September 2018, http://www.socialstyrelsen.se/publikationer2013/2013-12-13.

National Board of Health and Welfare 2013b, *Väntetider och patientens väg genom vården – exemplet multisjuka äldre. Delrapport [Wait time and the patient's transition- exemplified by the chronically ill older people],* viewed 30 September 2018, http://www.socialstyrelsen.se/publikationer2013/2013-6-34.

National Board of Health and Welfare 2014, *De mest sjuka äldre- överenskommelsen [The chronically ill older people- the agreement]*, viewed 30 September 2018, http://www.socialstyrelsen.se/publikationer2014/2014-11-22.

National Board of Health and Welfare 2015, *Åtgärdsförslag för att utveckla vården och omsorgen om de mest sjuka äldre- primärvård och korttidsboende vad behöver förändras? [Policy proposal to develop care for the chronically ill older people- primary care and short-term accommodation what changes are needed?]*, viewed 30 September 2018, https://www.socialstyrelsen.se/publikationer2015/2015-2-45.

National Board of Health and Welfare 2016, *Mest sjuka äldre och nationella riktlinjer: hur riktlinjerna kan anpassas till de mest sjuka äldres förutsättningar och behov [Chronically ill older people and national regulations: how the regulations can be adapted to the needs of the chronically ill older people]*, viewed 30 September 2018, https://www.socialstyrelsen.se/riktlinjer/nationellariktlinjer/omnationellariktlinjer/mestsjukaaldre.

National Board of Health and Welfare 2017, *Vård och omsorg om äldre. Lägesrapport 2017 [Care of the elderly- progress report 2017]*, viewed 30 September 2018, https://www.socialstyrelsen.se/publikationer2017/2017-2-2.

National Board of Health and Welfare 2018, *Statistikdatabas äldreomsorg*, viewed 30 September 2018, http://www.socialstyrelsen.se/statistik/statistikdatabas/aldreomsorg.

Naylor, M & Keating, SA 2008, "Transitional care: moving patients from one care setting to another", *American Journal of Nursing,* vol. 108, no. 9, pp. 58-63.

Nolte, E & McKee, M 2008, *Integration and chronic care: a review. Caring for people with chronic conditions: A health system perspective,* New York; Maidenhead, Berkshire, England;: McGraw-Hill/Open University Press.

Nyborg, I, Danbolt, LJ & Kirkevold, M 2017, “User participation is a family matter: A multiple case study of the experiences of older, hospitalised people and their relatives”, *Journal of Clinical Nursing,* vol. 26*,* no. 23-24, pp. 4353-4363.

Nyborg, I, Kvigne, K, Danbolt, LJ & Kirkevold, M 2016, “Ambiguous participation in older hospitalized patients: gaining influence through active and passive approaches-a qualitative study”, *BMC nursing*, vol. 15, no. 1, pp. 50.

Oborn, E & Dawson, S 2010, “Knowledge and practice in multidisciplinary teams: struggle, accomodation and privilege”, *Human Relations,* vol. 63, no. 12, pp. 1835-1857.

Olaison, A & Cedersund, E 2006, “Assessment for home care: Negotiating solutions for individual needs”, *Journal of Aging Studies,* vol. 20, no. 4, pp. 367-380.

Olsson, LE, Hansson, E, Ekman, I & Karlsson, J 2009, “A cost-effectiveness study of a patient-centered integrated care pathway”, *Journal of Advanced Nursing,* vol. 65, no. 8, pp. 1626-1635.

Oo, MT, Tencheva, A, Khalid, N, Chan, YP & Ho, SF 2013, “Assessing frailty in the acute medical admission of elderly patients. *Journal of the Royal College of Physicians in Edinburgh,* vol. 43, no. 4, pp. 301-308.

Ording, AG & Sørensen, HT 2013, “Concepts of comorbidities, multiple morbidities, complications, and their clinical epidemiologic analogs”, *Clinical epidemiology*, vol. 5, pp. 199–203.

Orvik, A, Nordhus, GEM, Axelsson, SB & Axelsson, R 2016, “Interorganizational Collaboration in Transitional Care - A Study of a Post-Discharge Programme for Elderly Patients”, *International Journal of Integrated Care,* vol. 16, no. 2, pp. 11.

Patton, M 2015, *Qualitative research and evaluation methods- integrating theory and practice*, 4th edn, SAGE, Thousand Oaks, California.

Polit, DF & Beck, CT 2012, *Nursing research: generating and assessing evidence for nursing practice*, 9 edn, Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Popejoy, LL, Moylan, K & Galambos, C 2009, "A review of discharge planning research of older adults", *Western Journal of Nursing Research,* vol. 31, no. 7, pp. 923-47.

