Coordination of the Clinical Care Trajectories of Acutely Hospitalised Older People:
A Qualitative Study on Healthcare Professionals Across Sectors

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by

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Preface and Acknowledgements

'What lies behind us and what lies before us are tiny matters compared to what lies within us'

-Ralph Waldo Emerson

When reflecting on the origins of my compassion for people's care and motivation to improve healthcare through research, I recall that as a small child I would join my mother for work. She started out as a homecare worker, later became a healthcare assistant before graduating as a social worker. In each of these roles, I witnessed how she so compassionately cared for others, and I believe that her ability to care has been deeply internalised in my DNA, for which I am eternally grateful. I ow that to you, **Mum**. Thank you!

Caring became central to my professional destiny as a midwife. When I applied to be a midwife almost 2 decades ago, I quoted Aristotle: '*A midwife should have a lady's hands, a hawk's eyes and a lion's heart'*. I believe that a researcher should have similar qualities: a lady's hands to be gentle with participants and all aspects of the data, a hawk's eyes to be constantly aware of essential landmarks and events and a lion's heart to be brave enough to walk the necessary line. To my **Father,** to me you have a lion's heart indeed, and I deeply admire you for your quiet strength and for always standing up for your beliefs. You taught me so much. Thank you!

Later, when the desire to challenge myself became too overwhelming to ignore, I obtained a Master of Science in Public Health. Again, my central motivational trigger was to optimise the health and well-being of others. It was important for me to focus on a topic that arose from a 'real world need' and would benefit the clinical practice level in my master's thesis. This lead to my crossing paths with **Helene Skjøt-Arkil** and **Christian Backer Mogensen,** who eventually became my co-advisors for my PhD thesis. I am deeply grateful to them for opening the gateway to research and accompanying me in my first steps. They further introduced me to **Jens Søndergaard** - the rock star of research. Thank you, Jens for your support, positive feedback, and innovative ideas along the way. My gratitude extends to my entire advisory team, but I am especially grateful to **Pernille Tanggaard Andersen**, my main

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I also wish to thank **Caroline Stephens** and **Liz Halifax** for making my trip to San Francisco an outstanding adventure, which will never be erased from my memory. To **Margit**, for a worshipped friendship despite our age difference, and for never allowing doubt in my capabilities and competencies to grow. This was an important reminder when the path seemed impassable. Finally, to **my family** and **friends** for reaching out and helping in every aspect of life and for creating joyful times and memories along the way.

My biggest and unequivocal gratitude goes to my husband and sons for constantly reminding me that, above all, I am a mother, wife, and part of a family. **Martin**, you are my counterpart and clearly the adaptive crank of our family. I owe you much more than a mere thank you! To my three sons, **Virgil**, **Sigge**, and **Eigil,** to the moon, the stars, and back again - I love you more!

In the end, with respect to the benefits of my research for society, I ask myself, 'Was it worth the effort?' Well, I do not yet know, but I hope so. You may judge for yourselves. However, one thing became conclusively clear to me along the way: in the words of Henry L. Mencken, 'For every complex problem there is an answer that is clear, simple, and wrong'.

Maiken Hjuler Persson,
Christiansfeld, September 2021

List of Publications

The thesis is based on the following publications:

Paper I:

Persson MH, Søndergaard J, Mogensen CB, Skjøt-Arkil H, Andersen PT. **Healthcare professionals' experiences and attitudes to coordination of care across health sectors.** (Submitted to BMC Health Services Review- undergoing review.)

Paper II:

Persson MH, Mogensen CB, Søndergaard J, Skjøt-Arkil H, Andersen PT. **Healthcare professionals' practice and interactions in older people's cross-sectoral clinical care trajectories when acutely hospitalized: A qualitative observation study.**
(Accepted for publication by *BMC Health Services Research*, August 2021.)

Paper III:

Persson MH, Mogensen CB, Søndergaard J, Skjøt-Arkil H, Boye LK, Andersen PT.
A qualitative analysis of intersectoral coordination of care: "If it is a 9 or 6 depends on perspective".
(Submitted to NursingOpen - undergoing review.)

English Language Summary

Introduction: Despite the initiatives to improve the coordination of care across health sectors and professions, studies show that challenges persist. This thesis focuses on the clinical care trajectories of acutely hospitalised people aged 65 years or over. The number of older people with multimorbidities and complex care needs is increasing, and the siloed nature of health care and increasing specialisation mean that multiple healthcare providers are often involved in care. This thesis explores the perspectives and practices of healthcare professionals across sectors and professions and contributes knowledge on how clinical care trajectories may be improved.

Aim and objectives: The thesis focuses on HCPs from a range of health sectors and aims to explore, identify and analyse the prerequisites for improving the CCTs of older people experiencing acute hospitalisation. The thesis is based on three scientific studies with the following aims:

- **Study I:** To identify and analyse HCPs' perspectives and approaches to intersectoral care coordination of acutely hospitalised older people
- **Study II:** To explore and analyse how HCPs' interactions and practice influence older people's CCTs when admitted to and emergency department (ED) and the challenges that emerges.
- **Study III:** To analyse the perspectives of HCPs from various sectors and professions on the barriers and facilitators of the coordination of the acute CCTs of older people.

Methods: The studies presented in this thesis are based on a range of qualitative research methods. In Study I, individual interviews were conducted with healthcare professionals (n = 13) across health sectors. Study II was based on observations and interviews in the clinical care trajectories (n = 7) of older people who had been acutely hospitalised.

Study III was based on two focus groups comprising a variety of healthcare professionals (n = 23) in which a clinical care trajectory based on empirical data from Study I and II was discussed.

Results: The individual interviews in Study I revealed the intersectoral work culture differences and diverse care approaches and practices influencing the coordination of care. Four themes affecting the coordination of care emerged from the analysis: (i) organisational factors, (ii) approaches to care, (iii) communication and knowledge, and (iv) relations.

Study II revealed a dissonance between system logics and the goal of person-centered care. This clash disturbs the healthcare practice and service culture with negative effect on the care and coordination of the clinical care trajectory limiting the opportunity for holistic care. The analysis of the healthcare practice revealed four themes: (i) "The end justifies the means – 'I know what is best for you'", (ii) "Basic needs of care overruled by system effectiveness", (iii) "Treatment as a bargain", and (iv) "Healthcare professionals as solo detectives".

In Study III, two themes emerged from the analysis of healthcare professionals' perspectives: (i) familiarity and relationships between professions and (ii) reduced care practices. The results show that there is limited familiarity between healthcare professions. Moreover, New Public Management (NPM) principles emphasise high efficiency and specialisation, resulting in health care becoming less humanistic and more checklist oriented, leaving little room for person-centered care and flexibility across the clinical care trajectory.

Conclusion: To understand why gaps in the intersectoral and interprofessional coordination of care occur, it is crucial to recognise the complexity of health care arising from for example sectoral and professional boundaries and specialisation. The results of this thesis underline the need to approach the intersectoral and interdisciplinary coordination of care from multiple levels to integrate healthcare services, improve the

clinical care trajectories of older people and embrace holistic, person-centered care, allowing focus to be on 'the entire person' and context. At the structural and organisational levels, there should be less focus on measures and checklists, and more resources should be prioritised to create stronger familiarity and interprofessional relationships across sectors to improve the care coordination. Respectful, empathic and holistic care that meets the entirely of an individual's needs rather than simply focusing on isolated problems should be universally embedded in healthcare practices, beginning with socialisation during educational programs.

Sammenfatning (Danish Language Summary)

Dansk titel:

Koordinering af ældres behandlingsforløb i forbindelse med akut indlæggelse: Et kvalitativt studie af sundhedsprofessionelle på tværs af sektorer.

Indledning: Til trods for at adskillige initiativer med sigte på mere solide og sømløse patientforløb har været introduceret, er koordinering på tværs af sektorer og professioner fortsat en udfordring. Denne afhandling fokuserer på patientforløb med ældre borgere på >65 år, der oplever akut hospitalsindlæggelse. Antallet af ældre med multiple sygdomme og deraf komplekse behandlings- og plejebehov er stødt stigende. Organisering, silo-opdeling og specialisering i sundhedsvæsenet betyder, at der ofte er et stort antal aktører involveret i pleje- og behandlingsindsatserne for disse ældre.
Afhandlingen afdækker og analyserer de sundhedsprofessionelles perspektiver og praksis i patientforløbene på tværs og bidrager således med essentiel viden om, hvor og hvordan de tværsektorielle patientforløb kan forbedres.

Hoved- og delformål: Afhandlingens overordnede formål er, med udgangspunkt i sundhedsprofessionelle på tværs af sektorer, at udforske og analysere forudsætninger og forbedringspotentialer for ældres patientforløb i forbindelse med aktindlæggelse.
Afhandlingen baserer sig på tre videnskabelige artikler med følgende formål:

- **Studie I:** At identificere og analysere sundhedsprofessionelles perspektiver og tilgange til tværsektorielt samarbejde og sammenhængende forløb for ældre, der indlægges akut.
- **Studie II:** At udforske og analysere hvordan sundhedsprofessionelles interaktioner og praksis påvirker ældres forløb i forbindelse med akut indlæggelse, og hvilke udfordringer der opstår.

- **Studie III:** At analysere sundhedsprofessionelles perspektiver på udfordringer og essentielle faktorer for et sammenhængende forløb på tværs af sektorer og faggrænser i forbindelse med ældres akutindlæggelse.

Metode: Der er anvendt flere, forskellige kvalitative metoder. Studie I er baseret på individuelle interviews med forskellige sundhedsprofessionelle (n=13) på tværs sektorgrænser. I andet studie er observationer anvendt i kombination med uformelle, individuelle interviews i forbindelse med patientforløb med ældre, der indlægges akut (n=7 forløb). Tredje og sidste studie baserer sig på to fokusgrupper med forskellige sundhedsprofessionelle (n=23) på tværs af sektorer, hvor en patientcase genereret på baggrund af empirisk data fra studie I og II, var genstandsfelt for diskussionen.

Resultater: Studie I peger på, at der eksisterer kulturelle forskelle og forskellige tilgange og praksis på tværs af sektorer, der påvirker koordinering af patientforløbet på tværs. Fire temaer med indflydelse på det tværfaglige og tværsektorielle samarbejde fremkom via analysen: (i) "Organisatoriske faktorer", (ii) "Tilgange til pleje og behandlingsforløbet", (iii) "Kommunikation og viden" og (iv) "Relationer". Studie II finder et dissonans i forholdet mellem system logikker og målet om personcentreret tilgang til patientforløbet. Dette misforhold forstyrrer den sundhedsfaglige praksis og arbejdskultur med negativ indflydelse på patient forløbet til følge i form af begrænsning i muligheden for at agere holistisk i omsorgen. Analysen af den sundhedsfaglige praksis afslører fire temaer: (i) "Målet helliger midlet – 'Jeg ved, hvad der er bedst for dig'", (ii) "Basale plejebehov tilsidesættes af systemeffektivitet", (iii) "Behandling til forhandling" og (iv) "Sundhedsprofessionelle som solo detektiver". Studie III påviste to temaer af relevans for det tværsektorielle og tværfaglige samarbejde; "Kendskab og relationer på tværs af professioner" og "reduceret omsorgspraksis". Resultaterne peger på en tendens til, at kendskabet til hinanden på tværs af fag- og sektorgrænser er begrænset, og at fokus på principper domineret af effektivisering og specialisering påvirker den sundhedsfaglige praksis til i højere grad at være tjekliste orienteret frem for baseret på humanistiske

værdier. Dette fører til ringe vilkår for personcentreret behandling og omsorg samt fleksibilitet i patientforløbet på tværs af sektorer.

Konklusion:

Det er afgørende at anerkende, at sundhedsvæsenet er komplekst i sin natur bl.a. grundet sektor-inddelinger, faggrænser og specialiseringer for at kunne forstå, hvordan barrierer for det tværsektorielle og tværfaglige arbejde kan opstå. Afhandlingens resultater fremhæver nødvendigheden af at adressere det tværsektorielle og tværfaglige samarbejde på flere planer for at skabe grobund for bedre sammenhæng i patientforløbene på tværs af sektorer og i højere grad sikre mere holistiske værdier og personcentrering, hvor fokus i forløbet er på 'det hele menneske' og rækker ud over den konkrete og enkeltstående problemstilling. På det strukturelle og organisatoriske plan bør der være mindre fokus på mål- og tjeklisteprocedurer, og flere ressourcer bør prioriteres på at skabe større kendskab og bedre professionelle relationer på tværs af sektorer for at forbedre de tværsektorielle patientforløb. Humanistiske værdier, som respekt og empati, bør integreres som universelle i den sundhedsfaglige praksis og kultur allerede som en del af den socialiseringsproces, der påbegyndes under uddannelserne.

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List of Abbreviations

ACCESS	Acute combined care for seniors in Sønderjylland
CAS	Complex adaptive system
CCT	Clinical care trajectory
CINAHL	Cumulative Index of Nursing and Allied Health Literature
ED	Emergency department
HCP	Healthcare professional
KL	Local Government Denmark
NPM	New Public Management
RC	Relational coordination
SOF	Samordningsforum
US	United States
WHO	World Health Organization

Glossary

Clinical care trajectory	The care and treatment of older people in general, regardless of the setting, healthcare sector or profession involved.
Healthcare professional	A general term used to cover a range of professions, including nurses, physicians and therapists, involved in the care of older people. When required, the precise profession is specified.
Hospital at home	Acute nursing services in the home as an alternative to hospital admissions or follow-up after discharge. Organisationally placed within the primary care setting under the jurisdiction of the municipality but often carried out in collaboration with general practitioners.
Older people/adults	Following the recommendations of the Danish Geriatric Society, the term 'older' is used to describe the participants in this study. 'Elderly' is associated with frailty, thus is stigmatising, while 'aged' is too vague given that everyone constantly ages (1).
We versus I	The terms 'we' and 'I' are used to distinguish between the tasks, decisions and reflections made in collaboration with the advisory team and those made single-handedly by me, respectively.

Thesis Outline

This thesis comprises eight chapters. Chapter 1 introduces the thesis and places the studies into context, including a conceptualisation and clarification of concepts. Chapter 2 presents the background and structure of the research project 'At the FOREFRONTof older people's care'. Chapter 3 provides the project rationale, aims and objectives. Chapter 4 outlines the research methodology, design and methods and provides ethical and methodological reflections. Chapter 5 presents the applied theory. Chapter 6 summarises results, while Chapter 7 discusses the results and methods applied. Chapter 8 outlines the main conclusions and implications and provides the final perspectives and reflections.

Chapter 1: Introduction to the Project

The quality and coherence of care has been on the political agenda for decades (2). On a global level, healthcare systems are becoming increasingly complex (3), largely because of structural changes, ageing populations, increased specialisation and treatments and evolving patient demands (4). Care coordination across healthcare systems has received considerable attention globally (5, 6). Similar to other European countries (7, 8), Denmark is addressing challenges in the organisation and coordination of healthcare delivery through its National Goals for Healthcare (9). Despite the increasing recognition of the importance of care coordination, the concerns are not new (10, 11), and intersectoral and interdisciplinary coordination are still acknowledged as challenging (12, 13).

Although the Danish healthcare system is generally regarded as functioning well and delivering high-quality services, it is fragmented, challenging the integration of care (4). Overall, the system is more suited to the efficient provision of acute interventions and specialised care rather than to long-term health care planning and addressing chronic conditions (13). The isolated focus of the various specialties and sectors may lead to inadequate care and poor health outcomes (3, 13). While each sector or discipline accesses or generates unique information as a piece of the patient puzzle, a seamless and coherent trajectory between healthcare sectors and providers is lacking (2).

Four factors have been highlighted with respect to meeting the challenges of integrating health care: the ageing population, the increase in people with multiple chronic conditions, accelerated treatments and increasing patient demands (6). Solutions for less fragmented and more integrated care will not emerge from the administrative level only (5). Researchers have drawn attention to the importance of collaboration and interaction between sectors, professions and service levels to provide a more seamless coordination of care for older people (2, 13). Given that healthcare professionals (HCPs) are on the frontline of care

coordination activities, it is important to consider their perspectives on the barriers and facilitators to improving the coordination of older people's clinical care trajectories (CCTs). Therefore, this thesis provides an in-depth qualitative analysis of the perspectives and practices of HCPs to improve the alignment of services between sectors and healthcare providers.

The following section briefly presents the challenges in the Danish healthcare system most relevant to older people and the historical healthcare reforms.

1.1 Coordination of Older People's Care

In general, people are concerned about their quality of life and the factors contributing to it. Ageing has been on the political agenda for years. Opinions are divided about whether the focus should be on increasing longevity or increasing the number of healthy life years (14). While life expectancy has increased overall (3), the additional years may be characterised by multiple health disorders and comorbidities, resulting in the increased need for health resources (13). Ageing is characterised by diversity (13). However, the global ageing generally challenges the delivery of healthcare services and resource utilization (3). An increase in age is associated with an increased incidence of chronic health conditions. Further, acute disease in older people living with chronic illnesses may increase the complexity of health evaluation and care needs (12, 15), which is a challenge for the healthcare professional set-up.

When older people in Denmark experience illness, they receive primary care in their own homes as much as possible, including from their general practitioner (GP). However, hospitalisation of older people is sometimes necessary to improve the chance of recovery. In this case, collaboration and coordination between sectors is pivotal to healthcare outcomes (10, 13).

Compared with other age groups, older people make greater use of emergency department (ED) services (11, 15). It has been argued that the ED setting is inappropriate for the care of older and more vulnerable people (e.g. those with dementia) because it is characterised by critical care approaches with high workflow and rapid patient turnover (16). Following acute hospitalisation, older people may experience functional decline or other adverse health outcomes (12). Therefore, hospitals focus on minimising the length of stay as much as possible to reduce the risk of adverse health outcomes. When older people are acutely hospitalised, they are often transferred from one sector or service provider to another. Different conditions (Chronic versus acute) require different approaches; thus, healthcare delivery becomes even more challenging when a range of specialists and providers, including GPs, municipalities and hospitals, must be engaged in the care (12). Therefore, the older population with simultaneous chronic and acute conditions is more likely to experience gaps in their CCTs because of the high number of transitions and different healthcare providers (10), making it an appropriate group for evaluating intersectoral care coordination.

1.2 A Brief History of Healthcare Reforms

This section presents a brief historical overview of the Danish healthcare system to highlight the current challenges in the intersectoral coordination of CCTs. Since the 1970s in Denmark, various reforms have been implemented to improve healthcare services and resource utilisation (8, 17). These changes have included the passing of various acts regarding the allocation of responsibilities, centralisation and de-centralization to different levels of government (17, 18). Alongside, privatisation and economic incentives of public services have gained increasing acceptance, and in 1993, Denmark gave patients the right to choose the hospital in which to be treated, which was subsequently expanded to include the right

to choose a private hospital (17). These new trends marked the start of an increase in marketization (17), popularly known as New Public Management (NPM) (19, 20).

A more comprehensive reform in 2007 resulted in the transfer of tasks and responsibilities from the mid-level jurisdictions (referred to as 'regions' following the phase-out of counties) to the municipalities (17). As a part of the increased specialisation and restructure of healthcare services and treatment, the overall number of counties (originally the mid-level government) and municipalities has been reduced (17). The reforms have also seen the reorganisation and centralisation of acute and critical care (21). To achieve effective, streamlined and high-quality acute care services, the National Board of Health has recommended the establishment of acute care hospitals and EDs (18). Centralisation has resulted in the establishment of 21 EDs across the country to which all adults, including older people, are directly admitted for acute care (22).

1.2.1 Evolving relationships between patients and healthcare professionals

The new administrative rationale has resulted in the need for modifications to the public sector, including healthcare educational programs (19, 23). The demands for evidence-based health care, a higher degree of specialisation, greater competency and flexibility in problem-solving increased (24, 25). The changes caused different needs of competencies and collaboration between multiple professions, creating professional challenges and putting HCPs under pressure (2, 15, 26).

There have also been renewed calls for greater patient involvement and cooperation with HCPs, with an emphasis on partnership (27). Patients are now considered experts of their own lives, with the potential to contribute to their own treatment plans. Thus, the needs and expectations of patients have changed (28, 29). This view differs from earlier perceptions about the relationship between HCPs as experts and patients as laypeople and passive

recipients of treatment and care (30, 31). This new emphasis on patient involvement has altered perceptions about the CCT, leading to the development of patient care pathways (32). The patient care pathway concept originated in the industrial sector (32) but was introduced to health care in the 1980s (33). A focus on personal perspectives and integrity is strongly encouraged as being key to patient safety (34), quality and efficiency of care (32, 35), and has led to a less linear perception of CCTs, (25,26) which cause new requirements for care coordination activities (36).

