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Strategic Intelligence Monitor on Personal Health Systems Phase 3 (SIMPHS3)

BLMSE (Sweden)
Case Study Report

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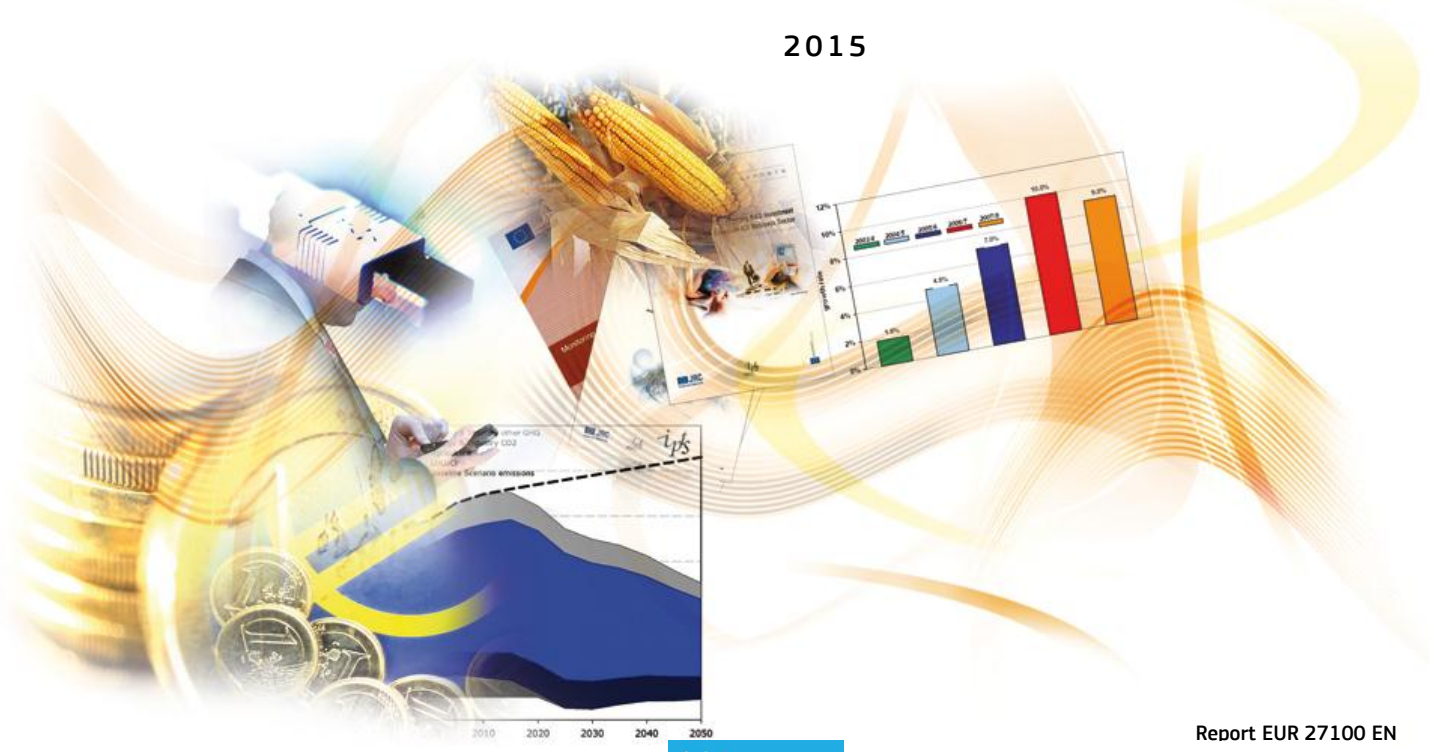

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Abstract
In 2012 the Swedish Association of Local Authorities and Regions made an agreement with the Swedish government to foster integrated care for elderly suffering from complex health conditions. It resulted in an initiative that aims at developing patient-centred health and social care services based on the specific needs of the elderly population. The Better Life for Most Sick Elderly (BLMSE) initiative strives to encourage, strengthen and intensify cooperation among municipalities and county councils by means of economic incentives and performance-based bonus schemes. The main target group is the sick, elderly population. However, the preventive measures applied within the framework of the initiative strive to avoid people from becoming part of this group.

Preface

The Strategic Intelligence Monitor on Personal Health Systems (SIMPHS) research started in 2009 with the analysis of the market for Remote Patient Monitoring and Treatment (RMT) within Personal Health Systems (PHS). This approach was complemented in a second phase (SIMPHS2) with the analysis of the demand side, focusing on needs, demands and experiences of PHS by healthcare producing units (e.g. hospitals, primary care centres), healthcare professionals, healthcare authorities and patients amongst others.

Building on the lessons learnt from SIMPHS2 and from the European Innovation Partnership on Active and Healthy Ageing initiative, SIMPHS3 aims to explore the factors that lead to successful deployment of integrated care and independent living, and define the best operational practices and guidelines for further deployment in Europe. This case study report is one of a series of case studies developed to achieve these objectives.

The outcomes of SIMPHS2 are presented in a series of public reports which discuss the role of governance, innovation and impact assessment in enabling integrated care deployment. In addition, through the qualitative analysis of 27 Telehealth, Telecare and Integrated Care projects implemented across 20 regions in eight European countries investigated in SIMPHS2, eight facilitators have been identified, based on Suter's ten key principles for successful health systems integration.

The eight main facilitators identified among these as necessary for successful deployment and adoption of telehealth, telecare and integrated care in European regions are:

- Reorganisation of services
- Patient focus
- Governance mechanisms
- Interoperable information systems
- Policy commitment,
- Engaged professionals
- National investments and funding programmes, and
- Incentives and financing.

These eight facilitators have guided the analysis of the cases studied in SIMPHS3 and a graph showing the relative importance of each facilitator is presented in each case study.

