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Primary care managers' perceptions of their capability in providing care planning to patients with complex needs

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ABSTRACT

Objectives: The aim of this study was to investigate primary care managers' perceptions of their capability in providing care planning to patients with complex needs. Care planning is defined as a process where the patient, family and health professionals engage in dialogue about the patient's care needs and plan care interventions together.
Methods: Semi-structured interviews with 18 primary care managers in western Sweden were conducted using Westrin's theoretical cooperation model. Data were analysed using a qualitative deductive method.
Main findings: Results reveal that the managers' approach to care planning was dominated by non-cooperation and separation. The managers were permeated by uncertainty about the meaning of the task of care planning as such. They did not seem to be familiar with the national legislation stipulating that every healthcare provider must meet patients' need for care interventions and participate in the care planning.
Implications for practice: To accomplish care planning, the process needs to cross – and overcome – both professional and organisational boundaries. There is also a need for incentives to develop working methods that promote local cooperation in order to facilitate optimal care for patients with complex needs.

1. Introduction

Patients with complex care needs who require long-term contact with healthcare services are in danger of 'falling through the cracks' when transferring from one healthcare provider to another [1–5]. Therefore, in many countries, primary care units are responsible for coordinating care efforts so that they function optimally. Primary care has, however, been criticised for lacking the ability to manage these patients' acute and unplanned care interventions [6,7]. This study aims to investigate primary care managers' perceptions of their capability in providing care planning to patients with complex needs. The reason for studying primary care managers was because the rules governing care planning are included in legislation on primary care.

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2. Background

2.1. Patients with complex care needs

Patients with complex care needs often suffer from multi-morbidity, that is, having two or more chronic medical conditions [5,8,9]. What is common in this group is the need for regular contact with, and treatment from, various healthcare providers, which means that the need for coordinating care measures is crucial [10–14]. Moreover, care coordination has proven to be particularly important before, during and after hospitalisation [15–17].

2.2. Care planning

To optimise care efforts, health professionals need to engage in joint care planning. Baker et al. [18] suggest care planning as a process, where the patient, family and health professionals engage in dialogue about the patient's care needs and plan care interventions together. Care planning has been described as the challenge to accomplish a formal and anticipative action plan adjusted to address the needs of the patient. Care planning is proactive, in contrast to informal and reactive adaption. Multi-morbidity patients with complex care needs are especially vulnerable to the caregiver's ability to provide care. Their pathways of care are often difficult to predict and their need for services alter with their current status. Having close inter- organisational collaboration is necessary in order to provide care planning [3–5]. The concept of care planning in this study is the establishment of partnerships among multiple organisations across a range of sectors that bring together multiple perspectives and a common way of addressing the care needs of multi-morbidity patients [19].

Research in this area has mainly focused on inpatient care [20–24]. Several studies show that high-quality care planning in hospitals and regular contact with primary care lead to fewer hospital re-admissions [18,25–28]. Bélander and Hollander [29] highlight two successful models for care planning for patients with complex care needs. One model requires cooperation across care provider boundaries and the other, a common health authority at a regional or national level. It is also considered beneficial for the patient if primary care is given a clearly stated responsibility [30,31]. However, several studies point out the lack of consensus for the definition of care planning and that there is uncertainty about the division of responsibilities among the care providers involved [32,33].

In Sweden, where the data for this study was collected, primary care and municipalities provide healthcare and treatment for patients with complex care needs. The primary care is a part of the county council, which supplies the municipalities with general practitioners employed at primary care centres. The municipalities provide health and social care on a daily basis, e.g. nursing homes and home-healthcare services. The inter-organisation cooperation required during admission and discharge from hospitals, in order to address the patient's need for care interventions, is regulated by legislation. Specifically, cooperation between primary care and municipalities is supposed to provide the patient a cross boundary service of medical and social care. Legislation pertaining to primary care states that care planning is to be included and must be drawn up for patients in need of care interventions. Moreover, the plan must clearly state *what* interventions are needed, *who* has overall responsibility and *how* interventions are to be implemented [34].

Even though cooperation and the commitments of the primary care are regulated in some countries, there is still a lack of compliance with the directives. In a study from Sweden, Carlström et al. [35] reported that patients discharged from the hospital returned to the hospital in order to get support for pain and nutrition problems. Even though the patients were discharged from the clinic and referred to the primary care, the patients did not experience that they received the expected service [35]. In particular, elderly patients with complex care needs tended to 'fall through the cracks' [24,26,34,36].

With few exceptions, there is a lack of studies that focus on the care planning initiated by primary care to prevent rehospitalisation as well as to optimise care interventions for patients living at home. Therefore, care planning from a primary care perspective will be the focus of this study.

2.3. Theoretical framework

Axelsson and Bihari-Axelsson [37] describe collaboration in healthcare contexts as a combination of vertical and horizontal integration. According to them, collaboration is based on a combination of management control and inter-organisational coordination in a structure of social networks. In the model by Axelsson and Bihari-Axelsson [37], the opposite of collaboration is competition that is common on markets, which are free from management control or social networks. Ovretveit [38] prefers the concept of integration in order to describe collaborative efforts. Integration, according to Ovretveit [38], is a combination of different caregivers building a common organisation in order to optimise the service provided. Based on Ovretveit's definition, coordination means to organise resources from different organisations in a way that the result exceeds the sum of the actions of respective organisations.

The current study investigates cooperation on several levels using Westrin's theoretical model [39,40]. The model was developed in a Swedish organisational context and designed for public healthcare organisations. It analyses cooperation based on the following four levels: (1) *Separation* which means non-cooperation, that is, the parties act separately (see Axelsson and Bihari-Axelsson) [37]; (2) *Coordination* which refers to the synchronising and exchanging of services, or to parties referring patients to one another; (3) *Collaboration* which means that the parties working with a patient collaborate and provide overall solutions and follow-ups; and (4) *Integration* which implies fusion, that is, the parties perform one another's tasks together and without prestige [40]. In this study, we use the theoretical model as a tool to assess the degree of inter-organisational cooperation in order to provide continuity for patients with complex care needs. Westrin's theoretical cooperation model was used for this paper because of its appropriate division of several levels between the