The following section briefly presents the current Danish healthcare system to provide an understanding of the daily context of HCPs and setting the scene for this thesis.

1.3 Setting

1.3.1 Current healthcare system in Denmark

The healthcare system in Denmark has undergone many changes over time. This section provides an overview of the current healthcare system with a specific focus on the aspects relevant to this thesis.

Denmark has a population of approximately 5.8 million people and is renowned for its well-established health system (19), referred to as a 'universal model' (17). Health care is universal for all Danish residents and is financed predominantly through taxation, similar to healthcare systems in other Scandinavian countries (37). Denmark is divided into three administrative levels: national, regional (comprising five regions) and municipal (comprising 98 municipalities). The national government, which includes the Ministry of Health, is considered the highest level of authority and is in charge of the overall structure and regulatory framework of the healthcare system (38). The regions and municipalities, which are governed by democratically elected officials, play a more direct role in the delivery of healthcare services (6). The regions own and manage the hospitals and are

responsible for the services provided by self-employed specialists such as GPs. Most hospitals are publicly owned, with less than 4% of hospital beds being in private hospitals (38).

All Danish citizens are eligible to be listed with a GP (and the vast majority are) (37). Approximately 3,600 GPs actively serve the Danish population, and the average person visits a GP seven times per year. Almost all GPs are self-employed and work under contract for regions, which also organise the provision of after-hours medical services (37). GPs are remunerated via capitation (approximately 30%) and fees for services (approximately 70%) (6, 38).

Given the redistribution of more acute and complex tasks to the municipalities, the National Board of Health has recommended that municipalities establish their own acute care services (18). These services may be in the form of specialised nurses in acute care teams (39) or specialised beds at nursing homes. (21) They also include 'hospital at home', a service that *'provides active treatment by healthcare professionals in the patient's home for a condition that otherwise would require acute hospital inpatient care'* (40, p1). The municipalities are responsible for primary prevention, health promotion, rehabilitation and home care services, including hospital at home (2). The different services relate to different legislation, including the *Social Services Act* (41) and the *Healthcare Act (42)*. Services in relation to personal assistance such as dressing, bathing and cleaning are delivered through the *Social Services Act (41, 43)*, while nursing assistance such as the administration of medication is under the *Healthcare Act* and may be provided through a referral from the hospital or GP (42, 43).

Healthcare agreements were introduced as a supportive tool to these healthcare reforms (44). These agreements described the allocation of tasks and responsibilities, including the hospitalisation of older people, to government jurisdictions and care providers (17, 44). The Region of Southern Denmark and its municipalities have formulated a collaborative

agreement tool known as SAM:BO[1], which describes standardised, intersectoral cooperation for nine different examples of health trajectory cases (45, 46).

When older people under municipal home care or nursing services are acutely admitted to the ED, an electronic record is automatically sent to the hospital, stating the level of assistance and types of services the older person usually receives from the municipality. In most cases, patients remain in the ED for up to 48 hours, after which they are either discharged or transferred to another department (e.g. the geriatric ward) for further treatment. Alternatively, if the patient is eligible, treatment may be continued within municipal care services, including hospital at home (21, 47). If the hospital stay exceeds 48 hours, the hospital is required to send a report to the municipality with the expected treatment and the patient's post-hospitalisation care needs. The hospital is responsible for deciding when a patient is ready for discharge, while the municipality is expected to be ready for the patient handover. For this to occur, the hospital must send a modified report to the municipality if the older person is expected to need a higher level of assistance post discharge. Thus, based on the hospital's evaluation, the municipality is in charge of adjusting the level of care in collaboration with patients and their relatives.

The Danish healthcare system is illustrated in Figure 1, which is an English language adaptation of Vrangbæk et al.'s model[2] in the book *Health Promotion in Municipalities and Local Communities: Between Research, Planning and Practice (4, p127)*.

[1] SAMarbejde om BOrger/patientforløb
[2] Modified and re-printed with permission.

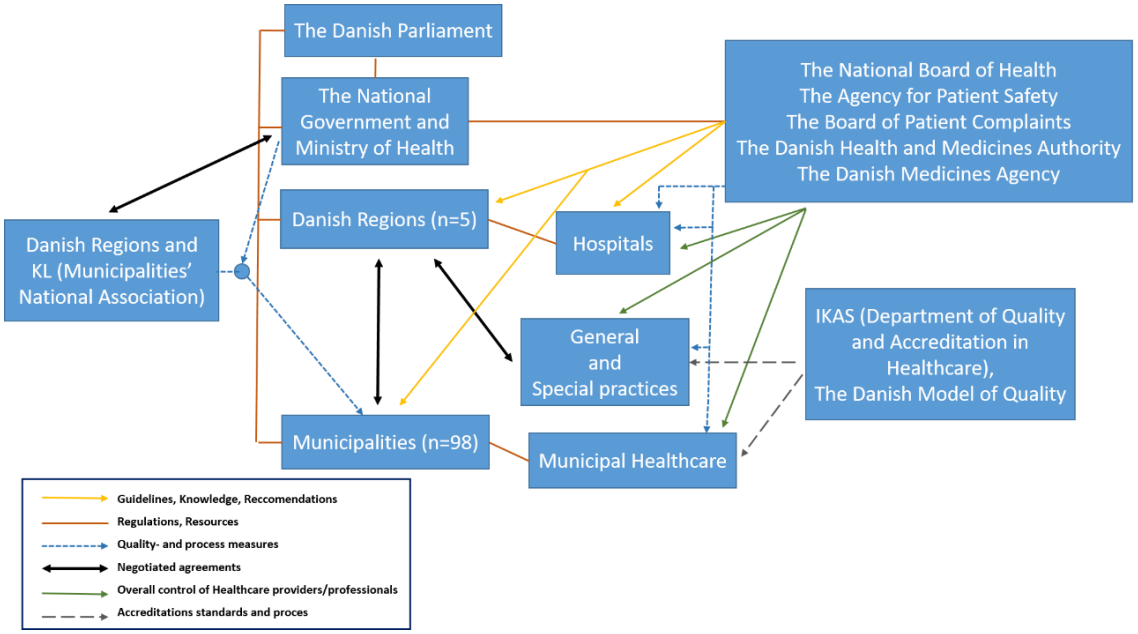

Figure 1: Danish healthcare system (4, p127)

Local Government Denmark (KL) and Danish Regions are the representative organisations for the municipalities and regions, respectively, when negotiating with the government. The national government, KL and Danish Regions have collaboratively developed national healthcare goals and continue to contribute knowledge and recommendations to all actors in the healthcare system. The accreditation-based Danish Quality Model is soon to be phased out in general practice and is optional for municipalities (4).

1.3.2 Demographic setting

The overall setting for this thesis is the nation of Denmark, which has approximately 5.8 million inhabitants (30) and is divided into five regions and 98 municipalities. The following subsections provide more specific detail.

1.3.2.1 Region of Southern Denmark

The research presented in this thesis was conducted in the Region of Southern Denmark, which comprises 22 municipalities and has approximately 800 GPs (48). The region has a population of 1.2 million people (49), (32) approximately 270,000 of whom are aged 65 years or more[3] (see Appendix IV). In 2018, the region managed 108,463 (of the 465,539 at the

[3] As per the first quarter of 2021.

national level) acute hospitalisations of people aged over 65 years (50). More specifically, the project was located in the Aabenraa campus of Hospital Sønderjylland.[4] Four municipalities, Aabenraa, Tønder, Haderslev and Sønderborg, are included in the catchment area of the hospital.

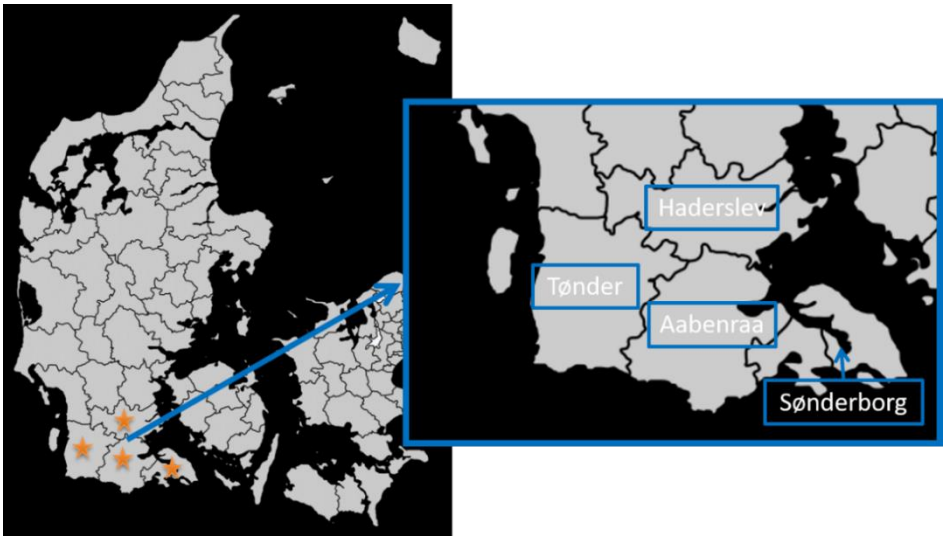

Figure 2: Regional setting and included municipalities

Note: The orange stars in the left-hand map show the location of the four municipalities.

1.3.2.2 Municipal structures

In general, Denmark is a decentralised country. Healthcare agreements (51) serve as overall guidelines to standardise intersectoral services and practices. However, the municipalities have significant room to manoeuvre in terms of self-organisation and planning, leading to significant differences and diversity between the 98 municipalities.

All municipalities are obliged to use a common documentation tool and method known as Fælles Sprog III to record municipal services and exchange data in relation to health care (52). The purpose of Fælles Sprog III is to standardise documentation practices, improve the

[4] Hospital Sønderjylland also has campuses in Sønderborg and Tønder. The Region of Southern Denmark comprises five hospitals, with a number of campuses spread across the region. The Aabenraa campus mainly receives acute care patients, including young people, children and pregnant women.

quality of data and facilitate the sharing and comparison of data between and within municipalities. Fælles Sprog III is targeted to services covered by the *Healthcare Act (42)*, formulated in 12 nursing problem areas (53),[5] and the *Social Services Act (41)*. The basic module of '*Fælles Sprog III*' is placed within a mutual platform '*KMD Nexus'*, which is provided by an external provider '*KMD*' (54). Although the tool is standardised, each municipality and municipal entity can design and establish its own targeted functions. Similarly, the municipalities must provide healthcare services in alignment with a standardised service catalogue; however, each municipality can independently design and define services targeted to their needs and resources. Therefore, there are major differences in documentation practices between and within municipalities, meaning that the vision to standardise documentation practices using a centralised tool or method has not been fully achieved, and challenges in sharing data between providers persist.[6]

1.3.2.3 Included municipalities

All four municipalities (Tønder, Haderslev, Sønderborg and Aabenraa) included in this study are in the catchment area of Hospital Sønderjylland. With respect to population size, Sønderborg is the largest municipality with 73,796 citizens, Tønder the smallest with approximately 37,022 citizens, and Haderslev (55,339 citizens) and Aabenraa (58,587 citizens) are similar in size (55).[7] The proportion of older people may influence the provision and prioritisation of healthcare in the municipalities. In 2021, the proportion of older people ranged from 23.4% in Haderslev to 25.5% in Tønder. Although the proportion of older people is similar across the four municipalities, all have a high percentage of older people.

[5] The 12 problem areas are level of function, musculoskeletal system, nutrition, communication, sexuality, skin and mucous, psychosocial relations, respiration and circulation, pain and sensory impressions, sleep and rest, knowledge and development and excretion.
[6] The content of this section was based on cited sources, structured conversations with a municipal manager and municipal data expert, experience in the hospital setting and work processes in the ED.
[7] Population size as per the second quarter of 2021.

In comparison, the percentage of older people in Copenhagen Municipality in 2021 was 10.5% (56).

1.3.2.4 Municipal acute care functions

All four municipalities deliver acute care functions but structure them differently. Haderslev, Sønderborg and Aabenraa each have a municipal acute care team as a special taskforce. These acute care teams are typically available during the day and early evening until 10:00 pm, but opening hours may differ according to the available resources. In Tønder, acute and advanced nursing is a necessary competency for all primary care nurses. Thus, Tønder Municipality prioritises the qualifications of nurses at a more general level.

In conclusion, despite the existence of standardised structures, the municipalities are largely self-managing and diverse. It is difficult for hospital-based HCPs to overview the available services, which depend on the municipality's interpretations and implementation of the guidelines and standards, which can change in certain situations. This means that hospital staff require knowledge of individual municipal structures, which may challenge the delivery of equal services. The blurring of boundaries and the diverse structures and service possibilities across municipalities further challenge intersectoral care coordination.[8]

1.4 Introduction at a Glance

- The healthcare system is fragmented, specialised and complex.

[8] This information is primarily based on a conversation with an ED-experienced hospital manager and the knowledge and experience gained during my research.

- Despite the comprehensive efforts to achieve more seamless CCTs, coordination challenges persist nationally and globally.
- The structure of healthcare systems and increasing specialisation mean that multiple actors and care providers are often involved in CCTs.
- HCPs are central to addressing care coordination challenges because they have first-hand insight into the gaps and challenges in care. Therefore, this thesis focuses on HCPs and their practices.
- Life expectancy is increasing rapidly, contributing to an increase in the number of people living with multiple chronic illnesses.
- Acute illness in combination with other chronic conditions leads to a potential increase in the number of healthcare providers and transitions and further challenges care coordination.
- Older people's CCTs are appropriate for assessing and addressing intersectoral care coordination.

Chapter 2: Project Organisation, Conceptualisation and Clarifications

Chapter 2 presents the umbrella project and project-organisation. Further, relevant concepts applied or touched up-on in the thesis will be presented, elaborated, and clarified.

2.1 Project: At the FOREFRONT of Older People's Care

The collaborative umbrella project 'At the FOREFRONT of older people's care' came about as a result of a partnership between Hospital Sønderjylland, the municipalities of Tønder, Haderslev, Sønderborg and Aabenraa, GPs within these municipalities, University College South Denmark and the University of Southern Denmark. The umbrella project comprises several PhD research projects, each with an individual focus, such as the perspectives of relatives, older people or HCPs. This thesis represents an independent work addressing HCPs' perspectives on intersectoral care coordination.

In the south-western part of Denmark, hospitals, municipalities and GPs collectively wanted to improve the coordination of older people's CCTs between health sectors and service providers. Therefore, in 2013, a collaborative research project entitled 'Acute combined care for seniors in Sønderjylland' (ACCESS) (57) was initiated between Hospital Sønderjylland and the municipalities of Tønder, Haderslev, Sønderborg and Aabenraa, with the local leadership body Samordningsforum (SOF) i Sønderjylland (58) acting as the steering committee. 'SOF I Sønderjylland' is a local organ of leadership with representatives from Hospital Sønderjylland, the psychiatric hospital, the four municipalities (Tønder, Haderslev, Sønderborg and Aabenraa) and general practice, in charge of planning, coordinating and deciding how the healthcare agreements are implemented in the local context. The ACCESS project was based on a randomised, controlled trial conducted to assess how collaboration between health sectors could lead to the optimal care of acutely

hospitalised older patients (57). However, the project highlighted that a more exploratory approach to intersectoral collaboration was necessary to gain knowledge about the potential for improving the coordination of care across hospitals, general practices and municipalities in the Region of Southern Denmark. Hence, the idea for the 'At the FOREFRONT of older people's care' project was hatched. Figure 3 illustrates the structure of the overall project.

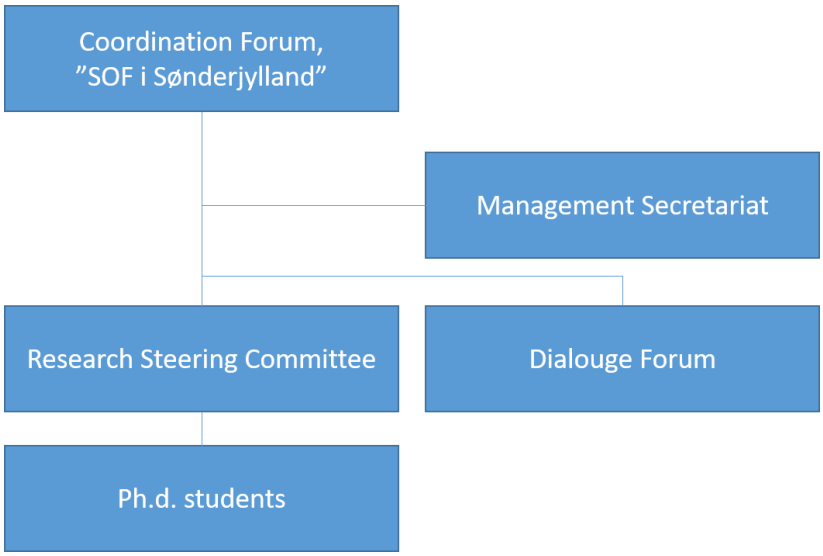

Figure 3: Structure of 'At the FOREFRONT of older people's care' project

Note: Figure 3 was generated by the management secretariat for presentation purposes.

SOF i Sønderjylland (58) is the coordination forum and project owner. The management secretariat is responsible for research planning and consists of two representatives from the research steering committee, who are the direct contacts to the coordination forum. The research steering committee includes PhD students and their advisors, who are from various sectors, backgrounds and research traditions, and representatives of older people and their relatives (user involvement is further discussed in Chapter 7). The dialogue forum, in which the preliminary results are reported and discussed, consists of local managers from hospital and municipalities, PhD students and the management secretariat. The dialogue forum and research steering committee both meet approximately every 6 months.

2.2 Conceptualisation

The relevant concepts are introduced and clarified in the following sections.

2.2.1 Healthcare as a complex adaptive system

Given that this thesis focuses on the coordination of health care, the structure of the healthcare system is central. According to Charles Perrow (1925–2019), we live in a society of organisations (59). Healthcare organisations may be defined as organisations built on complex technologies and social systems (60, 61), which aligns with complex adaptive system (CAS) theory (62). In this thesis, CAS theory underpins how healthcare organisations and systems are viewed. Therefore, CAS theory is briefly presented below.

Complex adaptive system theory originated in the 1980s and offers a view of the world that is less predictable and linear than previously believed. A CAS is characterised by multiple interacting agents (referred to as components) that can adapt and learn, creating a dynamic web between them (63). A CAS may be defined as *'a collection of diverse parts interconnected such that the organization (or organism) grows over time without centralised control ... a CAS is generated by the adaptive interactions of its components'* (61, p235).

A CAS is multilayered and involves physical, social, and biological systems (64). With respect to this thesis, it refers to social systems within healthcare organisations. A CAS is unique and highly context dependent (65). The core characteristics of a CAS include the **self-organisation of agents** (meaning that individuals, internal systems and entities respond to parameters such as information flow, level of connectivity or power), **nonlinearity** (i.e. unpredictable relationships; for example, a small input can have a significant effect on output because of the interconnectivity among agents), and **emergence** (random reactions to the actions of other agents, with the potential to create new paths or patterns across the system) (61).

2.2.2 Care coordination

The coordination of care has been on the agenda since at least the 1970s (8) and has attracted attention at multiple levels, including the political and practical levels (7). The terms 'coordination' and 'integration' with respect to care are used interchangeably (7).[9] These terms have a wide range of meanings (66) and ambiguous definitions, and consensus is lacking (7). The coordination or integration of care can refer to different types of integration (e.g. service integration is considered a single process, regardless of time, place or discipline) or different levels (e.g. organisational or clinical levels) (7). The World Health Organization (WHO) states that the continuity of care and the coordination of care are two closely related concepts. The continuity of care *'reflects the extent to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and references'* (67, p8). Care coordination is *'a proactive approach to bringing together care professionals and providers to meet the needs of service users, to ensure that they receive integrated, person-focused care across various settings'* (67, p8). WHO further stresses that care coordination and the continuity of care are especially important for people suffering chronic and complex conditions, (52) which is relevant to this thesis.