In addition to the above facilitators analysed in each case report, a specific section is dedicated to the analysis of care integration. It should be noted that the definition of vertical and horizontal integration used in this research is taken from the scientific literature in the field of integrated care.[1] This definition differs from the one mentioned in the European Innovation Partnership on Active and Healthy Ageing Strategic Implementation Plan.[2] We define horizontal integration as the situation where similar organisations/units at the same level join together (e.g. two hospitals) and vertical integration as the combination of different organizations/units at different level (e.g. hospital, primary care and social care).

[1] Kodner, D. (2009). All together now: A conceptual Exploration of Integrated Care.

[2] http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/operational_plan.pdf (page 27)

Table of contents

LIST OF TABLES

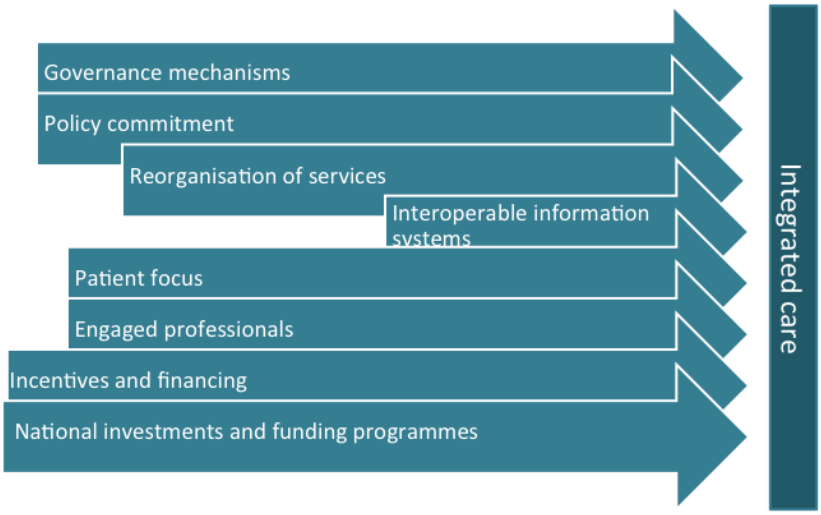
LIST OF FIGURES

Case outlook

In 2012, the Swedish Association of Local Authorities and Regions came to an agreement with the Swedish government to foster integrated care for older people suffering from complex health conditions. It resulted in an initiative that aims to develop patient-centred health and social care services based on the specific needs of the elderly population. The Better Life for Most Sick Elderly (BLMSE) initiative strives to encourage, strengthen and intensify cooperation among municipalities and county councils by means of economic incentives and performance-based bonus schemes. The main target group is the sick, elderly population. However, the preventive measures applied within the framework of the initiative are intended to stop people from becoming part of this group.

The areas covered by the initiative are comprised of coordinated health and social care, good pharmaceutical treatment, good palliative care, and good dementia care and preventive care. Several measures have been taken in order to improve and ensure the quality of care for the elderly, including the appointment of improvement leaders; the creation of leadership forums; the set-up of quality registers; the publication of outcomes online; the definition of performance-based financial bonuses; the definition of coordinated individual plans; and the implementation of trials through BLMSE funding to analyse the underlying reasons for avoidable admissions and readmissions. The provision of regular care services, however, such as municipal social and health care, primary and specialised care, inpatient and outpatient care, including the three largest emergency hospitals (tertiary care) and six hospitals with smaller emergency capacity (secondary care), remains largely unchanged under the BLMSE. The type of integration pursued by the BLMSE approach is mainly organisational, given that it facilitates the establishment of new kinds of relationships, the engagement and interaction of leaders, and the joint planning of activities. This, however, has also enabled the development of a new culture (normative integration), and service integration achieved through the coordination of service delivery. Vertical integration has been achieved to some extent through improved service provision, improved ways of transferring patients between caregivers, and better day-to-day communication between different caregivers. Service responsibilities and budgets remain separate, despite the fact that coordination and collaboration occur in a more or less structured way, depending on local circumstances. As a result, full integration has not been achieved in the case of the BLMSE.

One of the main facilitators of the initiative was the appointment of improvement leaders, who played a significant role as facilitators of organisational change in the teams established in the leadership forums. The coordinated individual plans (CIP) could also be considered as a tool to engage patients and professionals in a personalised care pathway which enhances the continuum of care. Furthermore, the quality registers that allow the comparison between units have facilitated continuous learning, quality improvement and management of services, especially in the area of dementia, preventive care for the elderly and palliative care. This benchmarking exercise has facilitated the allocation of performance-based financial bonuses. A major barrier is the extent to which organisations and budgets are still separate, despite the apparent advantages brought by coordination, and joint planning and delivery of services.


Governance mechanisms
Policy commitment
Reorganisation of services
Interoperable information systems
Patient focus
Engaged professionals
Incentives and financing
National investments and funding programmes
Integrated care

1 Background

1.1 Swedish Social welfare and health care services

The Swedish health care system is characterised by universal coverage, with around 4% of the Swedish population having a supplementary private voluntary health insurance (PHI). The basic rationale underlying the contracting of a private health insurance is faster access to specialised ambulatory serviced and elective treatment.

In terms of service provision, the publicly-financed health system covers public health and preventive service, primary care, inpatient and outpatient specialised care, prescription of drugs, emergency, mental health, home and long-term care, rehabilitation services and disability support, dental care for children and part of adult dental care. The responsibility for service organisation and financing rests with 21 county councils and the responsibility for elderly and disabled care lies with the 290 Swedish municipalities.

The Health and Medical Services Act sets out the respective responsibilities of county councils and municipalities for health and medical care in Sweden. The Act is designed to give county councils and municipalities considerable freedom with regard to the organisation of their health and medical services.[3]

Social services in each municipality are mainly responsible for providing care for the elderly. This is their duty under the Social Services Act. Municipalities are entitled to design health and social care services that are adapted to local conditions. This means that the support offered to elderly people may vary across the country.

What is common to service provision across the 21 counties and 290 municipalities, however, is the adherence to principles of human dignity, need and solidarity, and also cost-effectiveness of care provision.