Preyde, M, Macaulay, C & Dingwall, T 2009, "Discharge Planning From Hospital to Home for Elderly Patients: A Meta-Analysis", *Journal of Evidence-Based Social Work,* vol. 6, no. 2, pp. 198-216.

Rabiee, F 2004, "Focus-group interview and data analysis", *Proceedings of the nutrition society*, vol. 63, no. 4, pp. 655-660.

Reeves, S, Goldman, J, Gilbert, J, Tepper, J, Silver, I, Suter, E & Zwarenstein, M 2011, "A scoping review to improve conceptual clarity of interprofessional interventions", *Journal of Interprofessional Care*, vol. 25, no. 3, pp. 167–74.

Robben, SH, Heinen, MM, Perry, M, van Acterberg, T, Rikkert, MO, Schers, HJ & Melis, RJ 2015, "First experiences with a two-step method for discussing goals with community-dwelling frail older people", *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, vol. 18, no. 5, pp. 1559-1566.

Roberts, C & Sarangi, S 2005, "Theme-oriented discourse analysis of medical encounters", *Medical Education,* vol. 39, no. 6, pp. 632–40.

Robinson, A & Street, A 2004, "Improving networks between acute care nurses and an aged care assessment team", *Journal of Clinical Nursing,* vol. 13, no. 4, pp. 486-496.

Sabatier, P 1981, "Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis", *Journal of Public Policy,* vol. 6, no. 1, pp. 21-48.

Sarangi, S & Roberts, C 1999, *Talk, work and institutional order: discourse in medical, mediation and management settings*, Berlin: Mouton de Gruyter.

Scott, IA 2010, "Preventing the rebound: improving care transition in hospital discharge processes", *Australian Health Review*, vol. 34, no. 4, pp. 445-451.

Seben van, R, Smorenburg, SM & Buurman, BM 2018, "A qualitative study of patient-centered goal-setting in geriatric rehabilitation: patient and professional perspectives", *Clinical Rehabilitation*, 1-13, [Epub ahead of print].

Socialtjänstlag [Social Services Act], SFS 2001:453, Ministry of Health and Social Affairs, Stockholm Sweden, viewed 6 October 2018, http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/socialtjanstlag-2001453_sfs-2001-453.

Lag om ändring i lag (SFS 2003:460) om etikprövning av forskning som avser människor [Act on amendment to act on etichal review on humans], SFS 2008:192, Stockholm Sweden, viewed 6 October 2018, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2003460-om-etikprovning-av-forskning-som_sfs-2003-460.

Lag om valfrihetssystem [Act on Freedom of Choice System], SFS 2008:962, Ministry of Health and Social Affairs, Stockholm Sweden, viewed 6 October 2018, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2008962-om-valfrihetssystem_sfs-2008-962.

Lag om ändring i socialtjänstlag [Social Services Act], SFS 2009:981, Ministry of Health and Social Affairs, Stockholm Sweden, viewed 6 October 2018, https://www.lagboken.se/Lagboken/sfs/sfs/2009/900-999/d_597596-sfs-2009_981-lag-om-andring-i-socialtjanstlagen-2001_453.

Patientlag [Patient's Act], SFS 2014:821, Ministry of Health and Social Affairs, Stockholm Sweden, viewed 6 October 2018, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/patientlag-2014821_sfs-2014-821.

Hälso- och sjukvårdslag [Health and Medical Services Act], SFS 2017: 30, Ministry of Health and Social Affairs, Stockholm Sweden, viewed 6 October 2018, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag_sfs-2017-30.

Lag om samverkan vid utskrivning från sluten hälso- och sjukvård [Act on Collaboration at Hospital Discharge], SFS 2017: 612, Ministry of Health and Social Affairs. Stockholm Sweden, viewed 6 October 2018, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2017612-om-samverkan-vid-utskrivning-fran_sfs-2017-612.

Simonet, D 2015, "The New Public Management theory in the British healthcare system: A critical review", *Administration and Society*, vol. 47, no. 7, pp. 802-826.

Song, X, Mitnitski, A & Rockwood, K 2010, "Prevalence and 10-year outcomes of frailty in older adults in relation to deficit accumulation", *Journal of American Geriatrics Society*, vol. 58, no. 4, pp. 681-687.

SOSFS 2011:9 (2011). *Ledningssystem för systematiskt kvalitetsarbete. Föreskrifter och allmänna råd [Managerial system for systematic quality work. Directions and general advice],* National Board of Health and Welfare, Stockholm, viewed 6 October 2018, http://www.socialstyrelsen.se/publikationer2011/2011-6-38.