2.2.3 Patient-centered v. person-centered care

Patient-centered medicine was introduced as an alternative approach to the previous more paternalistic approach to care (28). Subsequently, it was stressed that patient-centered care was inadequate (68), and a distinction was made between patient-centered care and person-centered and their respective goals (28, 67). In the person-centered care of older people, a more holistic approach is taken, and there is a greater focus on the patient's history, networks, strengths and weaknesses. While the patient-centered approach is also holistic, it relies more on a medical rationale to understand patients' treatment and care needs to ease their suffering (28). The focus of both approaches is similar and includes empathy,

[9] Coordination of care (or care coordination) is the term most frequently used in this thesis.

individualised and holistic care, communication, respect and shared decision-making, but their goals differ. Patient-centered care aims to improve function, while the person-centered approach focuses on meaning (28). In other words, patient-centered care is somewhat a more somatic approach, with less focus on psychosocial factors and context.

2.2.4 Work culture

The term or concept 'culture'[10] is multifaceted and has a wide range of meanings, making it difficult to define, but it refers to a set of shared beliefs and values (69). It is not the intention of this thesis to provide a comprehensive description of the various aspects of culture. However, the concept of work culture is relevant to the thesis. Work cultures are shaped by legislation, organisational boundaries, mission statements, values and the practices and terminologies of the individuals and professionals involved. Work cultures emerge from different power dimensions and are intertwined with work processes and the relationships within the professional community and between employees (70) such as HCPs.

Organisational culture may be seen as static (70). However, according to the sociologist Zygmunt Bauman (1925–2017), culture is perceived non-static. Bauman considered the duality of culture as both a process and as something tangible and stable. He believed that culture arises from individual human biographies, the societal context and history (71). Culture unfolds around us and affects us and is simultaneously influenced by our actions and behaviours (71, 72). Thus, Bauman's perception of culture is suitable for this thesis because the interactions between HCPs and overall structures and procedures (At structural and organisational level) are relevant to care coordination.

[10] The term 'culture' in this thesis refers to 'work culture' in care coordination and interprofessional practice.

Chapter 3: Rationale for the Thesis and Research Objectives

Despite the comprehensive efforts and reforms to improve intersectoral care, challenges in care coordination across sectors and professions are still relevant. HCPs are important human resources with the potential to provide possible solutions to persistent challenges. HCPs are at the frontline of the daily coordination of CCTs across sectors and professions. Batalden and Davidoff (73, p3) argue that '*everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it*'. Therefore, it is assumed that:

- HCPs have first-hand knowledge that can contribute to the identification of how CCTs can be improved and become more seamless
- observing HCP practices can uncover tacit knowledge about care coordination across health disciplines and professions
- older people are suited to the study of intersectoral care coordination because they are more likely to have a higher number of HCPs and transitions in their CCTs arising from multiple morbidities and complex care needs.

Figure 4 illustrates the chosen research approach with the understanding that intended practice and real practice may differ.

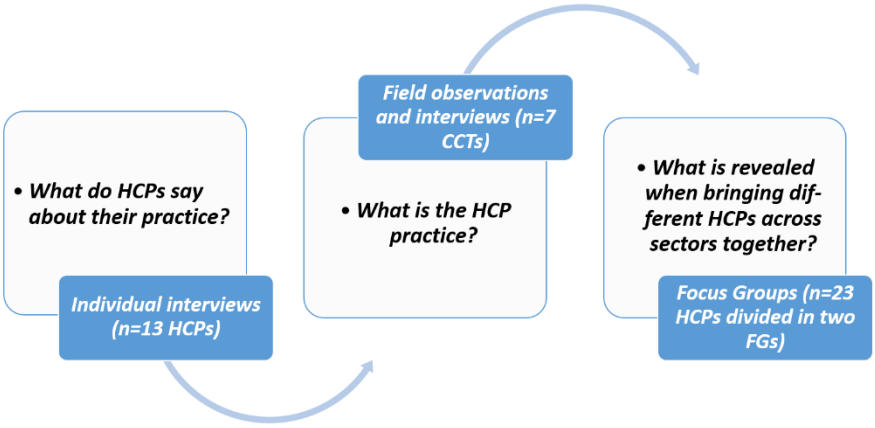

Figure 4: The research process in brief.[11]

3.1 Overall Aim

The above reflections on the role of HCPs in care coordination led to the overall aim of the thesis:

- The thesis focuses on HCPs from a range of health sectors and aims to explore, identify and analyse the prerequisites for improving the CCTs of older people experiencing acute hospitalisation.

3.2 Research Objectives of Individual Studies

3.2.1 Study I

The aim of Study I was to identify and analyse HCPs' perspectives and approaches to intersectoral care coordination of acutely hospitalised older people.

[11] The figure is re-presented with results in Fig. 10 p. 68

3.2.2 Study II

The aim of Study II was to explore and analyse how HCPs' interactions and practice influence older people's CCTs when admitted to and emergency department (ED) and the challenges that emerged.

3.2.3 Study III

The aim of Study III was to analyse the perspectives of HCPs from various sectors and professions on the barriers and facilitators of the coordination of the acute CCTs of older people.

Chapter 4: Epistemological and Ontological Foundation

'It depends not only on what you see, but what you see depends on how you see; for every consideration is not only a receiving, a discovery, but also a creation, and as far it is so, then it becomes essential, how the considerate is themselves'.[12]

—Søren Kirkegaard (1813–1855)

A researcher's epistemological and ontological foundation is reflected in their research interests and conceptions of truth. The researcher's set of beliefs guides their actions and reflects the research paradigm (74). The thesis is based on the interpretative research paradigm (75), which posits that knowledge and truth are non-universal, and reality, sense and meaning are individually created through interpretation (76). Further, one's perception of reality and truth depends on the context (77). With respect to this thesis, the interpretative paradigm means that the results that emerge from the analysis cannot be considered definitive but should be perceived as a subjective interpretation of what, to the best of our knowledge, is relevant to the exact context in which the research was conducted.

4.1 Methodology

The thesis focuses on the in-depth exploration and analysis of older people's CCTs from the perspectives of HCPs and observations of their practices. Therefore, qualitative research methods were applied. The research presented in this thesis was approached abductively using a combination of phenomenology and hermeneutics.

[12] English translation of the Danish Kirkegaard quote: 'Det beror da ikke blot på, hvad man seer, men det hvad man seer, beror på, hvorledes man seer; thi al betragtning er ikke blot en modtagen, en opdagen, men tillige en frembringen, og for så vidt den er dette, da bliver det jo afgørende, hvorledes den betragtende selv er' from Søren Kierkegaard's *Atten Opbyggelige Taler* (1845).

4.1.1 Hermeneutics and phenomenology

Given that the research presented in this thesis was aimed at analysing the perspectives and practices of HCPs, the research methodology included elements from both phenomenology and hermeneutics. The combination of hermeneutics and phenomenology in this thesis was inspired by Max van Manen (1942), who referred to his own methodology as hermeneutical or interpretative phenomenology (78). van Manen was preoccupied with people's being and existing and was especially inspired by Martin Heidegger (1889–1976) and Edmund Husserl (1859–1938), considered the founder of phenomenology as a methodological tradition (79). In this thesis, phenomenology and hermeneutics are used as an interchangeable combination including application of theory when relevant, and the level of interpretation may differ depending on context, which resonate the abductive approach presented below.

Phenomenology is rooted in the philosophical tradition and is concerned with the phenomenon of first-hand experiences between the subject (HCPs in this case) and the object (coordination of care in this case) (80). Therefore, the phenomenological approach involves the exploration of the subjective experiences of a particular phenomenon (81). In relation to this thesis, subjective experiences refer to the perspectives of HCPs, while the phenomenon refers to the coordination of care.

Hermeneutics is to the art of understanding or sense-making through interpretation (75). Given that the practices of HCPs may be somewhat tacit, interpretation and the hermeneutic approach is relevant. The term 'hermeneutics' originates from the Greek word *hermineuein* but was later translated into Latin (*interpretatio*) (80, 82), implying that hermeneutics is synonymous with interpretation. Hermeneutics is both an ontological concern and a method (80, 82). A key concept in hermeneutics is the hermeneutic circle, which illustrates that understanding the whole by understanding each part, and vice versa. This explains the dynamic and processual and interconnected relationship in our interpretation of parts of the world and the world as a whole, including the context dependency of sense-making (83).

As a concept, the hermeneutic circle may be related to the abductive approach applied in this thesis (discussed in the following section). Apart from the application of the hermeneutic approach in theory, a clear practical example of this approach was following my initial visit to the field for inspiration, which helped to form and perhaps even changed my preconceptions of care coordination. These visits also played an important role in developing the interview guide for Study I, where I drew on my experiences in the field to ask more in-depth questions (e.g. physicians' understanding of their interprofessional practice). The hermeneutic circle became a constant tool in my research because my preconceptions continually evolved (The processual and iterative relationship between the individual parts and the whole).

4.1.2 Abduction

An abductive approach was used in this thesis to alternate between theory and empirical observation. Charles Sanders Peirce (1838–1914) was the first to introduce abductive reasoning to science (84, 85). Peirce's perception of abduction and the generation of hypotheses differed between his early and late works. In his early works, Peirce considered abduction an evidencing process, while in his later works, he described abduction as a methodological approach or process (86). With respect to the present work, the concept of abduction is based on Peirce's later works—the 'surprising' instances in the data analytical process, the so-called 'breaches of understanding', which lead one to perceive the data or research differently (84). Thus, the process of data analysis is often iterative, moving backwards and forwards, which is also related to the hermeneutic circle, as explained above.

The following lists some concrete examples of the application of the abductive approach in my thesis:

- field visits prior to developing the interview guide for inspiration
- testing and modifying the interview guide over several steps
- changing the icebreaker exercise from the first to the second focus groups
- changing the inclusion criterion of age in Study II
- changing from wearing a nurse's uniform during field observations to wearing everyday clothing in Study II.

These examples are discussed further in the following sections.

4.2 Methods

'Not everything that can be counted counts, and not everything that counts can be counted.'

—William Bruce Cameron (87)

4.2.1 Qualitative enquiry

Qualitative research methods are suitable for exploring individual experiences or certain social phenomena (88). Because the research presented in this thesis attempted to capture the subjective views and experiences of HCPs with respect to care coordination across disciplines and analyse its effect on older people's CCTs, several qualitative methods were used.

4.2.2 The researcher's preconceptions

When conducting qualitative analysis, it is essential to be constantly aware of one's own preconceptions, which can affect the research process and construction of interpretations (88). In this section, I provide a brief picture of my initial preconceptions.

With a background as a HCP—specifically a midwife—I entered the field of healthcare research with a backpack of professional, first-hand experiences, providing me with a foundation of familiarity with healthcare practices. However, the majority of participants in the research were nurses, physicians and physiotherapists, and the main setting of the research was the ED, a department in which I had no experience. This raises the question about whether I was an insider or outsider, but as Adler and Adler (89) argue, one's role and perspective can evolve over time depending on the context and conditions. I found my role to be ambiguous, shifting from time to time. With my background as a HCP but my unfamiliarity with the ED, I was neither a total outsider nor a total insider; rather, I relate to what Lauren Breen (90, p165) refers to as the researcher 'in the middle'. In line with Breen's reflections, I considered this an advantage because I could benefit from both perspectives. Hence, I saw myself as a 'professional stranger' (91), which I considered an advantage for my research. For example, I was familiar with the professional terminology but was unfamiliar enough to be able to wonder and ask relevant questions.

Prior to conducting the individual interviews for Study I (92), I reflected on how I would introduce myself to the interviewees. I decided to be transparent about my HCP background on the basis that this would build trust and signal that I was familiar with medical terminology, which I considered an advantage. However, I was aware of remaining as neutral as possible in my position, appearance and rhetoric. When transcribing the conducted interviews, I noticed that I largely succeeded in remaining neutral. However, I occasionally found myself interrupting in my eagerness to know more or simply show my attention and signal that I understood the interviewee's point. I also discovered challenging

instances such as when a GP threw the ball back at me, asking, 'What do *you* think [defines a coherent CCT]?'. The question took me by surprise, and I responded with my thoughts rather than turning the conversation back to the participant. To this day, I do not know whether the GP, who was highly experienced, was testing my knowledge or simply wished to discuss the topic further. Either way, I learned from the experience and believe that it made me a more skilled interviewer.

In the following, some examples of my changing preconceptions are given.

In some instances, my previous preconceptions became obvious to me only once I realised that they had changed. For example, when I was writing up the results (in Study I) and beginning to realise the complexity of intersectoral care coordination, it became clear that I had previously perceived the CCT as a linear and fragmented process, exemplified by my use of 'before, during and after hospitalisation'. Thus, the precise moment of hospitalisation or discharge was considered a breakpoint in the CCT. Given that I had intended my research to contribute to creating more seamless CCTs, this is somewhat ironic. My perception of the fragmented nature of CCTs may have arisen from my own experience as a HCP in which health care was separated by disciplinary boundaries, and transitions created challenges in the coordination of care between disciplines.

The more deeply I engaged in the research field, the more complex the healthcare system and care coordination appeared to be. My naivety and failure to understand this complexity initially came into focus during the observational studies. Originally, I intended to focus only on HCPs, which was also a premise to be part of the umbrella project. However, it soon became clear that following older people's trajectories required me to develop a relationship with them, first so that I could obtain access to them, and second so that I would appear legitimate, enabling them to share their histories and thoughts with me. Further, omitting other perspectives than the HCPs' was not only impossible but also captivating for my research giving the objective to capture how the CCTs where affected. This was particularly

highlighted in Eli's case (Trajectory 2, Paper II (93))—if I had only focused on the nurses' perspectives, the problems in Eli's CCT would possibly not have been identified.

To summarise, my preconceptions changed several times along my research journey. Sometimes this occurred suddenly (as in Eli's trajectory described above), but mostly it was a process as my knowledge continually evolved. Having advisors from different research traditions (e.g. social and medical sciences) and backgrounds (e.g. sociology, medicine and pharmaceuticals) contributed enrichening discussions and was an advantage for the evolving process.

4.2.3 Applied Literature

Identifying and accessing relevant literature is a core principle of academic research (94). I used multiple databases to conduct systematic searches for articles relevant to this thesis. My search strategy was adjusted according to the functions of the individual databases. The main databases I used were PubMed, Cumulative Index of Nursing and Allied Health Literature (CINAHL), SweMed+ and Web of Science. I developed my search strategy using key concepts from my research questions. Initially, I identified the relevant medical subject headings and synonyms for each key concept. This block-building strategy consisted of four facets (search terms): 'healthcare professionals', 'interdisciplinary/intersectoral collaboration', 'older adults in acute hospitalisation', and 'coordination of care'. The identified synonyms for each term were combined using the Boolean operators 'OR' and 'AND', resulting in a complicated search string. Given that my mother tongue is Danish, and English is the only other language that I have mastered at an advanced level, I applied a language filter. Moreover, I applied a 10-year limitation to my search to find the most recent literature on the topic (see Appendix V for the search strategy used in PubMed). In addition, I set up email alerts in PubMed to keep me abreast of any new and relevant literature. I also searched for literature using the 'pearl growing' or 'snowballing' method,

which consists of manually searching the literature for relevant articles. Additional grey literature was most often identified from attended PhD courses, and recommendations from colleagues in my professional network.

4.2.4 Research flow, study design and data sources

This thesis is based on three individual studies. Prior to conducting these studies, I visited different sites for inspiration and knowledge and to show respect to the HCPs participating in my research. This involved spending a full day each in the ED, with the municipal acute care team and with a GP in general practice and a weekend with the after-hours medical service. My experiences and inspiration informed the creation of the interview guide and the planning and conducting of interviews.

In Study I (See Paper I (92)), I individually interviewed 13 HCPs to gather data about their experiences in and perspectives of intersectoral care coordination and interprofessional collaboration in the CCTs of older people who have been acutely hospitalised. In Study II (See Paper II (93)), I used a combination of observations (93 hours) and informal interviews to assess how the practices and interactions of HCPs affected the CCTs of acutely hospitalised older people ($n = 7$). In Study III (See Paper III (95)), I conducted two focus groups involving a total of 23 HCPs to gather their perspectives on the critical factors affecting the coordination of older people's CCTs. A patient trajectory was generated based on the results of Studies I and II and used as the subject for discussion in the focus groups.

The three studies were conducted chronologically (see Figure 4), which was based on the assumption that the individual interviews would elicit HCPs' perspectives on their practices, while the observations would reveal more about their actual and possibly tacit practices. As Pierre Bourdieu (1930–2002) pointed out, HCPs may lack awareness about their practices, leaving the potential for observations to reveal deeper and more

subconscious layers (96). Further, according to Spradley (1933–1982), when studying cultural behaviours such as HCP practices, it is essential to consider three aspects: what people do, what they know, and what they make and use (practice) (97). Finally, the focus groups brought the participants together in the same room, revealing the differences and similarities between professions and sectors and providing the potential to generate mutual knowledge about gaps in intersectoral care coordination.

Table 1 provides an overview of the three studies.

Table 1: Overview of study designs, applied methods and data sources

	Study I [92]	Study II [93]	Study III [95]
Design	Qualitative	Qualitative	Qualitative
Objective	Analyse the perspectives and approaches of HCPs with respect to the intersectoral coordination of care of acutely hospitalised older people	Analyse the effect of HCPs' interactions and practices and the challenges that emerge in the CCTs of older people admitted to the emergency department	Analyse the perspectives of HCPs across health sectors and professions on the barriers and facilitators in coordination of care for older patients
Method	Semi-structured, individual interviews	Observations and interviews	Focus groups (two)
Sample size	13 HCPs	7 older people's CCT	23 HCPs
Data sources	Verbatim transcripts	Field notes, transcripts, memos	Transcripts of video recordings and notes from focus groups
Analysis	Systematic text condensation inspired by Malterud [82]	Data process approach inspired by Andersen et al. (2018)	Abductive listening of interview recordings inspired by Revsbæk and Tanggaard [71]

Note: HCP: healthcare professional; CCT: clinical care trajectory.

4.2.5 More about methods and some methodological reflections

The following sections present details about data handling and the sample populations in each study.

4.2.5.1 Study I: Individual interviews

4.2.5.1.1 Data collection and sample

The data for Study I were gathered at the end of 2017 and beginning of 2018. Using an interview guide (see Appendix VII) and open questions based on the principles of Kvale and Brinkmann (98), I performed 13 individual semi-structured interviews with HCPs from a range of sectors. The interview guide was tested on HCPs and modified twice prior to the final data collection. I conducted interviews until no substantial new knowledge emerged based on a pragmatic evaluation of saturation (99).

Using the snowball sampling method (100), 13 participants were recruited from professional networks established primarily during the ACCESS project (57). All four municipalities and sectors and a range of professions, functions and experiences were considered. The inclusion criterion for participants was involvement in the coordination of care for older adults. Table 2 presents the details of the sample population.

Table 2: Study 1: Participants

Profession	*N*	Municipality/hospital
General practitioner	1	Municipality 1
General practitioner	1	Municipality 2
General practitioner	1	Municipality 3
General practitioner	1	Municipality 4
Physician	1	Hospital
Nurse	3	Hospital
Primary care nurse	1	Municipality 1
Primary care nurse	1	Municipality 4
Acute care team nurse	1	Municipality 2
Acute care team nurse	1	Municipality 3
Municipal nurse, other function	1	Municipality 3

Note: Municipality numbers are un-specified for blinding purpose. The numbers only serve to illustrate the representation of all four municipalities.

Participants each decided on the time and place of the interview. In all cases, the interviews took place during the day at participants' workplaces. In total, the duration of the interviews was just under 11 hours, approximately 50 minutes each. All interviews were audio recorded and transcribed verbatim by me. Following each interview, I wrote reflections on my immediate thoughts and impressions.

4.2.5.2 Study II: Field observations combined with interviews

4.2.5.2.1 Preparing the observations and considering access

To prepare for the data collection from field observations, I considered several factors. To gain access to the field, I used a checklist (101, p379) (see Appendix VIII), which I discussed with both my principal advisor and the advisor who acted as the gatekeeper to my access

to the ED. As suggested by Buchanan et al. (102), this latter advisor was a well-respected physician and familiar face in the ED (an insider), making him a convenient choice.

Another consideration was to plan the most suitable way of recruiting the patient participants and observing their CCTs with attention to the quality of the generated data. Ideally, I would have followed the older person from the time and place of the decision to hospitalise them, which would have required me being present in their home or the GP clinic. Clearly, this would have involved considerable time and luck being in the right place at the right time. Therefore, a more pragmatic approach was chosen—participants were recruited at the ED as close as possible to the time of their admission. Initially, I attempted to gain access to participants immediately as they were being admitted to the ED; however, this interrupted the workflow given the numerous activities and HCPs involved at that time. Therefore, it was more appropriate and convenient for the older person to receive information and be asked to participate once the situation was less stressful for them.