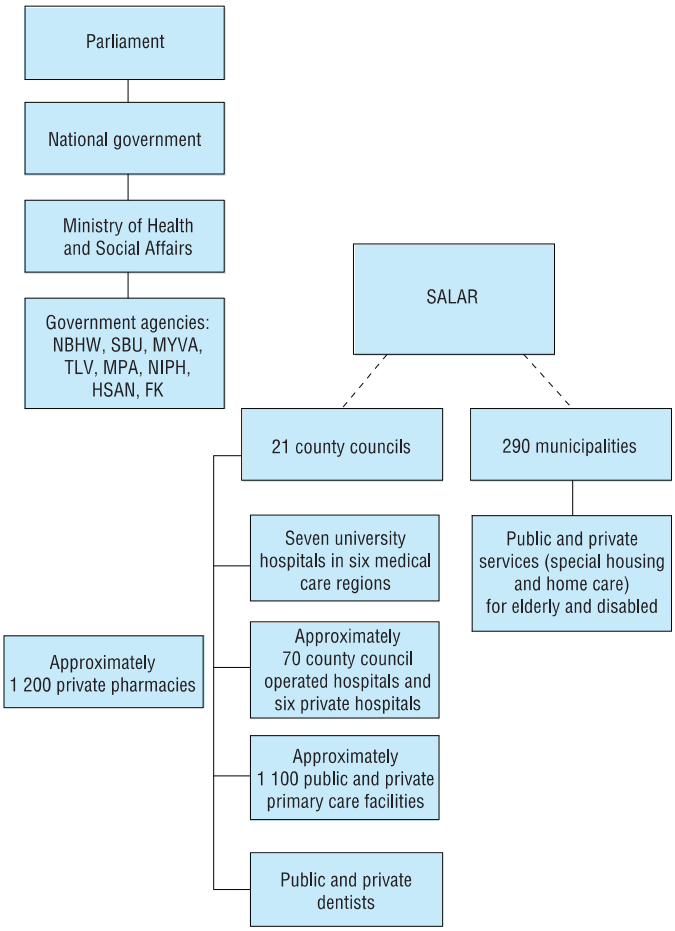
Next to the wide remit of the county councils in terms of organisation and service provision, and of the municipalities in the area of care for the elderly and disabled, the Ministry of Health and Social Affairs is responsible for overall health and health policy at the state level. The Ministry works closely with eight national government agencies that are directly involved in the areas of health, health care and public health in support of the strong local self-government. The National Board of Health and Welfare[4] is the most important government agency in this respect, supervising all health care staff, developing norms and standards for medical care and ensuring that these are respected. It is also in charge of dissemination of information, data collection and analysis. Other agencies are the Health and Social Care Inspectorate[5] that handles complaints and potential malpractice and the Swedish Agency for Health and Care Services Analysis that makes health care-related information available to citizens. The quality of health care is ensured by the National Board of Health and Social Welfare, together with the Public Health Agency of Sweden[6] and the Dental and Pharmaceuticals Benefits Agency through the setting up of systematic reviews on evidence and guidance for priority setting, which in turn serve as support for the programmes implemented at county level.

[3] http://www.gov.se/sb/d/15660
[4] http://www.socialstyrelsen.se/english
[5] http://www.ivo.se/om-ivo/about-health-and-social-care-inspectorate/Sidor/default.aspx
[6] http://www.folkhalsomyndigheten.se/about-folkhalsomyndigheten-the-public-health-agency-of-sweden/

The individual county councils and the municipalities determine the level of cost-sharing for each health visit and bed-day, but a ceiling for out-of-pocket spending is determined nationally so as to ensure that individuals do not have to pay more than a fixed annual amount. A separate maximum ceiling is also determined for pharmaceuticals. About 82% of all expenditures on health in Sweden are publicly financed, 72% by county councils, 8% by municipalities and 2% by the central state government. The county councils and municipalities levy proportional income taxes that serve to cover most of the health care service expenses, together with subsidies and state grants financed by national income taxes and indirect taxes.

GPs are often the first point of contact for adults, but primary care has no formal role as gatekeeper. Instead, team-based primary care is the most common practice in which GPs, nurses, midwives, physiotherapists, psychologists and gynaecologists provide treatment and prevention services. Sweden has more than 1,100 primary care practices spread around the country, of which two thirds are publicly owned. For both private and public practices a combination of fixed payment (capitation), fee-for-service and performance-based payments related to the achievement of targets applies.

Figure 1: Overview of the Swedish health system



Source: Anell *et al.* (2012)

1.2 Region of Skåne

The region of Skåne, or the Skåne Regional Council, is the self-governing authority of Skåne, the southernmost county of Sweden, and consists of 33 municipalities. The highest decision-making body is the Regional Council and the region is governed by the Regional Executive Committee. The competences of Region Skåne include:

- Health and medical services,
- Regional growth and development,
- Public transport,
- Culture,
- Interregional and cross-border cooperation.

The competences are financed mainly by income tax, and it is the Regional Assembly that decides the tax level. The Region and the municipal authorities cooperate closely in several areas. The Skåne Association of Local Authorities (Kommunförbundet Skåne) is the lead organisation for the 33 municipalities in Skåne. The activities can be summarised under four main headings:

- Safeguarding and supporting the development of local authority self-governance,
- Monitoring the local authorities ´ interests within all areas of activity,
- Promoting interaction between local authorities,
- Assisting local authorities in the development of their activities.

By creating a new regional structure for evidence-based practice together with the Skåne Regional Council, the Skåne Association of Local Authorities has taken a role in Skåne to implement the objectives of several *agreements* between the National Government and the Swedish Association of Local Authorities and Regions (SALAR). These agreements envisaged a nationwide effort towards large-scale changes, amongst which is the provision of health and social care for older adults with complex health conditions.