SOU 2016:2 *Effektiv vård. Slutbetänkande av en nationell samordnare för effektivare resursutnyttjande inom hälso- och sjukvården [Care efficiency. Final report from a national coordinator for more efficient utilization of resources within healthcare]*, Ministry of Health and Social Affairs, Stockholm.

Stake, RE 2000, "Qualitative case studies", In: Denzin NK, Lincoln YS, editors, 2nd ed., *The SAGE handbook of qualitative research*, SAGE, Thousand Oaks, California.

Storm, M, Schulz, J & Aase, K 2018, "Patient safety in transitional care of the elderly: effects of a quasi-experimental interorganisational educational intervention", *BMJ Open*, vol. 8, no. 1, pp. e017852.

Tinetti, ME, Charpentier, P, Gottschalk, M & Baker, DI 2012, "Effect of a restorative model of posthospital home care on hospital readmissions", *Journal of the American Geriatrics Society*, vol. 60, no. 8, 1521-1526.

Tinetti, ME, Fried, TR & Boyd, CM 2012, "Designing Health Care for the Most Common Chronic Condition – Multimorbidity", *JAMA*, vol. 307, no. 23, pp. 2493-2494.

Toles, M, Barroso, J, Colón-Emeric, C, Corazzini, K, McConnell, E & Anderson, RA 2012, “Staff Interaction Strategies that Optimize Delivery of Transitional Care in a Skilled Nursing Facility: a Multiple Case Study”, *Family & Community Health*, vol. 35, no. 4, pp. 334-344.

Toscan, J, Mairs, K, Hinton, S & Stolee, P & InforRehab Research Team 2012, “Integrated transitional care: patient, informal caregiver and health care provider perspectives on care transitions for older persons with hip fracture”, *International Journal of Integrated Care,* vol. 12, no. 2, pp. e13.

Ulin, K, Olsson, LE, Wolf, A & Ekman, I 2016, “Person-centered care- an approach that improves the discharge process”, *European Journal of Cardiovascular Nursing*, vol. 15, no. 3, e19-e26.

Vestjens, L, Cramm, JM & Nieboer, AP 2018, “An integrated primary care approach for frail community-dwelling older persons: a step forward in improving the quality of care”, *BMC health services research*, vol. 18, no. 1, pp. 28.

de Vos, A, Cramm J, van Wijngaarden, Jeroen DH, Bakker, Ton JEM, Mackenbach JP & Nieboer, AP 2017, “Understanding implementation of comprehensive geriatric care programs: a multiple perspective approach is preferred: Implementation of geriatric care programs”, *The International Journal of Health Planning and Management,* vol. 32, no. 4, pp. 608–636.

Waring, J, Bishop, S & Marshall, F 2016, “A qualitative study of professional and carer perceptions of the threats to safe hospital discharge for stroke and hip fracture patients in the English National Health Service”, *BMC health service research*, vol. 16, no. 1, pp. 297.

Watkins, L, Hall, C & Kring, D 2012, “Hospital to home: a transition program for frail older adults”, *Professional Case Management,* vol. 17, no. 3, pp. 117-123.

World Health Organization 2015, WHO global strategy on people-centred and integrated health services: interim report, viewed 30 sept 2018, http://www.who.int/servicedeliverysafety/areas/people-centred-care/global-strategy/en/.

World Health Organization 2015, World report on ageing and health. World Health Organization, viewed 30 September 2018, http://www.who.int/ageing/events/world-report-2015-launch/en/.

World Health Organization 2017, Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity, viewed 30 September 2018, http://apps.who.int/iris/handle/10665/258981.

World Health Organization 2018, Health topics Disabilities, viewed 30 September 2018, http://www.who.int/topics/disabilities/en/.

Wilhelmsson, K, Dunér, A, Eklund, K, Gosman-Hedstrom, G, Blomberg, S, Hasson, H, Gustafsson, H, Landahl, S & Dahlin-Ivanoff, S 2011, "Design of a randomized controlled study of a multi-professional intervention targeting frail elderly people", *BMC geriatrics,* vol. 11, no. 1, pp. 24-24.

Wong, S, Montoya, L & Quinlan, B 2018, "Transitional care post TAVI: A pilot initiative focused on bridging gaps and improving outcomes", *Geriatric nursing (New York, N.Y),.*

Xyrichis, A & Ream E 2008, "Teamwork: a concept analysis", *Journal of Advanced Nursing,* vol. 61, no. 2, 232-241.

Zurlo, A & Zuliani, G 2018, "Management of care transition and hospital discharge", *Aging Clinical and Experimental Research,* vol. 30, no. 3, pp. 263–270.

Zwarenstein, M, Goldman, J & Reeves, S 2009, "Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes", *The Cochrane database of systematic reviews,* no. 3, pp. CD000072.