4.2.5.2.2 Inclusion criteria and obtaining consent

Providing information about the study to participants (the older people and HCPs) and obtaining consent took place in a stepwise manner. Initially, I attended the morning meetings in the ED, where I was introduced by my advisor and described the purpose of my study and inclusion criteria to the HCPs. I then screened the patient flow management screens to identify trajectories meeting the inclusion criteria.

Exclusion criteria were applied to the following older people: those who were unable to provide informed consent, those in isolation because of the effect of personal protective equipment on HCP interactions and those who were being overseen or actively treated by my advisor because of the possible introduction of bias. The inclusion criteria were people aged 65 years or more (because comorbidities and complex care needs increase with age) and receiving daily home care (because they would be more likely to have several HCPs

involved in their care) (10, 103). Initially, the minimum age for inclusion in the study was 75 years, but this had to be lowered after several days in the ED in which no patients met my inclusion criteria. These patients were either unable to provide consent or did not receive daily home care. However, I did identify patients in the electronic database who were under the age of 75 years receiving daily home care and able to provide consent. Therefore, I pragmatically changed the age criteria to a minimum of 65 years. Nevertheless, the average age (81 years) in my sample population was still relatively high. Such modifications are often necessary in qualitative research to enable a more flexible design (101, 104). Moreover, 65 years is frequently used as the cut-off to distinguish younger people from older people (105), despite the diversity and multiple perceptions of different ages.

To assess whether patients were able to provide informed consent, I approached the nurses who were in charge of them. If the nurse believed that the patient would be capable of providing consent and was happy for me to conduct observations, I then approached the patient to assess their eligibility. Patients who were deemed incapable of providing informed consent were excluded. Each time I entered a patient's room to inform them about the study, I introduced myself as a researcher and wore a badge identifying myself as a PhD student. If the patient gave me permission to enter, I gave them detailed written and verbal information about the study and the purpose of my presence. If the patient accepted my invitation to follow their CCT, I obtained their written consent. I stressed that their participation would not affect their treatment and care and that they could withdraw at any time. Further, I informed them that their data would be anonymised.

Given that the study was approved by the management at Hospital Sønderjylland, I did not obtain written consent from the HCPs but informed them about the study and the purpose of my presence. All HCPs observed in this study gave their oral consent. After obtaining consent, I followed patients' trajectory closely during their hospitalisation and conducted field observations of HCP interactions throughout the CCT.

4.2.5.2.3 The population and data sources

I followed the CCTs of seven older people, which involved a total of 93 hours of observation and 10 hours of telephone interviews (see Paper II for details (93)). The average age of patients was 81 years, and four were female.

Field observations were conducted over a 5-month period (January–May 2019). Observations were combined with informal conversations or interviews (97) with the involved HCPs when relevant and possible. The observations were initiated in the ED (bedside facilities) in the daytime, because this was when I was able to gain access via my advisor. However, I also conducted observations in the late afternoons and early evenings as I followed the patients' CCTs. For example, if a patient was transferred to another ward (e.g. the geriatric ward), I followed and continued observing them until they were discharged. In other words, the trajectory guided my observations and the included HCPs.

During my observations of patients and HCPs, I signalled my attention by avoiding writing field notes. Instead, whenever possible, I withdrew to the staff lunchroom, a more informal place than the ward, where I wrote full detailed descriptions (106). When necessary, I made jottings (106) during my observations to support the subsequent process of writing 'thick descriptions' (107). My field notes were converted to more formal transcripts the same or next day. When relevant, reflective notes, similar to a reflective diary, were written at the end of the day.

During my conversations with and observations of the patient participants, I asked them about their usual healthcare services and the HCPs who had been involved in their acute hospitalisation. I then contacted these HCPs by telephone and asked for their perspectives on the older person's care coordination prior to hospitalisation. I conducted the same process following discharge. Those interviewed by telephone included GPs (and their

secretaries), primary care nurses, home care workers, physiotherapists and municipal assessment nurses.[13.]

To follow up with the older people, I contacted them by telephone 1, 2 and 4 weeks post discharge to find out about any care coordination activities that had taken place since discharge. This was also a way of showing interest in them following their hospitalisation. In my final telephone call, I took the opportunity to thank the older people for their participation and finalise my engagement in their CCT. A 30-day time limit was chosen because hospital readmissions is most frequently defined as re-hospitalisation within 30 days after discharge (108). During the telephone interviews, I took handwritten notes, which were immediately converted to a more detailed transcript following the conversation.

I initiated the CCT of one patient at a time to ensure that I was available to conduct observations and avoid having to choose between two trajectories in which relevant events were occurring simultaneously. The next CCT began during the follow-up period of the previous CCT. Unfortunately, two of the patients passed away during my research, one in hospital and the other during the 30-day period following discharge. However, I was able to follow up with their GPs and other relevant HCPs. (See Table 3 below for details about the observations and interviews).

4.2.5.2.4 My role and reflections of being an observer

As mentioned previously, I entered the field as a researcher but with a HCP background. Spradley (97) refers to the duality of the observer role, which aligns with the previous discussion regarding insider v. outsider perspectives (see section 4.2.2) and the researcher 'in the middle' (90). Spradley (97) distinguishes between levels of involvement and types of participation. I considered myself mostly observing participants (101), which is a low level

[13] A municipal employed healthcare professional with a job function to evaluate the older people's needs and determine the municipal services that should be allocated.

of involvement, occasionally shifting to a more moderate participation and degree of involvement (97).

Using the HCP lunchroom to write my field notes was an appropriate opportunity to observe elements of the work culture and have casual conversations, which contributed to the insider perspective. Further, wearing a nurse's uniform influenced my role, which is discussed in the following section.

4.2.5.2.5 Advantages and disadvantages of the nurse's uniform

Uniforms are connected with professional identity and show hierarchy and authority (109).[14] In my study, the uniform also played a central role in how I was perceived by patients, relatives and HCPs.

I wore a nurse's uniform during my initial observations because management wanted me to live up to the hospital hygiene standards. I agreed with this decision because I wished to be identified as a HCP. However, my role as a researcher was challenged because I was perceived as a nurse on several occasions, despite introducing myself as a researcher and wearing a badge identifying me as a PhD student. I was directly asked or implicitly expected to participate in certain situations, leading to dilemmas with respect to my involvement and ethics. While I was reluctant to become involved to avoid interrupting the research, I felt obliged to help the HCPs, patients or relatives. I often chose the pragmatic approach but always described it carefully in my field notes.

An example of a situation that challenged both my ethics and my methodological reflections was when I was observing Trudy (Trajectory 4) (see Paper II (93)) while wearing a nurse's uniform. I became aware that Trudy required a catheter as part of her treatment. However, Trudy did not want the catheter inserted, preferring to use a toilet chair. The nurse tried to

[14] In 2019, Hospital Sønderjylland introduced a new, less authoritative uniform (110).

convince her to have the catheter inserted, but Trudy's response was ambivalent. Another nurse, who was under the impression that Trudy had consented, arrived to insert the catheter and asked me to assist. Given the limited time to consider my position, I lent my assistance. I have spent much time reflecting on this situation, both during the incident and since. It challenged my ethics because I was unsure about whether the catheter was being inserted against Trudy's wishes but was under the impression that it was essential for her treatment. Because I had built a trusting relationship with Trudy, I believed that my presence and assistance with the procedure would be beneficial to her. The methodological dilemma arose from the fact that had I not assisted, I would have had a chance to observe the interaction between two nurses; however, by assisting, I could gain credibility with the nurse I assisted.

After discussing these dilemmas with my advisory team, we decided that I would only participate to the extent of what a patient's relative would do, even though this may be somewhat unclear. Further, the management permitted me to conduct my observations wearing casual, everyday clothing (see negotiation points 3 and 6 in Appendix VIII).

4.2.5.2.6 Being perceived as an ally

Conflicts could also arise from being perceived as one of 'them'. How others saw my role was challenging at times and could give rise to ethical dilemmas. To illustrate this, I will describe an instance in which I was wearing everyday clothing and was observing Lisa (Trajectory 5, Paper II (93)) in the geriatric ward. The collaboration between Lisa, her relatives and the HCPs seemed problematic and conflicting. In a situation at the geriatric department, where *Lisa's* daughter was present, two nurses were about to mobilise *Lisa* to an armchair – a situation I desired to observe as an opportunity to observe interactions between the HCPs. However, one of the nurses asked both the daughter and I to leave the room, which I considered an indication of her feeling uncomfortable being observed. I

understood—she felt threatened by my presence—and I left the room immediately. I wanted to tell her that my intention was not to judge but decided it was best to stay silent. In the hallway, Lisa's daughter initiated a conversation with me—I sensed that she considered me an ally in her dissatisfaction with Lisa's care. This placed me in a dilemma because I wished to provide a listening ear but did not want to be considered an ally or become involved in any conflict between her and the HCPs which would impact my role as a researcher. Therefore, I explained that I was a researcher and had no intention of taking sides, whether it was that of a patient, a relative or a HCP. The daughter acknowledged my statement.

I reflected afterwards about the nurse perceiving me as a threat. The fact that I was not wearing a uniform in this situation may have led her to perceiving me as equal to Lisa's daughter, with whom there was some conflict. This situation may have turned out differently had I been wearing a uniform, which may also have helped me distance myself from being drawn in as an ally.

In conclusion, while wearing a uniform does not position one as a researcher, it can contribute to both distancing from and identifying with different contexts, populations and perceptions.

Table 3: Observation hours and participant characteristics

Trajectory no. and pseudonym	Age (years)	Length of hospital stay (days)	No. days followed	Reason for admission	Discharged to	Total observation hours (days) *	Shift **	Observed HCPs/staff	Interviews and patient follow-up (duration in minutes)	Total interview time (no. contacts) ***
1. Eve	85	16	44	Fever, chest pain, pneumonia	Home	11 hours (4 days)	Day	Nurses, **** physicians, OT, PT, porter	Primary care coordinator (5), home carer 1 (10), home carer 2 (30), GP (15), assessment nurse ***** (10), PT (30), patient (10, 10, 5)	2 hours, 5 min (11 contacts)
2. Eli	75	4	32	Acute abdominal pain	Home	14 hours (2 days)	Day, evening	Nurses, physicians, porter	Nurse (10), primary care manager (15), primary care coordinator (5), GP (10), home carer (10), patient (15, 15, 5)	1 hour, 25 min (17 contacts)
3. Gordon	70	3	39	Falling episodes and functional decline	Home	13 hours (2 days)	Day, evening	Nurses, physicians, registrar	GP (30), primary care coordinator (5), home carer (20), nurse (25), patient (15, 10, 10)	1 hour, 45 min (11 contacts)
4. Trudy	84	2	3	Dehydration and rash	N/A	7 hours (2 days)	Day	Nurses, physicians, radiologist, porter	GP (10), home carer (10), nurse (35). Patient (N/A; died on Day 2 of hospitalisation, thus follow-up not possible)	55 min (5 contacts)
5. Lisa	83	17	39	Vomiting and diarrhoea	Home	14 hours (5 days)	Day, evening	Nurses, physicians, porter, cleaning and service assistants	Home carer (25), nurse (15), GP (10), assessment nurse (30), patient follow-up via relative (60 + text message); final follow-up not possible because patient died)	2 hours, 20 min (7 contacts)
6. Eric	78	9	37	Fall, dyspnoea	Home	8 hours (2 days)	Day, evening	Nurses, physicians, OT, PT, porter	Nurse (5), home carer (15), discharge coordinator (25), GP (N/A, long-term leave). Follow-up with patient via home carer (5 + text message)	50 min (8 contacts)

Trajectory no. and pseudonym	Age (years)	Length of hospital stay (days)	No. days followed	Reason for admission	Discharged to	Total observation hours (days) *	Shift **	Observed HCPs/staff	Interviews and patient follow-up (duration in minutes)	Total interview time (no. of contacts) ***
7. Karen	89	2	2 (transferred to another region for surgery, thus further observations not possible)	Fall	Rehabili-tation centre	7 hours (2 days)	Day	Nurses, physicians	Nurse (20), GP (N/A, unresponsive), Follow-up with Karen N/A (no mobile phone). Follow-up interviews of HCP conducted at rehab. centre	20 min (1 contact)
Other ^						19 hours (3 days)	Day	Not specified	Not specified	Not specified
Total						93 hours (22 days)				9 hours, 40 min (60 contacts)
Average per patient						13 hours (3 days)				1 hour, 23 min (9 contacts)y

Note: * Observation time refers to the total observation hours across the given number of days. ** Day shift: before 3 pm; evening shift: after 3 pm; *** Number of contacts includes follow-up interviews with the patients (and/or relatives) as well as telephone calls with administrative staff (e.g. secretaries and managers). Coordination activities are not counted as interviews. **** Nurses includes hospital, student and municipal nurses. ***** Assessment nurses are employed by the municipality to evaluate the needs of older people and determine the municipal services to be allocated. ^ General field observations conducted in the ED (at the bedside) during the day shift when it was not possible to recruit participants. OT: occupational therapist; PT: physiotherapist; GP: general practitioner.

Source: Persson et al. (93)

4.2.5.3 Study III: Focus groups

4.2.5.3.1 Data collection and population

Focus groups were chosen as the data collection method for Study III for different reasons. First, we wished to check the validity of the findings derived from Studies I and II. Second, bringing HCPs together from different backgrounds and sectors could generate new knowledge at the collective level (111).

4.2.5.3.2 Generating Anna's trajectory

It was important to me that the subject for discussion in the focus groups reflected both the empirical findings of Studies I and II as well as the HCPs' clinical experiences. Therefore, I drafted a CCT that represented the key issues raised during Studies I and II. I chose a female patient because the majority of participants in Study II were women (four women vs. three men). To obtain the most clinically relevant and recognisable description of a CCT, I discussed the draft several times with my advisor Christian Backer Mogensen, who was the most familiar with the clinical setting in which I conducted my research. I also discussed the draft with the municipal leader of the acute care team, a municipal nurse, and a PhD colleague who had clinical experience in the ED. My advisors approved the final version of Anna's CCT case (see Paper III (95)).

4.2.5.3.3 Participants

Originally, I intended to conduct one focus group per municipality (n = 4), but because the hospital would need to be represented in each, this would have necessitated a higher number of hospital-based HCPs. Therefore, we settled on a pragmatic solution, conducting two focus groups, with each representing two municipalities. As emphasised by Buchanan et al. (102), when there is a discrepancy between what is desired and what is practically possible, practicality wins.

To recruit HCPs I once again made use of an existing network—the dialogue forum of the 'At the FOREFRONT of older people's care' project to recruit HCPs. Given the variety of professions I encountered during Study II, I planned for the focus groups to include as much variety as possible while continuing to represent the municipalities, the general practices in the municipal catchment area and the hospital. Thinking about the characteristics of a sample is known as analytical selection practice (112). My advisor Christian Backer Mogensen served as an intermediary between myself and the GPs because none of the GPs I contacted responded. This strategy was successful, enabling me to contact and correspond with GPs once Christian had made initial contact with them. All the participating GPs received a fee for their participation time and to cover transportation costs.

Reducing the number of focus groups to two meant increasing the number of participants in each because I wished to include the abovementioned characteristics. The optimal size of focus groups is ambiguous (111, 113), but a rule of thumb is six to 12 participants per group (111). Twenty-five HCPs were invited to participate in the focus groups. Two of these HCPs were unable to attend because of their schedules, leaving 23 focus group participants in total (11 in one and 12 in the other). Thus, the focus groups were relatively large, meaning that more was required of me as the moderator (114) to ensure that all participants were included in the discussion. However, larger groups are encouraged if the central focus of the analysis is content rather than interactions (111), which was primarily the case for my study.

4.2.5.3.4 Location

Because the participants were from different sectors, I reflected on the ideal place to conduct the focus groups. I decided to conduct them at the Aabenraa campus of Hospital Sønderjylland but in a room separate from the clinical setting to provide a more neutral atmosphere. Nevertheless, the hospital-based HCPs were more likely to have been familiar with the location compared with the GPs and municipal employees.

As illustrated in Appendix XIII, I arranged the room with a large table that had sufficient space for everyone (apart from me because I wanted to signal that I was not part of the focus group discussion), a tablecloth and flowers, snacks and water, information material, consent forms and pens. Prior the focus groups I had created name tags for every participant, but the participants where free to choose where to sit. At one end of the room was a large video screen with a picture of 'Anna', and at the other was a board with a timetable of Anna's CCT (See Paper III (95)).

To safeguard the data, the focus groups were recorded; therefore, video and audio recorders were set up and tested in advance.

4.2.5.3.5 Moderator role

Focus groups enable researchers to be less intrusive than when making observations (115). As the moderator of the focus groups, I was aware of facilitating them in such a way that everyone had a chance to participate; however, I aimed to keep my interruptions to a minimum and intrude the process as little as possible. Similarly, as a midwife, I was familiar with facilitating a process ensuring as few interruptions as possible.

At the start of each focus group, I was more active, welcoming participants and ensuring that they were comfortable. Once all participants were seated at the table and had provided written consent, I facilitated an icebreaker game as a warm-up. In the first focus group, I introduced the exercise 'I have never...', encouraging each participant to finish the sentence. However, the exercise did not work as intended because it caused some confusion. Therefore, in the second focus group, I encouraged the participants to state their reason or motivation for participating instead. My advisor, Christian Backer Mogensen, was present to welcome the participants and acknowledge their participation. After participating in the icebreaker round, he withdrew to ensure that his presence would not affect and bias the process given his position and status.

First, I read Anna's case aloud, then encouraged the participants to share their immediate impressions and thoughts, highlighting that I would step back to give their discussion more room. I occasionally supported the discussion by clarifying questions or inviting quieter participants to share their thoughts. To conclude the session, I briefly summarised what had been discussed to ensure that I had captured its essence and allowed supplementary comments or viewpoints to be raised. Finally, I thanked everyone for their participation.

A PhD student colleague assisted me in the focus groups, primarily focusing on the non-verbal language between participants. We both wrote memos during the focus groups and discussed our immediate thoughts and impressions directly after each group.

4.2.6 Data analysis

To analyse the data, I used a variety of strategies, including the software NVivo 11 for Study I and a more manual approach for Studies II and II. For all three studies, I used an iterative procedure in line with the abductive approach. The following sections provide a brief description of the procedure in each study.

4.2.6.1 Study I: Individual interviews with healthcare professionals

All interviews were transcribed verbatim, and NVivo 11 was used to code the data. My approach to coding and analysis was inspired by Malterud's (99) systematic text condensation, which was applied exploratively with no a priori fixed theory or codes. Initially, the transcripts were read independently by each of my co-authors to develop familiarity with the content. This was followed by a stepwise and iterative open coding process (116, 117) to create meaningful units and subgroups. Finally, the subgroups were condensed to four overall categories: organisational factors, approaches to care, communication and knowledge, and relations (92). Figure 5 illustrates the process.

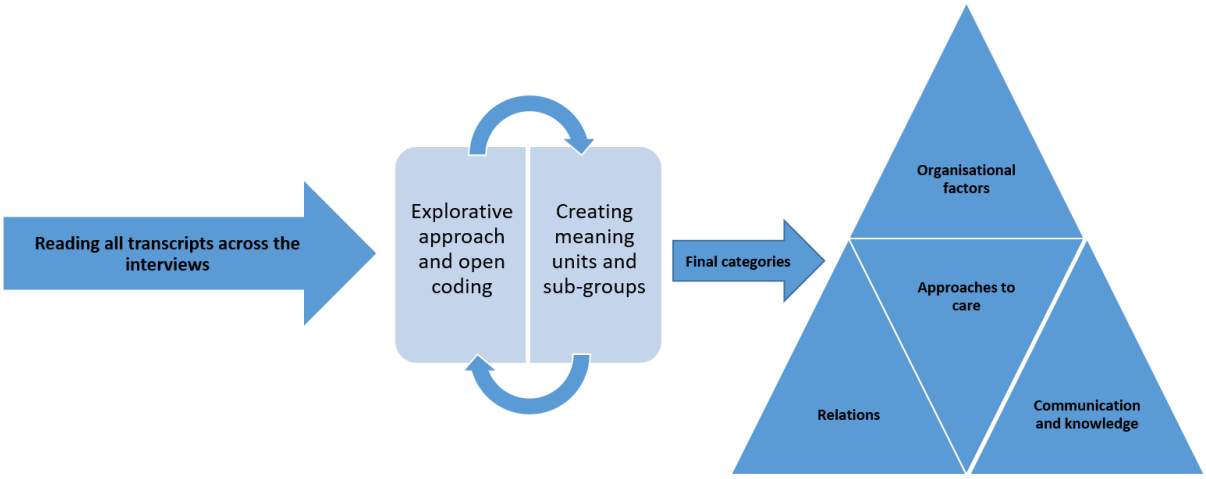

Figure 5: Study I: Analytical approach (92).