Table 1 - General information about Skåne

Geographical coverage km²	**11,035**
Inhabitants per km²	115
Number of inhabitants	1,274,069
Life expectancy at birth, years	83.7 females 79.7 males
Regional GDP (2011), billion SEK	404
Regional GDP per inhabitant (2011), SEK/inhabitants	317,000
General Practitioner Specialists /100.000 inhabitants (2011)	63
Specialists (incl. GP specialists) /100.000 inhabitants (2011)	291
Employed Licensed Health care Practitioners/100.000 inhabitants (2011)	2,188
Regional health care budget, SEK per inhabitants (2013)	21,036
Hospital beds (2012)	3,342
Hospital beds/1.000 habitants (2012)	2.6

Source: Sweden regional statistics

1.3 The Better Life for Most Sick Elderly case (BLMSE)

In 2012, the Swedish Association of Local Authorities and Regions (SALAR) came to an agreement with the Swedish government to foster integrated care for older adults suffering from complex health conditions. The initiative aims to develop patient-centred health and social care services based on the needs of the elderly, with special emphasis set on:

- Coordinated health and social care,
- Good pharmacological treatment,
- Good palliative care,
- Preventative care,
- Good dementia care.

The agreement also seeks to encourage, strengthen and intensify cooperation between municipalities and county councils through the provision of economic incentives and performance-based bonuses.[7] The following initiatives are among the most important ones:

Improvement leaders. To drive, inspire and facilitate changes. Improvement leaders have been appointed for a period of three years in all the counties in Sweden. They are change agents in this large-scale change effort and play an important role at a local level, as they drive and support performance. In Skåne, there are currently six improvement leaders employed by the Association of Local Authorities, supported 100% through national funding in 2014.

Leadership forums. (Ledningskraft)***.*** One of the main tasks for the improvement leaders has been to establish leadership forums and to make them "survive" on a voluntary basis. Cooperation and integration between social care organisations, primary care clinics and hospitals are crucial to achieving the aims of the national agreement.

Quality registers. A national quality register containing individualised data concerning problems, interventions and outcomes after treatment within health and social care production has been set up. The vision is to construct an overall knowledge system that is actively used on all levels. Four different quality registers are being used in the BLMSE project, two in the area of dementia,[8] one for preventive care[9] and one for palliative care.[10]

Online results and performance-based financial bonuses. A national portal[11] has been created and is being continuously improved, making it possible to follow the indicators of each region, municipality or unit (and/or compare these results with others). It is also used as the basis for calculating performance-based financial bonuses that encourage collaboration among the different care providers.

Coordinated Individual Plans (including an ICT tool). Of the different ways of improving the coordination of various caregivers' contributions, a Coordinated Individual Plan (CIP, In Swedish: Samordnad Individuell Plan, SIP) stands out as an important element. A CIP is a plan that is written when a patient receives both social care and healthcare services, in case there is a need to coordinate these services. The CIP has been stipulated

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7 Better life for the most sick elderly description - http://english.skl.se/activities/better-life
8 SveDem - http://www.ucr.uu.se/svedem/ and BPSD http://www.bpsd.se/
9 Senior Alert - http://plus.lj.se/senioralert
10 Palliativregistret - http://palliativ.se/
11 Kvalitetsportal Portal - http://kvalitetsportal.se/

by law since 2010, both in the Health and Medical Services Act and in the Social Services Act.

Trials through BLMSE funding for analyses. Several trials which aim to find out what could be done to improve coordination and integration have been made possible partly by BLMSE funding. One of these trials is ÄMMA, which stands for Elderly in Malmö Mobile Emergency team, a project that started in 2012 after an analysis of potentially avoidable admissions to Malmö University hospital. This analysis showed clearly that the most common reason for going to hospital was the lack of medical support in the home environment and/or lack of more long-term medical planning. This project created a team of experts from all three organisations (primary care, hospital and municipality) which can visit older people and make assessments and take measures in their homes, when the only option before was to take them to hospital. An evaluation has shown that in 77% of the cases, team visits have led to a reduction in hospital admissions.

2 Integrated care analysis

2.1 Dimensions

The main target group for this effort is sick elderly people. However, the preventive approach adopted within the framework of the initiative strives to reduce the number of elderly people who become sick.

The group of the “most severely ill elderly” has been defined in different ways, but in the Agreement it is described as “people over 65 years with substantial impairments due to age, injury or disease” and in “substantial need of social and/or health care services”. The notion of "substantial social care needs" refers mainly to people who reside in care homes or receive more than 25 hours of home care service per month, whereas substantial health care needs relates to people with multi-morbidity (three diagnoses in the last year), having had more than 19 hospital days, more than three hospital admissions or having made more than seven visits to a specialist doctor. Thus, the services focus mainly on preventive care management, chronic disease management and homecare management.

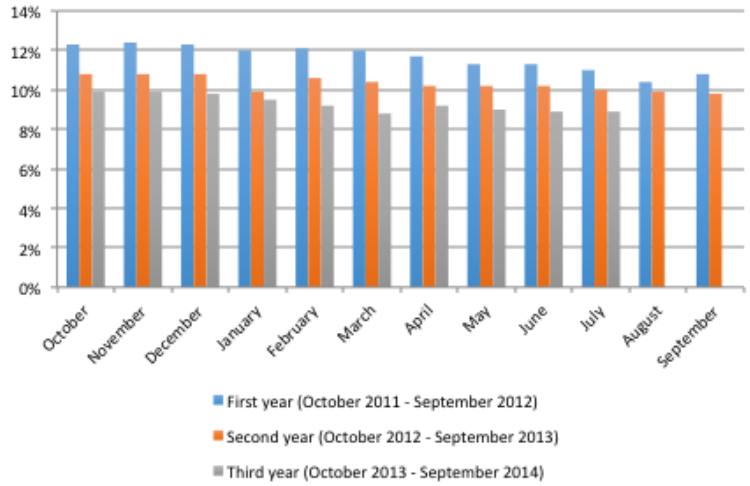
The type of integration that is enhanced by the BLMSE approach is mainly organisational, in the sense that new kinds of relationships are being shaped, not least among leaders who meet and plan their activities together. As a result a new kind of culture (normative integration) has emerged. By coordinating the delivery of services, service integration could also be achieved to a certain extent. In terms of vertical integration, the cooperation of different care actors, improving ways of transferring patients between caregivers and improved day-to-day communication between caregivers are indicators of better bridging the gap between the separate organisations. However, as service responsibilities and budgets remain separate, and as coordination and collaboration occur in a more or less structured way, depending on local circumstances, full integration has not been achieved.