Note: The analysis for Study I was more iterative than the illustration above demonstrates.

Although open coding is a data-driven process in which no theory is applied in advance, the final categories aligned with Gittell's relational coordination (RC) theory (118-120). Therefore, I read her works after coding the data, then applied the theoretical concepts from RC and social capital theory in the discussion in Paper I (92) to elaborate on the findings.

Table 4 provides examples of the empirical material and data analysis procedure.

Table 4: Study I: Examples of the coding process

Quotation	Meaning unit	Subgroup	Theme
Municipal nurse: 'Why is it that everything is so segmented? Who decided that when you are *only* in orthopaedic surgery or an orthopaedic department that you *only* take care of that?'	Box thinking	Structure and box thinking	Organisational factors
Hospital nurse: 'I think it is because we do not understand how the others work and because primarily I only have experience from the secondary [health] sector. If I had had experience from the primary [health] sector, I would know maybe more about how the work process was there ... so it is difficult to meet and feel that we completely understand each other'	Experience	Shared insights (across professions or sectors)	Communication and knowledge
Physician: 'It is actually very dangerous if you begin to define your area of responsibility too narrowly, and physicians' time is used for defensive medicine. And that caution or wariness is like a monster that can grow bigger and bigger. You end up needing bigger and bigger safety margins all the time'	Collaborative culture	Defensive medicine	Approaches to care
Municipal nurse: 'But if we have a general practitioner who is a bit laissez faire ... we also need a feeling of security. We need to know that we have a good prescription and action plan. If we do not have that, then it does not work'	Confidence	Trust	Relations

Note: Adapted from Paper I (92).

4.2.6.2 Study II: Observations and interviews

The analysis of the empirical material in Study II drew on inspiration from Andersen et al. (47), who relied on Blumer's (1900–1987) approach of allowing empirical instances to 'talk' directly to the researcher (47, 121). Initially, all field notes (from both observations and interviews) were read several times for each CCT. Immediate thoughts and impressions were written as memos (106). Then, each CCT was read independently to search for instances that were relevant to the study objective. All authors read the transcripts independently and discussed the instances. Preliminary categories were created, followed by the final categories, which represented condensed descriptions of instances in the trajectories. Throughout the analysis procedure, we benefited from having different backgrounds and representing different disciplines, including medicine, sociology, public health, pharmaceuticals, general practice, the ED and/or the university. These different perspectives increased the credibility and rigour of the study because all co-authors actively

contributed to interpreting the data. Finally, the theoretical perspectives of Jürgen Habermas (122, 123), specifically his system and lifeworld concepts, were applied to elaborate on the findings. The results show that there is some dissonance between the rhetoric on person-centered care and healthcare culture and practices. Therefore, Habermas's concepts partially explain our results. Figure 6 illustrates the analytical procedure.

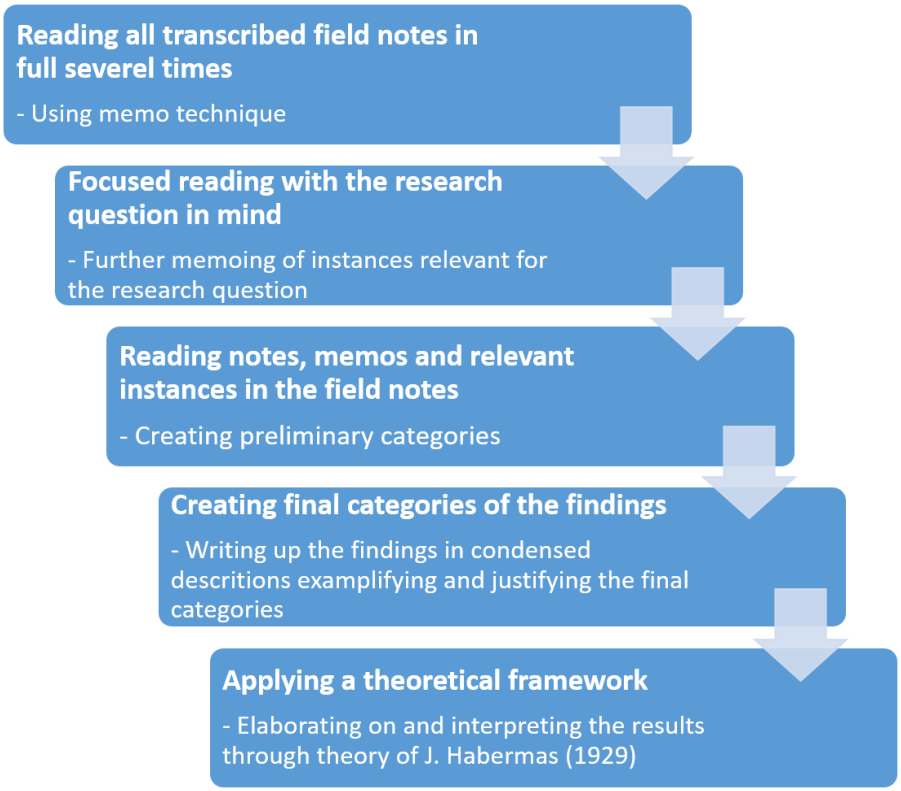

Figure 6: Study II: Analytical approach.

Note: Adapted from Paper II (93).

Table 5 below provides examples of the analysis to demonstrate transparency.

Table 5: Study II: Examples of data analysis

Instance	Memo example	Preliminary category	Extract examples of condensed description	Final category
Eve requests water in a sip cup after being transferred to the geriatric ward. She asks more than once but is overruled because of a nursing practice aiming to prevent swallowing failure and risk of pneumonia	Eve used a sip cup at the ED. In the geriatric department her wish is ignored. She is offered a straw instead to prevent swallow failure. Practice seems disrupted due to different approaches to patient needs	Conflict between practice and patients' needs	Because of her hemiparesis, Eve uses a sip cup (with a spouted lid) to drink without assistance. Despite her asking for a sip cup in the geriatric ward, the nurse arrives with a regular drinking glass. The nurse explains that drinking from a sip cup can contribute to swallowing failure, increasing the risk of pneumonia. As a compromise, the nurse gives Eve a straw. However, this is also impossible for Eve to use	The end justifies the means: 'I know what is best for you'
Lisa was admitted after several days of severe vomiting and diarrhoea. She had not eaten or drunk sufficiently for days. Two small juice boxes were placed beside her, but she was unable to drink because of the straight straw. She was not offered lunch either	I wonder what role basic care has in Lisa's CCT and if basic motivation to eat and drink and better preconditions (appropriate straw) would have benefited Lisa's CCT	Basic care needs	I ask if she would like something to drink. She says, 'Yes, but the apple juice is empty, and I don't like orange juice'. When I lift the apple juice, I realise that it is half full, but given the straight straw, it is impossible for Lisa to drink, giving the impression that it is empty. After locating a bendable straw, Lisa can drink by herself. Because Lisa had not eaten lunch and it was past noon, I asked her if she had ordered anything. 'No', she says, 'I don't feel like eating anything'. 'Well, what about a small soup then', I suggest. 'Well, I think I can eat that', Lisa replies	Basic needs of care overruled by system effectiveness
There are different perceptions about Eli's condition and the most appropriate treatment. The physicians argue about whether or not he is a cardiac patient	Organisational structures and power clashes between professions and entities affect care planning in CCTs	Care coordination across settings	Later, the nurse calls the medical department to arrange Eli's transfer to continue treatment for heart failure. The nurse at the medical department tells the ED nurse that she will try to arrange a 'trade' by moving one patient from the cardiology department to the medical department so that Eli can be transferred directly to the cardiology department. After hanging up the phone, the nurse turns to me and says, 'Well, now my patient is involved as a bargaining chip to receive the best treatment'	Treatment as a bargain

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Gordon is admitted by his GP for a thorough investigation after fall episodes in the home and a general decline in function. The GP is familiar with Gordon's use of alcohol	People who are unable to properly convey information are challenging for care coordination; the responsibility unintentionally misplaced onto the patient	Care is distorted by the patient's perspectives	During Gordon's hospital stay, he is examined by several physicians to find an explanation for his fall episodes. Each time Gordon is approached by a medical professional, he has an alternative explanation, reveals a new site of pain or raises an additional problem. This results in every physician having a new treatment focus for treatment	Healthcare professionals as solo detectives

Note: The content of the table is adapted from Paper II (93). CCT: clinical care trajectory; GP: general practitioner.

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4.2.6.3 Study III: Focus groups

The analysis in Study III drew on Revsbæk and Tanggaard's (84) abductive listening of interview recordings. Revsbæk and Tanggaard were inspired by George Herbert Mead's (1863–1931) thoughts on data analysis, that lived experiences can be relived and recalled in new ways and in new contexts (84). In other words, when one listens to or views recorded material, one can draw on the experiences and impressions from the exact interviews rather than relying merely on data such as written transcripts. I viewed the focus group video recordings abductively multiple times while writing notes and memos (106). The notes and memos were confined as empirical descriptions, which were discussed among the authors. The discussion resulted in creation of two categories, 'familiarity and relations across professions', and 'reduced care practices' (95). Participants (n=4) from both focus groups, who represented different sectors and professions, were invited to read and comment on the manuscript draft in which the preliminary results were reported. Eventually, all authors reached agreement about the final themes presented in Paper III (95).

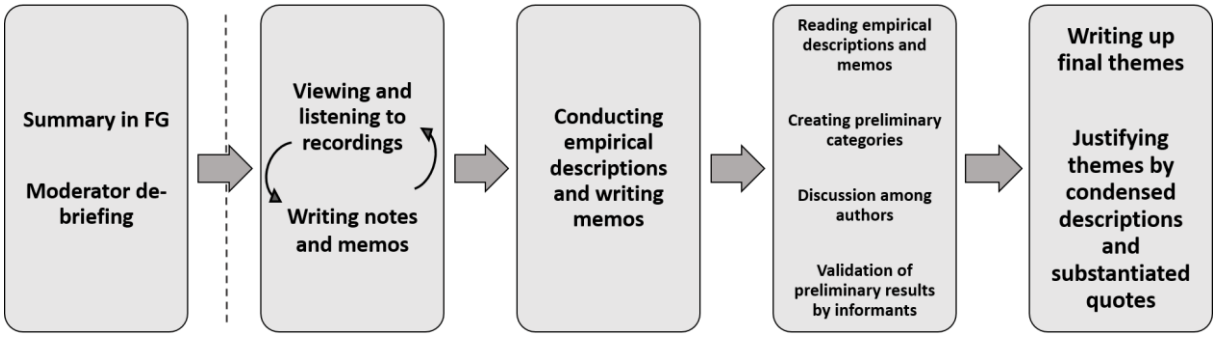

Figure 7: Study III: Analytical approach (95). Note: Adapted from Paper III (95). The analytical process was conducted iteratively. The dashed line illustrate that it can be argued, that the analysis process began already during the focus groups.

Table 6 provides examples of the analytical process.

Table 6: Study III: Examples of the analytical process

Empirical note	Memo	Preliminary category	Final theme	Substantiated quote
A municipal assessment nurse notes that Anna's case reminds her that distance in working relations affects care coordination	Relational aspects facilitate appropriate communication, and vice versa. Confirms findings in Study I	Relations across sectors	Familiarity and relations across professions	Assessment nurse: 'The better you know each other, the easier the communication. The more distance, the more difficult it gets'
Participants discuss that concrete challenges such as pain are easier to address; however, there may be other issues or causes behind them, e.g. loneliness	Focus on obvious symptoms may contribute to less holistic care and more fragmentation in the CCTs	Context and holistic view	Reduced care practices	GP: 'We react to pain, but there might be completely different issues behind that'

Note: Content refer to Paper III (95). CCT: clinical care trajectory; GP: general practitioner.

4.2.6.3.1 Participants' validation of results

User participation in research has increased in recent decades (124). This brings both advantages and disadvantages, and its conceptualisation is unclear (125). In this project, research participants were actively involved in the research committee, as previously described. In Study III, I took user involvement a step further by having four focus group participants from different professions and sectors validate the preliminary results. The participants were given the manuscript draft and asked to focus primarily on the results section but were invited to read and comment on the entire draft if desired. To accommodate their contributions, it was stressed that the manuscript was a draft only. Further, the participants were asked to consider whether the results reflected their perceptions of the focus group content and everyday clinical practices.

Involving the participants contributed positively to Study III because they confirmed the findings and their relevance to the clinical setting. Despite the risk of recall bias given the period between the focus groups and manuscript reading, all participants verified the

manuscript content and the reflection of their daily practice experiences. One participant was challenged by the English language in the manuscript. However, the validation process helped to pinpoint phrases in the draft that needed clarification to improve its readability for less academic populations.

The manuscript was revised based on the participants' contributions, but the final themes were retained because they were accepted by the participants.

4.3 Ethical Considerations

4.3.1 Formal approvals and data storage

This thesis follows the Danish code of conduct for research integrity (126). In accordance with the Declaration of Helsinki (127), written informed consent was obtained from the participants. All patients received information in writing. However, for observations, when it was impractical to provide written information to the HCPs (for example, if I was with a patient and a physician entered the room during the ward rounds), I provided oral information to seek approval for my presence (see Appendices VI and IX–XII for details on written information[15] and consent). All participants were informed about their rights to withdraw from the study at any time.

The studies were evaluated by the Regional Committees on Health Research Ethics for Southern Denmark, which certified that they were not notifiable to the committee (S-20172000-135) (see Appendix I). They were also registered by the Danish Data Protection Agency (17/31221) (see Appendix II). Further, the studies were evaluated by the Committee of Multipractice Studies in General Practice, which recommended the participation of GPs (25-2017) (see Appendix III). The Odense Patient Data Explorative Network

[15] All participants received a printed version of the project information pamphlet, which can be found in an updated electronic version here: http://www.sygehussonderjylland.dk/wm499408.

(www.sdu.dk/ki/open), a research unit at the University of Southern Denmark, supported the studies and provided a safe electronic environment for data storage according to data protection regulations.

4.3.2 Practising ethics

Ethical considerations are required when conducting social science research (128) because researchers may observe and document behaviours that were not intended to be seen (129). Special attention must be paid when researching vulnerable populations (101) such as older people who are hospitalised (130, 131). In this study, ethical considerations included whether my presence would breach patient privacy or cause increased physical or mental distress (101), which I made an effort to prevent. My use of my advisor Prof. Mogensen as an intermediary may have led to unintended coercion for both patients and HCPs given his position. Thus, CCTs in which my advisor was directly involved as a HCP were excluded, and his engagement as an intermediary was kept to a minimum. Nevertheless, he contributed to the legitimacy of the studies (e.g. when contacting GPs for Study III).

In healthcare research, special attention must be paid to confidentiality (132). It is important to be aware of the relationship between the researcher and the participants (129). Although my level of participation was interchangeable, I was constantly aware of ensuring patient privacy, integrity and acceptance of my participation and presence. While I was acting in the role of researcher, I was also there as a human, and conducting research does not arise from a value-free foundation (128). My ethics were grounded in my background in health care and awareness of ethical codes of conduct, thus were naturally embedded in my research. Any moral and ethical dilemmas, particularly those that arose during my observations for Study II, were addressed through critical reflection. For instance, in situations where either a HCP (e.g. Trudy, Paper II), a patient (e.g. Lisa, Paper II) (93) or a relative needed help, my level of participation shifted.

Chapter 5: Theoretical Approach

'Experience never simply speaks for itself. The language that we bring to it determines its meaning'.

—Henry A. Giroux (1943) (133)

This chapter presents the applied theoretical approaches, including Jody H. Gittell's RC theory, Pierre Bourdieu's concepts of social capital, field, habitus and practice and Jürgen Habermas's system and lifeworld concepts. The relevant theories were applied eclectically as appropriate, aligning with the abductive approach applied to the studies.

5.1 Relational Coordination

RC theory was founded by Professor Jody Hoffer Gittell from Brandeis University. It was initially applied to the aviation industry, subsequently spreading to other domains such as health care (134, 135). RC theory focuses on the relations between people (e.g. HCPs in this thesis) with the aim of optimising systems and processes and facilitating problem-solving (136). The core components of RC include shared goals and knowledge, mutual respect, timely and frequent communication, and accurate problem-solving focus (134). RC theory posits that respectful relationships characterised by shared goals and mutual knowledge facilitate adequate communications, and vice versa (134). In relation to RC, a focus on HCPs is relevant when aiming to optimise health care (coordination of care). The analysis in Study I revealed themes similar to the terminology used in RC theory. Thus, RC theory was applied to elaborate on the results.

RC has been described as a '*mutually reinforcing process of communicating and relating for the purpose of task integration*' (137). RC is both evidence-based and a measurable tool (RC Survey) which can be applied to small, simple systems (as a small workplace) or larger, more complex systems as big organisations or professional networks (134, 137). However,

RC was not measured in the present studies. A high level of RC may lead to a range of beneficial outcomes, including workforce motivation, service quality and efficiency and client satisfaction (134). Further, given that one of its core values is mutual knowledge between organisations, RC has the potential to facilitate innovation and learning (134, 138).

Gittell's work draws on the underlying ideas and concepts from social capital theory (120, 139), which are rooted in different traditions. RC is related to organisation and management research, while social capital is a sociological concept; however, both are concerned with social interactions and relations (139). Therefore, both theoretical concepts are relevant to this thesis. Perspectives and elements from Bourdieu, applied to Study I, are presented below.

5.2 Pierre Bourdieu's Social Capital and Applied Concepts

Pierre Bourdieu (1930–2002) was born in France and grew up in a working class community (140). As a result of his academic career, he became a well-known and respected sociologist and anthropologist preoccupied with understanding the mechanisms underlying the correlations between structures and actors (subjects) (141). According to Bourdieu, there is a clear connection between the development of theory, the analysis of empirical material and conceptual reflections (141). Bourdieu's concepts are especially relevant when analysing common patterns at the practical level (140), thus are applicable to this thesis.

5.2.1 Social capital

Along with other thinkers, Bourdieu was preoccupied with social capital and related concepts. His concepts of capital and power were inspired by the writings of Karl Marx (1818–1883) (140, 141). However, Bourdieu expanded the definition of capital from merely economic capital, adding three other elements: social capital, cultural capital and symbolic capital (141, 142). This thesis focuses on social capital (e.g. work collaboratives), which

Bourdieu considered the most important type of capital because it contributes to sustaining a society (143). Inspired by Putnam, social capital can be divided into bonding, bridging and linking capital (144). Bonding capital refers to the relationships within a group (e.g. nurses) or an entity (e.g. the primary care sector), bridging capital refers to the social capital between groups and entities, and linking capital refers to the hierarchical aspects of relationships within organisations (e.g. between managers and employees). However, Bourdieu related social capital more to social practices and interactions, making his perspectives particularly relevant to this thesis.

Bourdieu defined social capital as *'the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition'* (145, p251). Social capital may be perceived as reciprocity based (143), meaning that it can be exchanged between agents (e.g. HCPs). According to Bourdieu, the level of social capital depends on the relationships between agents but is also maintained by these relationships in daily practice (e.g. HCPs' coordination practices) (143).

5.2.2 Field

The concept of 'field' refers to the social arenas in which practices unfold. According to Bourdieu, all social arenas consist of different fields with their own sets of rules, values and structures. (127) Bourdieu describes a field as *'both a field of forces, whose necessity is imposed on agents who are engaged in it, and ... a field of struggles within which agents confront each other, with differentiated means and ends according to their position in the structure of the field of forces, thus contributing to conserving and transforming its structure'* (146, p32).

Fields contain various power structures and conflicts between agents. The boundaries of a field are determined by its capital resources and logics and the extent to which these are shared between agents (141). The agents in a field will strive to obtain control, thereby

adapting to the resources and level of capital available within the field. Thus, the boundaries of a field are not static (142).

In relation to this thesis, a field may be a certain sector (e.g. the primary healthcare sector) or workplace (e.g. the ED). However, with respect to logics, it may be argued that a shared professional background (e.g. GPs or nurses) could also be defined as a field, regardless of sectoral borders. Hence, the similarities and differences may vary depending on context.

5.2.3 Habitus

Bourdieu's concept of 'habitus' refers to the tacit, embodied practices and knowledge shaped by individuals' perceptions of and responses to their surroundings, contexts and experiences (142). Bourdieu described habitus as *'a set of principles; socially-constituted dispositions; subconscious schemes of perception; or strategies that produce particular practices'* (142, p10). Our reasons for doing certain things or acting in certain ways, either as individuals or groups, are based on our perceptions of what is most plausible and logical, what Bourdieu refers to as 'practical sense'(142). Thus, habitus is the simultaneous internalisation of objective structures (how we make sense of things) and the externalisation of our responses, practices and reactions to them. Unconscious practices are tacitly embodied and internalised within the individual or group (142). Thus, the concept of habitus is relevant to analysing HCPs' coordination practices.

5.2.4 Practice

Bourdieu distinguished between practical and theoretical logic (141). He described everyday practices as a result of the relationships between fields, habitus and capitals (142, 147). Individual or group practices are based on the perception of what is most plausible and logical, what Bourdieu refers to as 'practical sense' (142). Bourdieu argues that our practices reveal how we perceive the world around us but the practical processes are neither

fully conscious nor fully unconscious (142, 147). At the same time, social actions (e.g. HCPs' care coordination practices) affect the surrounding social structures. Thus, there is a mutual and dialectic connection between social structures (field and social arenas) and social practices (habitus) (142, 147). With respect to the coordination of care, this means that the legitimacy and logics of HCPs' practices depends on various elements, contributing to the formation of what makes most sense to the HCP in the given circumstances.

Aspect of what affect and shape the HCPs' practice can be discussed using the concepts of Jürgen Habermas, presented in the following section.

5.3 Jürgen Habermas and Applied Concepts

Jürgen Habermas (1929–) is a German philosopher and sociologist with numerous publications on philosophical and social theory (31, 148). A full presentation of his works is neither intended nor possible in this thesis. However, this section provides a brief introduction to Habermas and his 'system' and 'lifeworld' concepts, which were applied in Paper II (93).

Fundamentally, Habermas represents the Frankfurt School and critical theory (69). Critical theory relates to both the impact of the dominant politics on reality and the perception of knowledge and cognition (149). According to critical theory, reality may be objective but is continuously contested by competing groups. Knowledge is determined by power relations and structures and co-constructed in the interrelations between people or agents (76). Habermas claims that knowledge cannot be value free, thereby questioning the positivist tradition (150). More specifically, Habermas claims that the perspective from which we view the world is affected by linguistic and intersubjective structures (148, 151). According to Habermas, it is not possible to separate the subject from its social and linguistic context (object) because interpretive actions arise from that context – rather than a reaction against it (31). However, he stresses that society (system) and social life (lifeworld) are based on

different rationales (152) that influence practices and daily interactions (e.g. those between HCPs in a hospital setting).

The themes generated in Study II (93) imply that HCPs' practices are affected from the top down level in an undesirable and inappropriate manner, showing that the culture of health care may be dissonant to the concept of person-centered care. Jürgen Habermas's assumptions about the colonisation of the lifeworld by the system was useful for explaining the results. In relation to this thesis, the system refers to the healthcare system and related structures and boundaries, while the lifeworld concept refer to the perspectives and practices of HCPs.

5.3.1 System colonisation of the lifeworld

According to Habermas, the system, which is dominated by profit and market-based thinking, has unconsciously and continuously colonised our lifeworld and daily practices (HCPs' coordination practice) through the use of suppressive ideologies (80, 122, 123). Systems (including the healthcare system, which HCPs are part of) refer to the economic and administrative structures that operate independently of social norms and are ruled by efficiency, money and power (31). Habermas was opposed to dividing all aspects of social life into measurable systems, which he perceived as a deficit in system logics (152). The term 'lifeworld' refers to the perspectives and views of the individual as well as the social norms, morals and personal identities, where social integration based on communication and reflection is central (31, 152). Within the concept lies both the facilitators and barriers to self-understanding and the understanding of others (31); that is, to understand and be understood (80).

Habermas was preoccupied with the hidden power mechanisms operating within social practices and societal structures (123). Power exists in communication practices and at the

societal and structural levels. Habermas claims that communication patterns and practices are related to interpersonal relations and affected by societal development (123). He further suggests that the key to redressing power imbalances between system and lifeworlds lies in rational dialogue, social action, personal reflections and interpersonal interactions to activate the potential for freedom (30). This may include raising awareness about the influence of power from system structures (123). However, besides being system representatives, the HCPs bring their individual lifeworlds into their practices as well, which is important to take into account.

Chapter 6: Results

Chapter 6 briefly summarises the results of each of the three studies, then presents a synthesis of the overall results. Details and examples of analyses were presented in the previous chapter 4.

6.1 Study I: Summary of Findings

Study I aimed at analysing the HCPs' perspectives on the intersectoral care coordination of acutely hospitalised older people. This was based on the assumption that HCPs, being on the frontline of healthcare coordination, would be well suited to contribute their knowledge and perspectives on key issues to improve care coordination across sectors. The analysis resulted in four themes essential for the intersectoral coordination of care in older people's CCTs: organisational factors, approaches to care, communication and knowledge, and relationships (92).

The analysis generated insights into the complexity of the barriers and facilitators of healthcare coordination across different sectors and professions. The challenges represented by the themes and subthemes are complexly interrelated and occur at multiple levels, both vertically (i.e. structurally), and horizontally (i.e. across professions or organisations). Paper I (92) further claims, that top-down structural changes to improve efficiency, such as the reallocation of tasks and responsibilities away from the municipalities as seen in the Healthcare reform (17), have inhibited relationships and familiarity between sectors. Despite the ambitious efforts to create more seamless collaboration across sectors, gaps in care coordination persist, partially because of the continual increases in specialisation. A better balance between standardisation and flexibility is needed in the coordination and collaboration of intersectoral CCTs, but seems difficult given the current organisation of healthcare (92).

The themes and corresponding subthemes are presented in Table 7.

Table 7: Study I: Themes and subthemes

Theme	Subthemes
Organisational factors	Structure and box thinking Time and resources Responsibility Patient complexity Task coordination
Approaches to care	Us v. them Holistic v. quick fix Patient at the centre Defensive medicine
Communication and knowledge	Access to information Shared insights Competencies Continuity Rhetoric
Relations	Respect Trust Power span between professions Relatives and networks

Note: Adapted from Paper I (92).

The first theme, 'organisational factors', refers to the sometimes conflicting regulations, policies and procedures between healthcare providers, settings or sectors, inhibiting care coordination. These factors are particularly pertinent in a complex CCT such as when an older person is suffering from multiple morbidities and requires treatment from a range of providers (92).

The second theme, 'approaches to care', refers to the perspectives of different sectors and professions. In general, HCPs in the primary care setting, including GPs, were focused on more holistic, long-term care. In comparison, hospital HCPs were more oriented towards identifying the specific cause of hospitalisation and providing a quick fix (the 'one

cause, one treatment' approach) with the intention of minimising hospital stay and reducing the risk of functional decline. These different approaches may arise from fundamental differences in the daily practices and core tasks of the primary care sector (which focuses more on prevention) and the hospital (which focuses more on specialisation such as critical care). These different perspectives are reflected in the daily work processes and create an 'us and them' scenario, leading to further gaps in collaboration and coordination between sectors (92).

The most frequently mentioned concerns of the HCPs interviewed in Study I were related to the third and fourth themes, 'relations' (e.g. trust and respect) and 'communication and knowledge' (e.g. shared insights across professions and sectors, and positive rhetoric), respectively. The different workplace cultures and approaches to care coordination across sectors, professions and entities may lead to fragmentation of the CCTs. Each unit, whether it is a sector, a profession, or an entity, is likely to operate based on its own logic and predetermined procedures and tasks, inhibiting the formulation or achievement of mutual goals as RC theory claims as essential for care coordination. Figure 8 is based on the analysis in Study I and illustrates the complex interrelations of the identified themes and the dynamics of care coordination across and within health sectors (92).

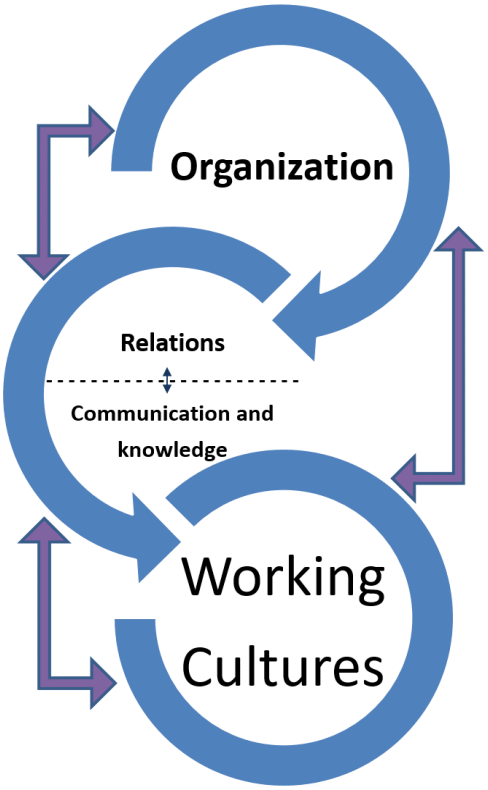

Figure 8: The dynamics of collaboration and care coordination.

Note: Adapted from Paper (92) .

6.2 Study II: Summary of Findings

The objective of Study II was to assess how the interactions and practices of HCPs influence the CCTs of acutely hospitalised older people. The observations of seven older people's CCTs showed that system and NPM logics lead to HCP practices being less person-centered and more fragmented than intended. Four themes emerged from the analysis: the end justifies the means, basic care needs are overruled by system effectiveness, treatment as a bargain, and HCPs as solo detectives (93).

The first theme, 'the end justifies the means', refers to HCP practices neglecting the individuals' needs and wishes, which can negatively affect the CCT, even if the HCPs have the best intentions (see Paper II, Trajectories 1 and 4–6, for empirical examples) (93). The

second theme, 'basic care needs overruled by system effectiveness', refers to the high workflows and organisational demands for efficiency and quality measures, which can overrule the basic care needs of older people. This may be caused by the need to prioritise resources tightly, leading to inappropriate care in CCTs (see Paper II, Trajectories 1, 2 and 5, for empirical examples) (93). The third theme, 'treatment as a bargain', relates to the activities or practices that may be linked to bargaining (marketization logic and rhetoric) rather than focusing on benefiting the older person (see Paper II, Trajectories 1 and 2, for empirical examples) (93). The fourth theme, 'HCPs as solo detectives' implies that healthcare practices are often characterised by monodisciplinary approaches, even though the treatment and care of older people may require input from various specialties and competencies. Thus, CCTs may be characterised by disrupted coordination or ambiguous care planning, placing unreasonable responsibility onto older people to accurately convey information (see Paper II, Trajectories 3 and 4, for empirical examples) (93).

In terms of Habermas's system colonisation of lifeworlds (122, 123), the lifeworlds (referring to the practices and work culture of HCPs) are continuously and increasingly being colonised by, for example, the NPM system, which focuses on operational efficiency and marketing and is dissonant to the person-centered care approach (93). Thus, Study II supports the findings of Study I (92) that HCP practices and work cultures are affected by structural and organisational factors.

6.3 Study III: Summary of Findings

The aim of Study III was to analyse the perspectives of HCPs across health sectors and professions on the challenges and facilitators of the coordination of older people's CCTs. Two themes emerged from the focus group data analysis: familiarity and relationships between sectors, and reduced care practices (95).

Familiarity and relations between health sectors and professions appeared to be lacking. Different perspectives and approaches to care may result in misunderstandings or divergent goals. The restructuring of healthcare organisations and the introduction of NPM were aimed at increased efficiency and specialisation, with healthcare practices being based on checklists. The investigation showed that little room remains for flexibility and person-centered approaches, and there is a risk of superficial and industrial care practices (reduced care practices) (95). Thus, Study III supports the findings of Study I (92) on the challenges arising from the different approaches to care coordination and perceptions of core tasks between sectors as a result of organisational factors, limiting familiarity and relationships between sectors and professions.

Further, Study III supports the findings in Study II (93) on the reduced emphasis on adequate communication and human values (e.g. empathy and compassion, which cannot be measured by checklists) and holistic care (i.e. focusing on the person as a whole and long-term care rather than a single issue). Study III contributes new knowledge about the potential bottlenecks in older people's CCTs and how they may be addressed. Finally, the participants provided rich insights into the practices and needs of collaborative HCPs across sectors aiming at mutual goals for the care coordination (95).

Based on the data analysis, we generated a hypothesis that the current healthcare structures and boundaries of HCPs's practices inhibit relationships and familiarity across sectors, further contributing to gaps and fragmentations in care coordination. In reverse, weak relations are a barrier to seamless care coordination (95).

Figure 9 illustrates the processual dynamic stated in our hypothesis.

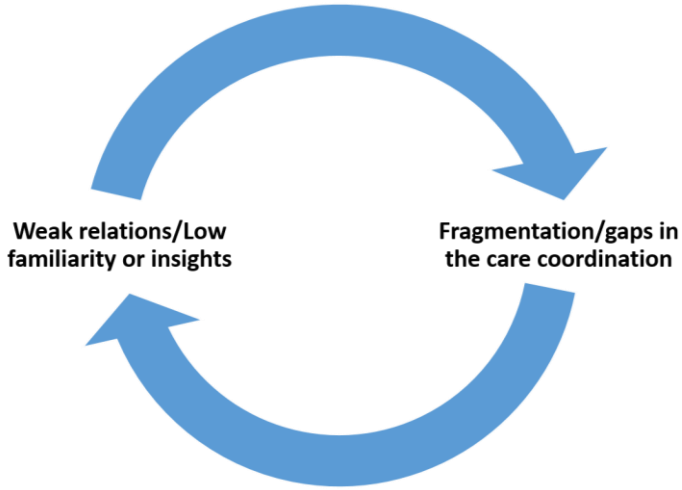

Figure 9: Study III: Illustration of hypothesis.

Note: Adapted from Paper III (95).

6.4 Synthesis of Results

In summary, the coordination of older people's CCTs across sectors is complex and is affected by multiple levels, including the structural, organisational, professional and interpersonal levels. Thus, care coordination should be addressed accordingly involving all of these levels.

The findings are briefly summarised in Figure 10 below.

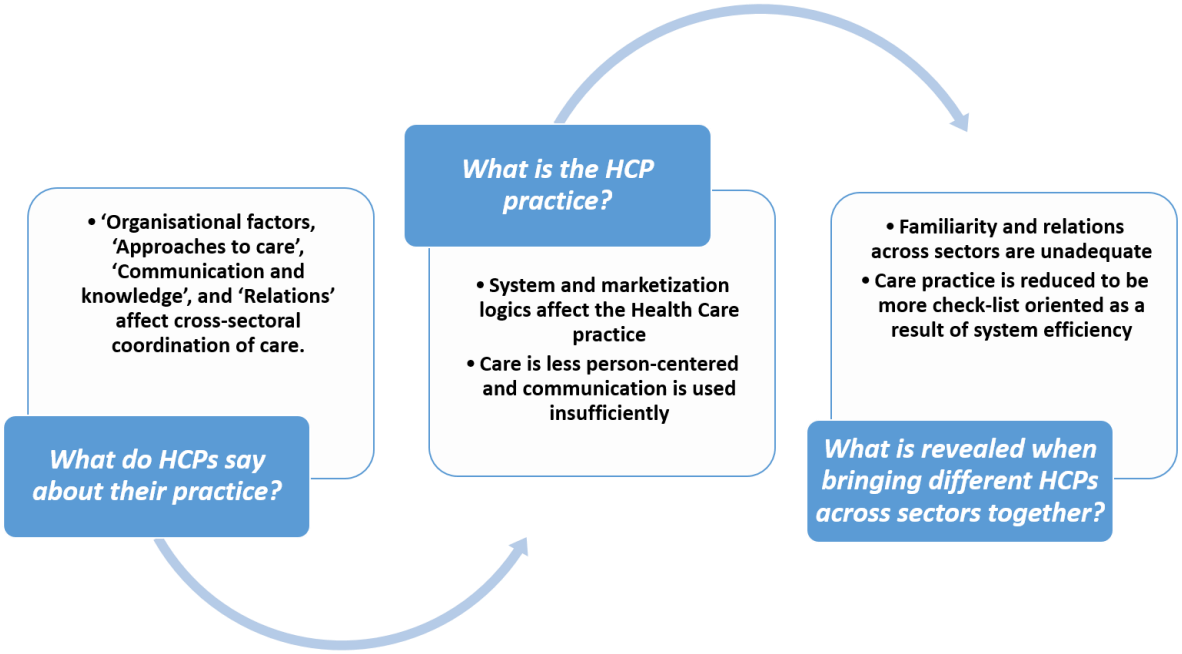

Figure 10: Overall research process.

The following chapter discusses the results from the three studies presented in this thesis and puts them in context of other studies and theoretical perspectives.

Chapter 7: Discussion

The key findings of this thesis indicate that the practices and interactions of HCPs in the coordination of care between sectors are complex, especially in older people's CCTs. Care appears to be automated, and practices are often based on checklists and quantifiable measures rather than being flexible and meeting individual patients' needs. Because perspectives and work cultures tend to differ between sectors, defining mutual core tasks and goals is challenging. Optimising system efficiency based on NPM principles inhibits relationships and familiarity between sectors. This thesis shows that relationships built on mutual trust and respect and appropriate communication are critical to care coordination. According to RC theory, appropriate communication refers to timely, accurate, frequent and problem-solving communication – elements that this thesis finds lacking. This thesis further suggests that the ability to attain and sustain relationships and familiarity and shared goals for care – in which adequate communication is central - is inhibited by organisational constraints and demands.

The barriers to care coordination should be addressed at multiple levels including the structural, organisational, interpersonal and professional levels. These levels are inextricably linked, which must be acknowledged to accommodate the complexity within care coordination and unpredictability of acute and critical CCTs across sectors.

7.1 Care Coordination in a Complex Adaptive System

As demonstrated in this thesis, care coordination is complex and inextricably linked to the structure and organisation of the healthcare system, which may be considered a CAS. Central to CAS theory is that individual elements are interconnected, meaning that a change in one element causes changes elsewhere, sometimes in unexpected or unpredictable ways (63). For example, when inadequate information is conveyed between sectors or actors, it

inhibits the coherency of the CCT and leads to a potential chain of errors that could have been prevented. A single error may not be crucial, but a series of even small errors may have severe consequences. Therefore, relevant and efficient intersectoral coordination is of utmost importance.

When CAS theory is applied to care coordination, CCTs are perceived as less linear and more uncertain or unpredictable. Initiatives or interventions to improve care coordination should be addressed likewise, making CAS theory relevant and appropriate. However, approaches based on CAS theory may conflict with dominant neoliberal ideologies such as NPM, which are often based on standardisation and reduce processes to linear chains in which each link can be measured and optimised for the sake of efficient resource utilisation. Thus, NPM does not sufficiently take complexity into account.

NPM generally builds on two ideas: (i) that public organisations are hierarchical and (ii) that the market is the dominant regulating factor (60). An example of the implementation of NPM strategies and marketisation in Denmark is that since 2002, the municipalities have been obliged to offer citizens who are eligible for home care the option of receiving private services as an alternative to public services. These new strategies have contributed to the marketisation of the public sector, implying that patients and older people receiving home care may be equated to consumers (153, 154). The aim of NPM is to emphasise service quality and increase consumer power, which may fundamentally be perceived as positive and aligned with the 'customer is always right' approach. Nevertheless, the dominant regulatory focus embedded in organisational NPM strategies is often inappropriate for healthcare services because it influences the values, work cultures and practices of HCPs. In the interest of human values and the desired person-centered approach, it is problematic to equate care to a negotiable product. Given that human health or illness and recovery or death are central elements of health care, the application of market logic and standardisation may be conflicting. Thus, the top-down regulatory approach used in NPM may result in the coordination of older people's CCTs becoming excessively automated and fragmented.

7.2 Clinical Care Pathways

Clinical care pathways are a method of improving care coordination in line with standardised procedures and case management. The concept was introduced in the United States (US) in the 1980s but is rooted in industry (32). The rationale behind clinical care pathways is to improve the quality of service delivery, increase the satisfaction of clients (patients and relatives) and optimise resource utilisation (33). A care pathway has been defined as *'a complex intervention for the mutual decision making and organization of predictable care for a well-defined group of patients during a well-defined period'* (32, p118).