2.2 Impact

The impacts can be measured through the indicators shown in the portal mentioned earlier. For example, one of the indicators for Skåne is the proportion of older citizens (75 years and over) being prescribed medications classified as inappropriate in the period October 2011 to July 2014. The figure below is an example of the kind of charts automatically generated in the Kvalitetsportal, which shows a positive trend over the last three years for

medication. The percentage of inappropriate mediations prescribed to the 75 years and older declined from October 2011 up until July 2014 (latest data available). It should be noted that the evaluation started in October so the years are being displayed from this month onwards (the data for August/September 2014 are not available yet).

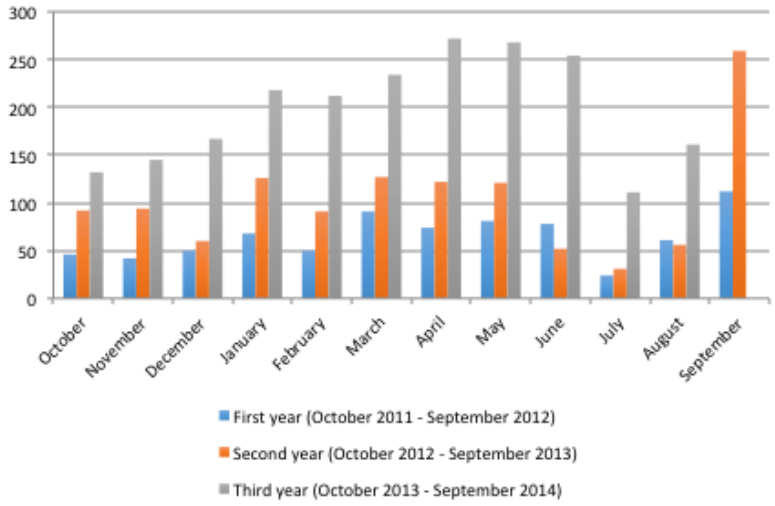
Figure 2: Inappropriate medications prescribed to 75 years and older)



Source: http://kvalitetsportal.se/

Such an improvement would probably not have happened without the increased contacts and communication between the different actors involved in the BLMSE initiative such as primary care, hospitals, municipal health and social care, and private providers at all levels. The same goes for process outcomes, which show increased adherence to routines, protocols and guidelines. A clear example of such a positive impact is the number of complete assessments for Behavioural and Psychological Symptoms of Dementia (BPSD) that have been carried out and registered since October 2011.

Figure 3: Number of BPSD assessments carried out and registered



Source: http://kvalitetsportal.se/

Lastly**,** another kind of impact can be sensed from the responses to these initiatives. A large number of staff members and political and healthcare leaders of different levels, from both health care and social care, and public and private institutions, are involved in one way or another in this new "movement". Overall there is a general perception that these issues are of utmost importance and that there is a need to move in the direction of more coordination and integration of services. However, no survey has been carried out to measure this type of perception.

2.3 Drivers and barriers

In most cases where positive changes are taking place, there has been a combination of drivers, including the different factors, measures, tools and steps described in Section 1.3. The main driver, however, is providing a coherent service that is satisfying from a patients' point of view. Improvement leaders have also played a key role as facilitators of organisational change mainly through leadership forums, establishing teams of different health and social care professionals which foster integrated care across the different health and social care providers. In this regard, the CIP could also be considered as a tool to engage patients and professionals in a personalised care pathway, enhancing the continuum of care.

In addition, the quality registers, which allow comparison between units, have facilitated continuous learning, quality improvement and management of services, especially in the area of dementia, elderly preventive care and palliative care. This benchmarking exercise has also facilitated the allocation of performance-based financial bonuses.

A major barrier, however, is the continuing separation of organisations and budgets. Even though the advantages of coordination, joint planning and execution of services is apparent, especially in situations of economic strain, the different organisations focus on their own survival. This separation also means that it is sometimes more difficult to dedicate resources (time and money) to carrying out work that seems to benefit another organisation's budget more than one's own, even though it could prove more beneficial to a patient.

Legal impediments caused by the split between the Health and Medical Services Act (HSL) on the one hand and the Social Services Act (SoL) on the other, reinforce this division even further in many cases, and could therefore make it extremely complicated for different caregivers to communicate.

Furthermore, as politically run organisations, both county councils and municipalities sometimes suffer from uncertainties (especially in the wake of elections) as to future terms and conditions. Decisions are therefore not always taken with a long-term systemic perspective in mind.

2.4 Organisation, health professional and patients

Regular services thus remain largely unchanged under the BLMSE. These services consist of municipal social care and health care (mainly all basic home-based care, except medical doctors), primary care (GPs, nurses etc. with around 150 primary care clinics), specialised care, both outpatient and inpatient, including the three largest emergency hospitals (tertiary care) and six hospitals with smaller emergency capacity (secondary care).

It should be noted that during the course of the BLMSE initiative, which started in 2013, an organisational change in health care provision took place independently from the BLMSE

initiative, which nevertheless had a direct (mainly positive) impact on its implementation. In that framework, the health care services provided through the county council were merged into three geographical areas. This means that primary care and hospitals merged into one organisation under a more unified management.

By focusing on problems that might arise from uncoordinated service delivery, several local arrangements have been established to tackle these problems and to deploy routines that allow joint planning of actions for individual patients. These arrangements range from setting a time and day for professionals from different organisations to meet for different purposes, to the creation of documents that detail respective responsibilities in different situations. In this way, health and social care professionals are encouraged to take account of and respect the patient's perspective. Ultimately, this reflects the main idea of the initiative: the adoption and implementation of a client-centred philosophy.