Care pathways are interdisciplinary and are used to standardise and evaluate patient-focused care processes. When introducing a care pathway, it is essential to consider how predictable the care process is and to what extent the team members agree upon the goal. There are different care pathway models (e.g. chain, hub, and web models) depending on the level of agreement and predictability of the process (32).

When care pathways were initially introduced, although they were claimed to be a patient-centered tool, in reality they were used to streamline HCP practices (155) in line with the NPM rationale. Subsequently, care pathways acknowledged the complexity of care, enhanced patient-centeredness and stressed the importance of involving relatives (32). Vanhaecht et al. (156) suggest that interviewing patients or observing clinicians may contribute beneficial knowledge to developing appropriate care pathways. This thesis embraces this suggestion and highlights the importance of addressing care coordination interventions at multiple levels, including the structural, organisational, professional and interpersonal levels, from different perspectives. This thesis does not provide a specific care pathway framework, but the results may inspire the development of future intersectoral care pathways. However, it is essential to take context and different population characteristics into account for tailored solutions (32, 156).

7.3 Person-Centered Care and Different Perspectives

It is widely acknowledged that patient involvement contributes to the quality and safety of care (35). Shared decision-making and other processes have been introduced to support patient involvement (29). Shared decision-making refers to collaboration between the clinical expert (the HCP) and the patient as the expert of their own life, contributing to mutual and well-founded decisions about care and treatment plans that are based on both professional, scientific knowledge and the individual's preferences and needs (157, 158). Although the framing of shared decision-making is partially standardised and includes systematic tools, the approach may be a way of increasing person-centered care, supporting value-based communication practices and being more explicit about patient engagement in their own treatment.

As mentioned above, information and communication are essential in supporting the participation and involvement of patients and to prevent merely symbolic involvement. Unfortunately, paternalistic approaches tend to be used rather than conveying adequate information (27). Communication should be used not only to convey information but also to invite patient involvement and facilitate a partnership between HCPs, patients and relatives. In this way, inappropriate practices such as those that focus more on standardisation and efficiency rather than on patient needs may be eliminated in favour of a more person-centered approach. While the partnership approach is often embedded in the mission statements of organisations and the intentions of HCPs, this does not necessarily equate to successful holistic and person-centered care in practice (2, 27, 29). Thus, initiatives to support the integration and realisation of person-centered care in practice need to be established.

This findings in this thesis support the need for adequate communication, not only between HCPs and patients but also between HCPs from different sectors (92, 93, 95). The findings of the three studies presented in this thesis imply that the different perspectives, knowledge

and work cultures between different HCPs and healthcare sectors complicate communications (92, 93, 95). The hospital sector appears to be oriented more towards acute conditions, in contrast to the primary care sector, which tends to approach care from a broader and more holistic perspective, complicating the formulation of shared goals and core tasks (92, 95). This also aligns with previous findings that sectors may share a vision of holistic and long-term care but differ in terms of practice because of different organisational boundaries and conditions, and predetermined procedures (2). Therefore, understanding healthcare practices and workplace cultures and ensuring greater involvement from the bottom-up direction, including HCPs, patients, relatives and other relevant stakeholders, is warranted.

7.4 Conflicting Logics and Professional Identities

The different logics with respect to standardisation on the one hand and individual needs and flexible care solutions on the other are contradictory (154). The increasing demand for NPM approaches and increasing specialisation have modified HCPs' identities and roles (23, 25). The term 'hybrid professions' (159) was introduced and refers to the different logics (both professional and managerial) within which HCPs must operate in a rapidly interchangeable way depending on the context or situation (160). This can leave HCPs facing dilemmas in their daily care coordination practices (160, 161), potentially conflicting with their professional identities built on human values such as empathy and compassion. However, HCPs' abilities to shift between or adapt to different logics is necessary for problem-solving and delivery of high-quality health care in an – at times – unpredictable setting (aligning with CAS theory).

7.4.1 Interprofessional collaboration

Interactions and collaborations between HCPs may be considered a universal means of addressing healthcare and care coordination challenges, including the achievement of person-centeredness, system optimisation and problem-solving (24). However, various definitions for interprofessionalism exist, including interdisciplinary and cross-disciplinary collaboration (24, 162-165).

WHO describes, that a *'collaborative practice happens, when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care. It allows health workers to engage any individual whose skills can help achieve local health goals'* (166, p7). Thus, the WHO provides a broad perspective on what constitutes interprofessional practice, highlighting the complexity of care coordination.

Nevertheless, it is important to be aware of one's professional scope, strengths and limitations to know how and when to collaborate interprofessionally (167). If one's own role is not clear, it is difficult to be aware of the roles and competencies of others. However, there must be a balance between rigidity and flexibility in one's professional role to eliminate gaps in the CCT, which align the findings in study I (92). An adaptive and flexible approach is often needed to achieve efficient and seamless care coordination; however, being a hybrid professional can cause dilemmas for HCPs. Thus, it may be argued that interprofessionalism and a collaborative practice culture is not only a matter of relaxing professional boundaries but also a question of explicitly raising awareness about individual professionalism (167). In this way, it may be possible to distinguish interprofessionalism from parallel practice to better utilise professional competencies and interprofessional collaboration in problem-solving and care coordination (168). It is important to note that acting as a solo professional, hybrid professional, multi-professional (parallel practice) or interprofessional is interchangeable, depending on context. None of these profiles represent the ultimate universal goal, but awareness of the role one plays in

certain situations is crucial for collaboration and coordination of care. Sometimes, a CCT depends on a single specialised HCP's evaluation or treatment, whereas in other situations the outcome of a trajectory depends on multiple professionals contributing their unique perspectives to care planning.

7.4.2 Relational coordination of clinical care trajectories

HCPs' interactions and practices have been the subject of this thesis to suggest strategies to improve care coordination. According to Gittell, empathic connections are important in sustaining a relational society and coordination of care across sectors and professions.[16] RC theory claims that interpersonal relations and interactions, including communication practices, affect the quality and delivery of healthcare services (134). According to RC theory, care coordination across professions and sectors depends on empathic relationships built on mutual trust and respect (118, 119, 134), similar to the findings of Study I (92). As highlighted in the previous section about person-centered care, adequate and appropriate communication is essential for RC. Improving RC may contribute to more seamless CCTs of better quality due to a result of fewer delays and errors (134) (similar to the intension behind introducing NPM).

Although RC has been applied to various healthcare settings, it originated in the US aviation industry. Thus, it has been debated whether it is fully applicable to health care elsewhere (e.g. universal healthcare in Denmark) and whether it adequately acknowledges the complexity of humans and health care (24). Further, it has been stressed that RC fails to account for the power structures within healthcare organisations that challenge interprofessional practice (24) as addressed in Paper II (93). Although NPM has been introduced in Denmark, the Danish public healthcare sector is predominantly based on

[16] In a newsletter from the Relational Coordination Research Collaboration sent by email in October 2020, Gittell states that *'the relational society is based on human empathetic connections across difference at the micro level, coordinated collective action at the meso level, and coalitions for policy change at the macro level'.*

universal health care, in contrast to the US public sector (The setting where RC arose), which is dominated more by marketisation and privatisation. Therefore, given its lack of focus on the differences in contextual power structures, RC may not be an adequate solution to existing coordination challenges in the Danish context. However, it may be used to highlight the importance of relationships and familiarity across sectors and between HCPs which are lacking due to the siloed nature of the healthcare organisation.

7.5 Application of Habermas to the Findings

As suggested above, RC may not adequately consider the full effect of power structures, an issue that preoccupies Habermas. Habermas claims that economic and political systems (108,141) subconsciously affect the practices and perspectives of individuals in suppressive manner, which he refers to as the system colonisation of lifeworlds (122, 169). With respect to this thesis, this infers that HCP practices are colonised by system structures such as governance, organisational barriers and regulation of predetermined procedures. According to Habermas, the dominant logic and domains of the system, in which NPM is embedded, may explain HCPs' practices becoming more automated, with a focus on superficial checklists rather than on person-centered and holistic care that acknowledges individual needs as found in Study II (93). A similar practice culture dominated by checklist-approaches is referred to as the 'audit society' (170).

Reduced care, represented in the findings of study III (95), may be the result of time constraints (47, 171), which also relate to structural barriers and organisational resources. It has further been shown, that a reduced care practice can occur due to a mis-integration of humanistic values, such as empathy and compassion, within the care practice (172). Inadequate care practices may arise from the poor socialisation of HCPs during their education or job orientation, the demand for resource efficiency or the organisational work culture. Thus, the dominant power structures in terms of resources, demands,

organisational boundaries and educational programs play an important role in HCP practices.

Given that the influence of powerholders (system) often plays out on a subconscious level, as claimed by Habermas, it is important to raise awareness about the system's effects on healthcare practices. According to Habermas, one way of doing this is through dialogue (122, 123). Communication should be as power neutral as possible to enable different perspectives to come through and facilitate mutual understanding (122, 169). Thus, communication skills, which are similarly important in RC, are essential for person-centered care and care coordination. This pertains to communication not only between HCPs but also between HCPs and patients (and their relatives if relevant). Such dialogue may shed light on where and how healthcare practices have become distorted or colonised. Further, it may lead to a better understanding of patients' needs (their lifeworlds), contributing to more person-centered care. However, Habermas has been criticised for being overly focused on communication and less focused on the effect of surrounding, cultural values (31). Further, it has been argued that Habermas is too dualistic in his distinction between lifeworlds and systems and too laborious in his perception of the impact of the system (148). Therefore, it is important to note that neoliberal ideologies such as NPM are not the only explanation for coordination challenges and inappropriate care practices. Interactions at the meso level between HCPs are also important, although these may be affected by the system as well.

7.6 Healthcare Practices: Sense-Making Through Bourdieu

Bourdieu's theoretical concepts were applied as the framework in Study I (92) to elaborate on the findings on HCPs' perspectives of care coordination practices. Bourdieu argues that social practices (in this case, HCPs' collaboration and coordination practices) are both a process and a product that unfold interchangeably at both a conscious and an unconscious level (142, 173). Practices are affected at the interpersonal level as well as by the surrounding

structures (142), including organisational boundaries and workplace cultures, supporting the argument in this thesis that care coordination is complex (92, 93, 95). According to Bourdieu, the key to changing practice (e.g. in care coordination) is first-hand experience and embodied knowledge because practices arise from habitus, a component of our experiences and partially subconscious knowledge (173). A change in workplace culture, including that in the healthcare setting, cannot occur overnight—it requires a comprehensive effort, and management plays a central role in creating a social space and work culture (70). Therefore, first-hand experience and shared knowledge of workplaces and procedures across sectors is crucial for adequate collaboration and coordination practice as it would improve the understanding of each other's contexts.

Therefore, Habermas and Bourdieu agree that a change in practice (e.g. care coordination and collaboration) is facilitated by a change in perspective (Shared insights). However, Habermas stresses the importance of communication and the influence of the system, while Bourdieu is more preoccupied with embodied experience and knowledge to reshape HCP practices. Thus, they have different ideas about the origins of change—Habermas (123) describes change in the communicative interactions between people, while Bourdieu (142) describes change as an internal process (i.e. embodied knowledge), although it is partially affected by the social space and arenas. This thesis argues that both communication and first-hand experience are important to broaden HCPs' perspectives and increase the possibility of mutual understanding and goals to improve intersectoral care coordination (92, 93, 95).

7.7 A Combination of Standardisation and Flexibility

Increasing treatment complexity and new ways of collaborating and coordinating care in the healthcare system necessitate a new era in healthcare organisation and planning, education and competencies. No single, fixed or linear solution will solve the challenges of

care coordination. Instead, an adjustable balance between standardisation and flexibility is required (174), while taking the individual into account. Standardisation serves to support the quality and delivery of equal and highly professional care (at the national and international level). Standardisation is necessary to some extent because it can ensure equitable resource utilisation. However, excessive regulations, economic incentives (e.g. municipalities partially financing hospital treatments) and the checklist approach revealed in this thesis (92, 93, 95) potentially conflict with the coordination of care and person-centeredness. Nevertheless, person-centered care is here to stay and should continue to be prioritised in the future to improve the quality of healthcare services.

The increasing focus on involvement at the practical and community level (i.e. patients, relatives and HCPs) and bottom-up solutions may be described as the 'new power' paradigm, which is characterised by informal governance, self-organisation, the maker culture and greater participation. In contrast, 'old power' is characterised by managerialism, expertise and specialisation, patronage, less participation and power as a finite resource (175).

A successful initiative that emphasises the needs of the individual in health care is the Buurtzorg model, which has been developed by a private, non-profit supplier of integrated health care in the Netherlands (176). The Buurtzorg model is an approach to care based on an onion, with the inner layer being the self-managing patient, the middle layers being their informal networks (e.g. relatives and friends) and the Buurtzorg team (a self-managing team of HCPs) and the outer layer being the formal networks (HCPs already known to the patient). Experiences of the Buurtzorg model show that self-management is a means of improving healthcare services (176), thus care coordination. It has been argued, that improving care coordination require structural changes that allow more room for HCPs to self-manage their practices, rather than a cultural revolution (177). This align the self-organisation in CAS theory (63). However, the findings of this thesis show that the structure of healthcare organisations affects workplace culture and practices, and vice versa (92, 93,

95). Thus, a combination of interventions at multiple levels (structural, organisational, professional and interpersonal) is required for more sustainable solutions for care coordination across sectors and professions. Meanwhile, it is important to acknowledge the potential dilemmas and conflicts associated with change. Standardised procedures and checklists may be convenient because they serve as a framework supporting professional practice and identity and protect against potential errors (i.e. defensive medicine as found in Study I (92) and III (95)). Further, standardisation contributes to the vision of equal health care for all, regardless of context, time and place, even though the vision does not always fit the reality of practice. However, these regulatory regimes limit the room for flexibility within HCP practices to accommodate individualised and person-centered care. Thus, there will be advantages and disadvantages, as well as ambiguity and dilemmas, arising from any change in coordination practices. Therefore, the 'one size does not fit all' approach is more relevant than ever with respect to healthcare organisation and planning of CCTs and HCPs' practices.

7.8 Methodological Reflections, Strengths and Weaknesses

The research presented in this thesis benefits from several strengths. The project was aimed at generating useful knowledge for the future improvement of care coordination. Applying a qualitative approach using a range of methods enabled an in-depth analysis of HCPs' practice and perspectives and gave them a voice. This is critical for future initiatives to improve the intersectoral coordination of care because meaningful solutions are provided from the bottom up (Aligning the 'new power paradigm'). For myself as the researcher, it was empowering to conduct research at the hands-on, practical level, which was relevant for the HCPs and thereby facilitated the motivation and engagement of them. As the HCP participants were engaged in and actively contributed across sectors, professions and functions, they contributed to a more nuanced picture of care coordination challenges.

7.8.1 Study rigour

Throughout the research process, I strived to be as transparent and systematic as possible. To ensure transparency, I thoroughly described the analytical approaches used. Four criteria—credibility, authenticity, integrity and criticality (178)—were implemented to support the validity of the studies. Credibility was enhanced by involving all co-authors in the interpretation of results. Authenticity was enhanced by including a range of HCPs and sectors to create a balance between descriptions, interpretations and analysis (179). Integrity was enhanced by being aware of my preconceptions (to eliminate the risk of biased interpretations) and explicitly expressing the role of the moderators. Criticality was addressed by providing examples of descriptions, substantiated quotations and demonstrating the analysis procedures in tables and figures. Further, validity was improved through member checking (180) (i.e. inviting participants to validate the preliminary results in Study III (95)) and concluding the focus groups by summarising the discussions in line with the abductive approach.

In qualitative research, the topics of legitimacy, transferability and external validity have long been debated (181). According to Kvale and Brinkmann (98), the generalisation of qualitative studies can be divided into three domains: statistical generalisation (random sample selection), naturalistic generalisation (analysis of experiences and tacit knowledge) and analytical generalisation (transparency of methods and contextual descriptions). The analysis of HCPs' experiences and tacit knowledge contributes to naturalistic generalisation, while the thorough, systematic and transparent procedures in the empirical analysis contributes to analytical generalisation.

Context is always unique. However, Gadamer (182) claims that there may be some universality in the particular. Thus, the transferability of results from this research to other contexts is encumbered with some uncertainty. However, the challenges embedded in intersectoral coordination and interprofessional collaboration are somewhat generic and

may be found in other, similar healthcare systems. Therefore, this thesis contributes useful and current perspectives to the debate on the intersectoral coordination of care.

7.8.2 A piece of the puzzle

By exploring the perspectives of HCPs, this thesis makes an independent contribution to the overall collaborative project 'At the FOREFRONT of older people's care'. Both the independent studies and the overall collaborative project involved user participation and member checking in various ways, helping to validate and strengthen the findings. User involvement in the umbrella project included the participation of patients and relatives in the regular meetings of the research steering group, eliciting valuable perspectives that contributed to the preliminary findings and implications and benefited the research overall.

Being part of a collaborative project has been both beneficial and challenging. My PhD colleagues and I supported each other professionally and personally during the process, which was beneficial. For example, my search alert occasionally highlighted literature that was more relevant to my colleagues; thus, I was able to share these articles with them.
The independent studies contributed to research diversity, but there was also a need for coherence between studies. Consideration of all relevant stakeholders (i.e. those representing all four municipalities) was important during the data collection process. However, I believe that the advantages outweighed the challenges, and the overall project has benefited from the various perspectives, providing a broader and more nuanced picture of intersectoral care coordination of which this PhD thesis is an important piece. Further, being part of a research collaborative highlighted the similarities and differences between studies, enabling one to emphasise one's own unique findings. Thus, the positive and balanced shifts between the individual contributions and the collaborative approach were beneficial to the overall research.

Chapter 8: Conclusions and Implications

8.1 Conclusions

The overall aim of this thesis was to generate evident knowledge about the perspectives and practices of HCPs in the intersectoral care coordination of acutely hospitalised older people, contributing to the future improvement of intersectoral healthcare services.

The starting point of this thesis was based on the assumption that focusing on HCPs could contribute in-depth first-hand knowledge about where and how CCTs can be improved. Involving HCPs could reveal subconscious or tacit knowledge about care coordination across health sectors and professions. Further, the CCTs of older people were appropriate to the research because older people are more likely to have multiple morbidities, requiring a range of HCPs and more complex care activities.

This thesis is based on in-depth qualitative research comprising three studies. Study I entailed individual interviews with HCPs ($n = 13$) across sectors (including nurses, physicians and GPs). Study II involved observations and unstructured interviews in intersectoral CCTs ($n = 7$). Study III involved two focus groups with a total of 23 HCPs from a range of sectors, including nurses, home carers, physicians, GPs and physiotherapists. These studies generated multiple valuable findings, adding value to future healthcare planning and practice.

The findings of this thesis reveal the ongoing challenges in care coordination and the appropriate utilisation of resources, which are vital to address. Recognising the complexity of the healthcare system is essential to creating more sustainable and seamless CCTs across sectors and professions. The desire to achieve high efficiency and the optimal utilisation of scarce resources has, in many cases, contributed to inappropriate care practices based on market logic and checklist procedures rather than on holistic, person-centered care and long-term perspectives. While holistic care emphasises values such as compassion and

interest in individual patients that goes beyond the specific health condition, it is difficult to implement in the current system. Checklist measures and indicators are often used to evaluate the quality of care and delivery of healthcare services. This can result in fragmented care practices and reduced care values. From an administrative perspective it may seem, that as long as HCPs precisely follow checklist procedures and standards, they have fulfilled their tasks. However, automated practices and streamlined linear solutions are often insufficient, suboptimal and dissonant to person-centered care. Individual patient needs and situations along with the increasing specialisation of healthcare resources and organisations are calling for new structures.

The current workplace culture is in need of change to one in which holistic and human values are universally integrated into care. To accomplish this mission, resources should be allocated as a priority. Creating such a culture not only requires organisational resources but also a tailored socialisation effort during HCPs' educational programs. These efforts would support the shaping of professionals that can more adequately adapt their practices to person-centered care.

Familiarity and relationships between sectors and professions have been somewhat suppressed by new structural boundaries and requirements, including NPM ideologies, fewer resources for HCP interactions and electronic communication and documentation methods. Different perspectives from different sectors contribute to this conflict; for example, the hospital sector tends to focus on acute care needs rather than on long-term solutions. These differing perspectives inhibit the formulation of mutual goals and core tasks across sectors, which would benefit the coordination of CCTs.