2.5 Information and Communication Technologies

ICT has been crucial for many parts of the work within BLMSE, starting with the pivotal role of the quality registers. As mentioned in Section 1.3, there are four different quality registers:

SveDem[8] is the national quality registry on dementia disorders, which aims to improve the quality of diagnostics, treatment and care of patients with dementia disorders. In this register, patients newly diagnosed with a dementia disorder are recorded and followed-up on a yearly basis by each participating unit. Age, gender, heredity, Body Mass Index (BMI), mini–mental state examination (MMSE) scores, diagnoses, medical treatment, support from community, and time from referral to diagnosis are examples of parameters registered in the web-based application.

BPSD[8] (Behavioural and psychological symptoms of dementia) aims to improve the quality of care of patients with dementia to achieve a national standard of care for these patients throughout Sweden. The register has a clear structure that allows the frequency and severity of BPSD to be outlined using the NPI scale (Neuro Psychiatric Inventory) and current medical treatment to be documented. It also provides a checklist for possible causes of BPSD and offers evidence-based care plan proposals to reduce BPSD, including an evaluation of the interventions used. This system generates an individual care plan which supports the care of people with dementia.

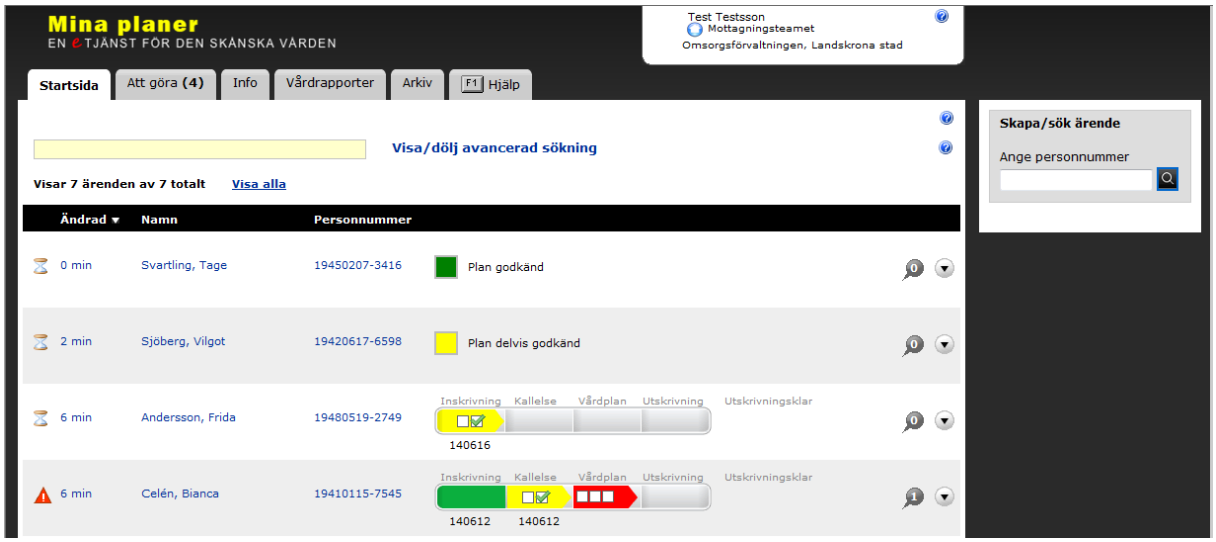
Senior Alert[9] is a national quality register that seeks to ensure a preventative approach to falls, pressure ulcers, malnutrition, poor oral health and bladder dysfunction/incontinence. Senior alert is based on an overall approach, where registration in the quality register, preventative measures, reflection on results and continuous improvements of measures are the key ingredients. Senior Alert targets all professionals and businesses in the field of health and social care.

Palliativregistret[10] is based on a questionnaire with 30 questions which is answered by the staff in charge, after the death of a patient. The questions address the quality of care delivered during the patient's last week of life. The collected data is used for research and serves as a direct basis for making changes, pointing out needs at different levels, and is also used for local audits. Once per year, participating units fill out a second questionnaire about structure and routines at the local unit.

Kvalitetsportal Portal[11] contains the results of indicators within the five areas of the BLMSE considered in the agreement. These results form the basis for receiving shares of the almost one billion SEK of yearly bonuses (statsbidrag). Thus, actors are encouraged to continuously improve. Sources for these results are the four above-mentioned quality registers, the national database for prescribed medications and reports from every county council on how many patients are admitted for avoidable reasons, and how many unplanned readmissions occur within 30 days of patients leaving a hospital.

The CIP-tool. In order to facilitate the use of CIP, a technical platform already used for planning hospital discharges, has been adapted to also record the CIP. The tool is currently being tested (from mid-2014) and implemented on a large scale in Skåne. The colours in the following figure represent the extent to which some tasks need to be completed and by whom - red meaning that something has to be completed by my role (I/my organisation), yellow that the case is under process (someone else has to complete some step) and green that the step/plan has been completed.

Figure 4: CIP tool: my plans



Source: CIP-tool website

At the same time, due to technological problems and the legal impediments mentioned earlier, these systems (both this platform and the registers) are far from fully optimised and their interoperability is currently limited. There are plans to integrate the information from the quality registers with patients' clinical records, especially through the register senior alert, but the solutions still appear to be too cumbersome.

2.6 Governance

The national agreement aims to stimulate more efficient use of resources, so that health care and social care fulfil the needs of the elderly people. The work carried out under this national initiative should become an integral part of the regular activities of county councils and municipalities. Even though no administrative, organisational or legislative changes have taken place under the scope of the BLMSE´s effort on integration, several voluntary measures, tools and steps and new funding mechanisms have been launched and promoted in order to achieve better and more patient-centred service delivery. Among the basic eligibility requirements for municipalities and counties to participate in the BLMSE

initiative (see Section 1.3) is the need for a political decision based on a regional Action plan for improvements and for the implementation of an agreed joint political structure (among politicians from the region and the municipalities) for management and co-operation.[12]

This management and co-operation structure is comprised of three main instruments in relation to the BLMSE governance model. First, at the regional level, the *improvement leaders* drive, inspire and facilitate changes across/among all the organisations and professionals involved in health and social care delivery. The improvement leaders are guided by a regional steering committee, which consists of representatives from both the region and municipalities, who coordinate several of the national agreements on health and social care.
Second, at the local level, the *leadership forums* initiated and stimulated by the improvement leaders offer open discussion forums with relevant representation in each of the 33 municipalities. These forums focus on a local Action Plan for Improvement which promotes a new dialogue among all professionals, based on the belief that the decisions on how to achieve a coordinated service delivery have to be discussed and taken at the local level. Leadership forums have been formed in some way in all counties in Sweden, but Skåne is unique in having established teams in every municipality. This instrument has clearly fostered the development of inter-professional teams across the continuum of care and encouraged the participation of all the stakeholders.
Third, the Action Plan for Improvement also considers the *performance-based financial bonuses*. The largest part of the performance-based bonuses consists of predefined (national) amounts divided among the municipalities and the counties that have reached the established minimum goals within each of the five areas of concern (Coordinated health and social care; Good pharmacological treatment; Good palliative care; Preventative care and Good dementia care).

2.7 Organisational processes

As already indicated, this initiative is not about implementing fixed processes in the management of tasks, but about giving incentives to organisations to move in the direction of more satisfied patients and caregivers and better use of resources. This is being measured on a national basis, e.g. through the ratios of readmissions and avoidable admissions.

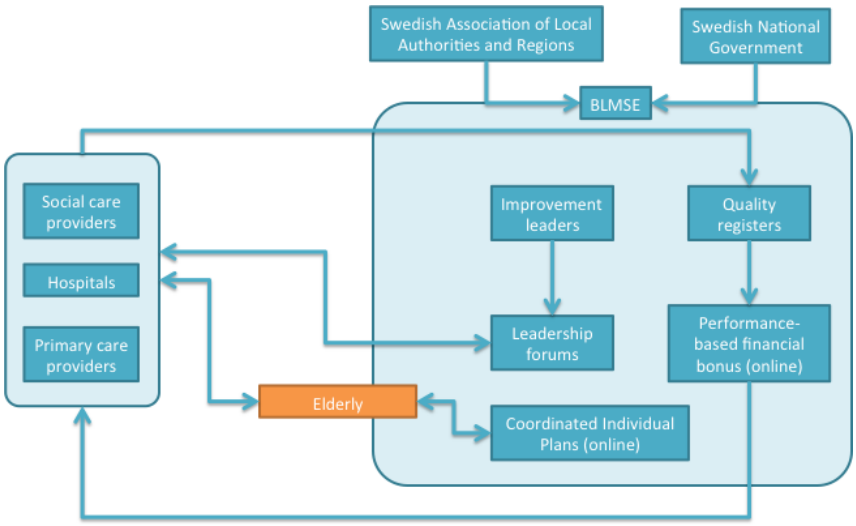
It is believed that this measurement could best be achieved through a locally established process and decision-making. Several solutions are currently under evaluation and trial within the region and the country. In this context, a number of tools have been proposed, the most important ones is comprised of the four quality registers (good pharmacological treatment; good palliative care; preventative care and good dementia care) and the platform for establishing the CIPs.

As described in Section 1.3, the BLMSE agreement has been implemented using six main tools including the appointment of improvement leaders, the creation of leadership forums, the set-up of quality registers, the implementation of performance-based financial bonuses

[12] These requirements have been fulfilled in Skåne, even though the management structure is still far from being considered permanent.

(based on performance results available online) and the definition of Coordinated Individuals Plans (available on an online platform shared between caregivers), complemented by trials of other innovative ways of working. The following figure sketches the organisational process.

Figure 5: BLMSE Governance



Source: Authors elaboration

On the one hand, the improvement leaders stimulate and organise the leadership forums where all the health care actors involved in health and social care provision interact in order to achieve the objectives of BLMSE. This informal space acts as an enabler of organisational change for each provider. In order to make the process open and to share ideas between teams, all information (action plans, routines, statistics etc.) is put on the shared Projectplace.[13] Furthermore, all the teams have the chance to meet up with all the other teams in Skåne four times a year. These one day-gatherings have had between 100 and 150 participants so far and have offered an important opportunity to exchange ideas and receive information of common interest.

On the other hand, the quality registers have been defined at national level so that all the health and social care providers can provide different data about caregivers in the care process. All data gathered is used to benchmark the different providers following the objectives established at national level for each register. The results of this analysis are used to calculate a financial bonus which stimulates further improvements. The data can also be used by health and social care professionals to establish, in close collaboration with the elderly, the Coordinated Individual Plan.

2.8 Reimbursement model and economic flow

Under this initiative, some extra money has been provided by the national government. The largest part forms the performance-based bonuses consisting of a predefined amount divided among the municipalities and the counties that have reached the established minimum goals within each of the five areas of concern. These areas are coordinated health and social care; good pharmacological treatment; good palliative care; preventative care and good dementia care) and there are 13 bonus-related indicators (e.g. amount of BPSD assessments, coverage of risk assessments in care homes, lower use of inappropriate

[13] https://www.projectplace.com/

drugs and fewer unplanned readmissions). Extras have also been transferred from the national government to the holders of the four quality registers and to the 21 counties in order to hire and pay the improvement leaders during these years.

3 Transferability

The close collaboration between organisations that have historically been separated can sometimes be rather complicated, despite the obvious need for cooperation for the sake of the patient. Starting at the local leadership level by arranging forums for discussions and decision-making across the organisations has received a very positive response in the BLMSE case in Skåne. The approach adopted could constitute a lesson that could be of interest to other regions and organisations.

The Skåne Association of Local Authorities and the Region of Skåne have agreed to keep the improvement leader posts and to keep stimulating the work within the local leadership forums for at least one more year. Results will also still be tracked on the portal, despite the absence of bonuses.

To follow up and study what will happen once the economic incentive and, eventually, other kinds of support cease, can also be of interest to others. It remains to be seen whether the approach adopted in this case will bring about changes that could lead to sustained co-operation and continuous improvement, or whether key people back off from their commitments once the direct economic compensation has gone. The economic incentive has to be evaluated in order to identify to what extent this measure could be considered as an effective way of fostering integrated care.

Promoting better ways of doing things through performance-based bonuses has probably facilitated this process to a great extent and constitutes an interesting experience that could be transferred to other countries in Europe especially to those countries, where municipalities have a role in the health and social care systems. On the one hand, the main barriers hindering transferability relate to the legal and institutional frameworks of the different health systems and to what extent these frameworks can be adapted to allow the establishment of similar performance-based bonuses. In addition, it is important to emphasise that this system is supported by an IT system that collects and benchmarks all the information. Thus, the need to implement a system of this kind could still hinder transferability.

On the other hand, the establishment of *improvement leaders* and *leadership forums* as an "informal" intervention could be easily transferred to other contexts, where the organisational culture has the absorptive capacity to embed this innovative way of engaging health professionals.

4 Conclusions

The Better Life for Most Sick Elderly (BLMSE) initiative aims to encourage, strengthen and intensify cooperation among municipalities and county councils to deliver patient-centred care and fulfil quality standards. An important aspect of this initiative is the economic incentives and performance-based bonus schemes that it includes. The main target group is the sick, elderly population, but the preventive measures applied within the framework of the initiative strive to stop elderly people becoming sick.

The areas covered by the initiative are comprised of coordinated health and social care, good pharmaceutical treatment, good palliative care, and good dementia care and preventive care. Several tools have been set up to improve and secure quality of care for the elderly. The most important ones consist of: the appointment of improvement leaders; the creation of leadership forums; the set-up of quality registers; the provision of online results *a*nd related performance-based financial bonuses; the definition of coordinated individual plans; and the implementation of trials through BLMSE funding for analyses.

The type of integration pursued by the BLMSE approach is mainly organisational, given that it facilitates the establishment of new forms of relationships, the engagement and meeting of leaders, and the mutual planning of activities. The positive impact on organisational integration further enabled the development of a new kind of culture (normative integration), and service integration achieved through the coordination of service delivery. Vertical integration has been achieved to some extent through improved service provision, improved ways of transferring patients and better communication between caregivers. Nevertheless, the service provision and budgets continue to remain separate, which means that full integration has not been achieved in the case of BLMSE. Indeed, the merging and joint operation of organisations is rather difficult, even though it would have obvious advantages and sometimes even appears to be a necessity.

In terms of impacts, this initiative can be regarded as having many. It has allowed the quality of services provided to the elderly to be improved by encouraging and promoting coordination and dialogue among health care actors. This has improved process outcomes in terms of increased adherence to routines, protocols and guidelines. In addition, the initiative has received huge positive feedback from the staff members and leaders involved. For many participants, the possibility to get together and meet in unprecedented constellations has given them a renewed perspective on their day-to-day work. This goes both for the local groupings of leaders in the forums and for the regional one day-gatherings, which have been an important opportunity to exchange ideas and receive information of common interest.

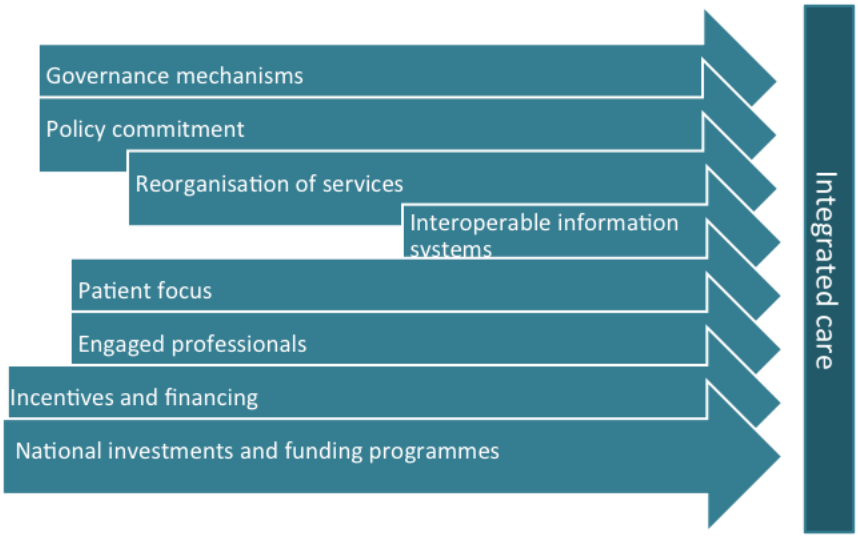
The main facilitators of the BLMSE initiative relate to the existence of national investment and funding programmes fostered by policy commitment at regional and national level. These facilitators have encouraged the creation of the improvement leader position and of the leadership forums as “informal” governance mechanisms which foster collaboration among health and social care professionals and health and social care providers. This “informal” governance has also encouraged professional engagement.

In addition to these tools, BLMSE has also developed at national level quality registers that have been implemented at the local and regional level. Though these registers are not interoperable with the IT-systems of the different providers, they have allowed comparison between units. These comparisons are the basis for calculating the performance-based

financial bonuses that encourage collaboration among the different providers. This collaboration is also reflected in the coordinated individual plans, that focus exclusively on patients' needs.

By starting at the local leadership level, and arranging forums for discussions and decision-making across the organisations, the BLMSE case in Skåne has performed well and received a very positive response. As regards transferability, the initiative therefore provides interesting lessons that could be of interest for other regions and organisations within the country and other European settings.

Figure 6: BLMSE facilitators



Source: Authors elaboration

References

Anell A, Glenngård AH, Merkur S. Sweden: Health system review. *Health Systems in Transition*, 2012, 14(5):1–159.

Sweden Regional Statistics: http://www.regionfakta.com/ and http://www.scb.se/Statistik/_Publikationer/OV0904_2014A01_BR_22_A01BR1401.pdf and http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19330/2014-1-16.pdf

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