Due to the complexity, care coordination across sectors should be addressed at multiple levels, including the structural, organisational, professional and interpersonal levels. Such coordination would integrate healthcare services between sectors more adequately and enable more person-centered CCTs and would emphasise human values such as empathy

and compassion. At the upper levels (i.e. the structural, organisational and management levels), there should be less focus on quantifiable checklist measures to achieve a better fit between organisational mission statements and the activities at the practical level (HCPs' practices and work culture). Facilitating relationships and familiarity between sectors and professions should be prioritised because sharing insights and knowledge would be beneficial to the coordination of care.

Given the complexity of the healthcare system, changes may be unpredictable, thus should be introduced prudently. Therefore, modifications should be allowed to ensure that the change is positive. This will require comprehensive cooperation between all stakeholders, both vertically and horizontally, as well as the targeted involvement of patients and relatives.

8.2 Implications

'All change seems impossible, but once accomplished, it is the state you are no longer in that seems impossible'.

—Alain (1868–1951)

Denmark is expected soon to implement a new healthcare reform, which will be applied at both the professional and administrative levels and is aimed at creating a more coherent healthcare system. The aim is to create 21 collaborative clusters in relation to acute care across municipalities, general practices and hospitals (183). The present thesis is particularly relevant with respect to these imminent healthcare reformative changes. The implications of this research are highlighted below.

8.2.1 Implications for practice

It is important to acknowledge the complexity of the healthcare system and the unpredictability of change. Therefore, it is essential to allow room for necessary adjustments in any new intervention because processes are not linear. Every system change should be monitored and evaluated, both quantitatively and qualitatively, to ensure it is contributing to a more coherent healthcare system and seamless CCTs between sectors.

Relationships between HCPs and familiarity across sectors should be prioritised to enable liaisons in care coordination and the formulation of mutual definitions and shared goals. This could be integrated into educational programs, recruiting strategies and job training activities to support and prioritise embodied knowledge. Because some people find it easier to form relationships than others, it may be advisable to integrate relational training at the structural level (e.g. simulation training of HCPs to improve relational competencies).

Communication is essential for appropriate care coordination. However, communication should be based on effective and secure relationships rather than being reduced to simply conveying information. However, gaining access to relevant and adequate information between sectors is a challenge. There is a need to find solutions for shared access or mutual systems that provide an overview of patient status and information, independent of sectors and context.

This thesis shows that the focus on efficiency and specialisation in health care has inhibited the prerequisites for creating and sustaining relationships. As a result, care practices are less focused on individual needs and more oriented towards checklist measures. Thus, resources should be allocated from both the structural and the organisational levels to facilitate and support interpersonal relationships and familiarity between sectors and professions.

A better balance between standardised, highly specialised healthcare services and individual patients' needs and wishes should be emphasised to encounter both healthcare

services of high quality and person-centered care approaches. Skills and competencies must be developed to ensure such person-centered care approaches based on human values such as empathy and compassion. Given that patients are being directed more towards the primary care sector, the choice of hospital could also include the choice of sector. The primary care sector is becoming more capable of handling complex care needs (e.g. hospital at home services); therefore, when it is possible to provide treatment outside of hospitals, patients should be given the free choice. This would acknowledge the diversity of individual preferences and allow for greater flexibility. However, it must also be based on giving patients adequate information in line with the shared decision-making (157) approach.

HCP specialisation should be supplemented with a stronger foundation of general skills in interprofessional collaboration and insightful knowledge about the healthcare system and intersectoral care coordination. These professional skills should be included in undergraduate and postgraduate educational programs as part of a professional socialisation process. Further, to improve care coordination and collaboration, the education of HCPs involved in home care should generally be prioritised because these workers play an important role in detecting functional decline in older people. HCPs who have daily contact with older people in their homes tend to be less educated. To act preventively and promote health, these HCPs need adequate skills and training. Thus, their educational programs need to be reassessed to include the complex tasks they regularly face. This could contribute positively to interprofessional collaboration because increased skills and knowledge would facilitate relationships between professions built on respect and trust.

8.2.2 Implications for research

This thesis makes an independent contribution to the overall umbrella project ‘At the FOREFRONT of older people’s care’. To further address the complexity of coordinating older people’s CCTs, it is recommended to synthesise the research findings from all

collaborative projects covering the perspectives of people other than HCPs, including older people and their relatives. The collective findings may contribute valuable knowledge to future interventions in relation to care coordination practices.

More research on how to facilitate sustainable relationships and familiarity across sectors is recommended. The RC Survey tool may be a useful means of determining how RC between sectors may be improved to create better care coordination and more coherent CCTs. Further, if implemented, the upcoming collaborative clusters across sectors should be evaluated according to their relational effects. It is important to involve HCPs and other stakeholders with frontline knowledge in both practice and research initiatives. The partnership approach may lead to more sustainable solutions and should be prioritised in any practice or research intervention.

Further, the methodological experiences conducting observations of CCTs in Study II, which revealed different and more superficial layers of HCP practices, could be applied to quality assessments and improvements. Following patients' CCTs may contribute important knowledge and be a valuable supplement to ordinary quantitative surveys on issues such as patient satisfaction.

Finally, it is important to acknowledge complexity and unpredictability when initiating change. As the chairperson for Danish Regions, Stephanie Lose, stated, *'Think big, start small, scale up rapidly'* (184, p53).

8.2.3 Implications at a glance

Table 8 presents the research implications.

Table 8: Implications at a glance

Practical implications	Complexity should be acknowledged and addressed in any system change or intervention
	Relationships, familiarity and liaison between sectors and professions should be facilitated at the structural and organisational levels
	Communication is key to improving the balance between standardised treatment and flexible, person-centered care
	Shared access to a quick overview of relevant information should be provided
	High specialisation should be combined with general competencies across professions
	Improvement of skills and competencies of HCPs with the lowest educational levels should be prioritised
Research implications	The collective findings of the project 'At the FOREFRONT of older people's care' should be synthesised and used in future care coordination interventions
	Mapping and following patients' CCTs may be a valuable supplement to ordinary quantitative surveys on the quality and safety of care
	Research on the development of relationships and familiarity in health care is warranted
	Collaborative clusters in relation to new healthcare reforms should be evaluated according to their relational aspects

8.3 Final Reflections on Future Healthcare Coordination

Clearly, the coordination of care is a complex matter that cannot be solved by a single, quick-fix intervention. Therefore, intersectoral coordination of CCTs will be part of the public and political agenda in the future.

This research was partially undertaken during the COVID-19 pandemic, which has introduced additional challenges into the coordination of care. The spread of COVID-19 across the globe has affected everyone, not only within the healthcare system but also across the entire community as restrictions (e.g. social isolation) have been introduced. This has necessitated a great deal of flexibility and collaboration between professions and functions. Healthcare systems have had to comprehensively adapt to the rapidly evolving healthcare needs, and it has been necessary to reconsider the existing resources, procedures, competencies and ways of coordinating care. Never before have professional expertise and specialisation, which are related to 'old power', been so important. However, to combat the threats posed by the pandemic, it has been necessary to create partnerships and use cooperative approaches. Therefore, it is not a question of old versus new power but more a question of how the two may be combined in a meaningful and appropriate way. In this way, the global crisis has reminded us that relationships are critical. This raises the question, 'What are we without our relationships?', be they professional or personal. The expression 'together but separately', which has been repeatedly stressed throughout the pandemic, now has a new meaning when applied to health care. For the intersectoral coordination of care to be successful, relationships and collaboration are crucial. This is not an either–or situation but involves a balance between specialisation, standardisation and flexibility (i.e. a combination of new and old power). If we truly intend to achieve more person-centered healthcare and individualised treatment, then we need to adapt the system to fit such a vision. Otherwise, we risk only partial success or even outright failure.

8.4 Postscript

'By three methods we may learn wisdom: first, by reflection, which is noblest; second, by imitation, which is easiest; and third by experience, which is the bitterest'.

—Confucius (551–479 BC)

I confess to having travelled down all three of these roads to achieve knowledge or wisdom. Sometimes these roads felt too rough, too demanding, too steep, too lonely, too narrow or simply never-ending. Nevertheless, I kept walking! Some say that bitter chocolate is the tastiest—either way, I like chocolate, and I like learning.

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Appendices

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Appendix I, "The Regional Committee on Health Research Ethics' evaluation"

Dear Maiken

Thank you for your e-mail where you have requested to be informed of whether your research project should be notified to the Regional Committees on Health Research Ethics or not.

Your request has been assessed by the Chairman of the Regional Committee on Health Research Ethics for Southern Denmark, Jens Michael Hertz.

The Secretariat has assessed that your project is **not notifiable** to the Committee, cf. Committee Act Art. 14, paragraph 1. The decision is based on the fact that your research project is based on interviews and observations. It does not include human biological material, and there is no intervention.

In Denmark, the responsibility of evaluating biomedical research projects lies within the responsibility of the Research Ethics Committee System. A biomedical research project is an activity planned according to research methods aiming at producing new, valuable knowledge about human biological and psychological processes, either in relation to healthy persons or for the purpose of prevention, recognition, relief, treatment or cure of diseases, symptoms and pain, including affecting bodily functions.

For further information regarding notifiable projects and the Research Ethics Committee System, please consult the website of the National Research Ethics Committee: www.nvk.dk

The Committee's decision on not to notify the Committee of your project does not constitute any ethical consideration or negative evaluation of the content of the project itself.

Complaints procedure:
According to the Committee Act Art. 26 paragraph. 1, the Committee's decision can be appealed to The National Committee on Health Research Ethics within 30 days after the decision is received.

The National Committee on Health Research Ethics may, for the sake of securing the rights, deal with elements of the project not covered by the complaint itself.

This can be done via: Dketik@DKetik.dk

The complaint must be justified and be accompanied by a copy of the decision of The Regional Committee on Health Research Ethics for Southern Denmark and the files which the Committee has decided on the basis of.

On behalf of the Committee,
Yours Sincerely,

Venlig hilsen

Katrine Hoeg
Specialkonsulent, cand. jur.
Kvalitet og Forskning, De Videnskabsetiske Komitéer for Region Syddanmark

E-mail: Katrine.Hoeg@rsyd.dk
Direkte: 76638220
Mobil: 20598930

Region Syddanmark
Regionshuset
Damhaven 12, 7100 Vejle
Hovednummer: 7663 1000
www.rsyd.dk

Appendix II: "The Danish Data Protection Agency's approval"

Maiken Hjuler Persson
Lærings- og Forskningshuset
Sygehus Sønderjylland

Afdeling: Lærings- og Forskningshuset
Kontaktperson: Kirsten Asmussen
Kirsten.k.asmussen@rsyd.dk
Direkte tlf. 2899 4042

Dato: 15.september 2017
Journal nr. 17/31221

Vedrørende anmeldelse af:

På FORKANT – Belysning af de sundhedsprofessionelles vinkel for styrket tværsektoriel indsats omkring ældre

Ovennævnte projekt er den **15. september 2017** anmeldt til Datatilsynet via Region Syddanmarks paraplyanmeldelse for sundhedsvidenskabelig forskning efter Persondataloven. Projektet medtages på Region Syddanmarks oversigt for paraplyanmeldelsen 2012-58-0018 "Sundhedsvidenskabelig forskning i Region Syddanmark.

Det fremgår af anmeldelsen, at du er projektansvarlig for projektets oplysninger. Behandlingen af oplysningerne ønskes påbegyndt den **1. september 2017** og forventes at ophøre den **31. marts 2021**.

Oplysningerne vil blive behandlet på følgende adresse: **Sygehus Sønderjylland, Kresten Philipsensvej 15, 6200 Aabenraa.**

TILLADELSE

Lærings- og Forskningshuset ved Sygehus Sønderjylland meddeler hermed, på vegne af Region Syddanmark, tilladelse til projektets gennemførelse.

Region Syddanmark fastsætter i forbindelse med tilladelsen nedenstående vilkår:

Generelle vilkår

Tilladelsen gælder indtil: Den 31. marts 2022.

Ved tilladelsens udløb skal du særligt være opmærksom på følgende:

Sygehus Sønderjylland
Kresten Philipsens Vej 15
6200 Aabenraa
www.sygehussonderjylland.dk/forskning

Region Syddanmark

Dato 15. september 2017
Journal nr. 17/31221

Hvis du ikke inden denne dato har fået tilladelsen forlænget, går Region Syddanmark ud fra, at projektet er afsluttet, og at personoplysningerne er slettet, anonymiseret, tilintetgjort eller overført til arkiv, jf. nedenstående vilkår vedrørende projektets afslutning.

Region Syddanmark gør samtidig opmærksom på, at al behandling (herunder også opbevaring) af personoplysninger efter tilladelsens udløb er en overtrædelse af persondataloven.

1. **Maiken Hjuler Persson, ph.d-studerende, Sygehus Sønderjylland** er, som projektansvarlig på vegne af Region Syddanmark som dataansvarlig, ansvarlig for overholdelsen af de fastsatte vilkår.

2. Oplysningerne må kun anvendes til brug for projektets gennemførelse.

3. Behandling af personoplysninger må kun foretages af den projektansvarlige eller på foranledning af den projektansvarlige på vegne af Region Syddanmark som den dataansvarlige og på dennes ansvar.

4. Enhver (herunder ansatte i Region Syddanmark), der foretager behandling af projektets oplysninger, skal være bekendt med de fastsatte vilkår.

5. De fastsatte vilkår skal tillige iagttages ved behandling, der foretages af databehandler.

6. Ved brug af databehandler indgås databehandleraftale mellem Region Syddanmark og databehandleren.

7. Lokaler, der benyttes til opbevaring og behandling af projektets oplysninger, skal være indrettet med henblik på at forhindre uvedkommende adgang.

8. Behandling af oplysninger skal tilrettelægges således, at oplysningerne ikke hændeligt eller ulovligt tilintetgøres, fortabes eller forringes. Der skal endvidere foretages den fornødne kontrol for at sikre, at der ikke behandles urigtige eller vildledende oplysninger. Urigtige eller vildledende oplysninger eller oplysninger, som er behandlet i strid med loven eller disse vilkår, skal berigtiges eller slettes.

9. Oplysninger må ikke opbevares på en måde, der giver mulighed for at identificere de registrerede i et længere tidsrum end det, der er nødvendigt af hensyn til projektets gennemførelse.

10. En eventuel offentliggørelse af undersøgelsens resultater må ikke ske på en sådan måde, at det er muligt at identificere enkeltpersoner.

11. Eventuelle vilkår, der fastsættes efter anden lovgivning, forudsættes overholdt.

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www.sygehussonderjylland.dk/forskning

Elektroniske oplysninger

12. Adgangen til projektdata må kun finde sted ved benyttelse af et personligt fortroligt password. Kun personer, der er beskæftiget med eller har et andet sagligt formål til projektet må tildeles et password til projektets data. Passwordet skal afgrænses således, at den enkelte projektdeltager alene har rettigheder til de funktioner, der er relevante for denne, fx forespørge, inddatere eller slettepersonoplysninger. Udformning og udskiftning af password bør følge Region Syddanmarks "instrukser for brug af it".

13. Hvert halve år skal det kontrolleres, at projektdeltagerne har de korrekte rettigheder.

14. Der skal foretages registrering af alle afviste adgangsforsøg. Hvis der inden for en fastsat periode er registreret et nærmere fastsat antal på hinanden følgende afviste adgangsforsøg fra samme arbejdsstation eller med samme brugeridentifikation skal der blokeres for yderligere forsøg. Der skal følges op på afviste adgangsforsøg.

15. Der skal foretages logning af alle anvendelser af personoplysninger i forbindelse med projektet. Loggen skal mindst indeholde oplysning om tidspunkt, bruger, type af anvendelse og angivelse af den person, de anvendte oplysninger vedrørte eller det anvendte søgekriterium.

16. Såfremt identifikationsoplysninger enten er krypterede, eller erstattet med et id-nummer, skal loggen alene indeholde oplysninger om bruger og tidspunktet for behandlingen (se, gemme, søge, opdatere m.v.)

17. Loggen skal opbevares i 6 måneder, hvorefter den skal slettes. Ved særligt behov kan loggen opbevares i op til 5 år.

18. Nøglefiler – krypteringsnøgle, kodenøgle m.v. – skal opbevares forsvarligt og adskilt fra personoplysningerne.

19. Ved behov for adgang til projektets data uden for Region Syddanmarks lokation/netværk, skal dette ske via enten en VPN-forbindelse eller en Citrix-forbindelse.

20. Ved overførsel af personhenførbare oplysninger via Internet eller andet eksternt netværk uden for Region Syddanmark skal der træffes de fornødne sikkerhedsforanstaltninger mod, at oplysningerne kommer til uvedkommendes kendskab. Oplysningerne skal som minimum være

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forsvarligt krypteret under hele transmissionen. Overføres data inden for Region Syddanmarks netværk sker overførslen krypteret/sikkert.

21. Data må ikke opbevares lokalt på fx C-drevet på pc'er eller USB-nøgler. Dog kan der ske sikkerhedskopiering af data til udtagelige lagringsmedier. Disse skal opbevares forsvarligt aflåst og således, at uvedkommende ikke kan få adgang til oplysningerne.

Manuelle oplysninger

22. Manuelt projektmateriale, udskrifter, fejl- og kontrollister, m.v., der direkte eller indirekte kan henføres til bestemte personer, skal opbevares forsvarligt aflåst og på en sådan måde, at uvedkommende ikke kan gøre sig bekendt med indholdet.

23. Manuelt projektmateriale skal slettes, når det ikke længere er relevant for projektet, dog senest ved projektets afslutning **den 31. marts 2022**.

Oplysningspligt over for den registrerede

24. Hvis der skal indsamles oplysninger hos den registrerede (ved interview, spørgeskema, klinisk eller paraklinisk undersøgelse, behandling, observation m.v.) skal der uddeles/fremsendes nærmere information om projektet. Den registrerede skal heri oplyses om den dataansvarliges navn, formålet med projektet, at det er frivilligt at deltage, og at et samtykke til deltagelse til enhver tid kan trækkes tilbage.

25. Den registrerede skal endvidere oplyses om, at projektet er anmeldt til Datatilsynet via Region Syddanmark efter Persondatalovens bestemmelser, samt at der for projektet er fastsat nærmere vilkår til beskyttelse af den registreredes privatliv.

Indsigtsret

26. Den registrerede har ikke krav på indsigt i de oplysninger, der behandles om den pågældende.

Videregivelse

27. Videregivelse af personhenførbare oplysninger til tredjepart må kun ske til brug i andet statistisk eller videnskabeligt øjemed, der ikke er uforeneligt med det formål, hvortil dataene oprindeligt er indsamlet.

28. Videregivelse til tredjepart må kun ske efter forudgående tilladelse fra Datatilsynet, jf. Persondatalovens § 10, stk. 3. Datatilsynet kan stille nærmere vilkår for videregivelsen samt for modtagerens behandling af oplysningerne. Ansøgning om tilladelse til videregivelse af data til tredjepart sker via den lokale kontaktperson.

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Ændringer i projektet

29. Væsentlige ændringer i projektet skal anmeldes/meddeles til den lokale kontaktperson (som ændring af eksisterende anmeldelse).

30. Ændring af tidspunktet for projektets afslutning skal altid anmeldes/meddeles til den lokale kontaktperson.

Ved projektets afslutning

31. Senest ved projektets afslutning skal oplysningerne slettes, anonymiseres eller tilintetgøres, således at det efterfølgende ikke er muligt at identificere enkeltpersoner, der indgår i undersøgelsen.

32. Alternativt kan oplysningerne overføres til videre opbevaring i Statens Arkiver (herunder Dansk Dataarkiv) efter arkivlovens regler.

33. Sletning af oplysninger fra elektroniske medier skal ske på en sådan måde, at oplysningerne ikke kan genetableres. Der bør i denne forbindelse tages kontakt til din lokale it-afdeling, jf.
instruks for brug af it i Region Syddanmark.

Ovenstående vilkår er gældende indtil videre. Region Syddanmark forbeholder sig senere at tage vilkårene op til revision, hvis der skulle vise sig behov for det.

Region Syddanmark gør opmærksom på, at denne tilladelse alene er en tilladelse til at behandle personoplysninger i forbindelse med projektets gennemførelse. Tilladelsen indebærer således ikke en forpligtelse for myndigheder, virksomheder m.v. til at udlevere eventuelle oplysninger til dig til brug for projektet.

Region Syddanmarks paraplyanmeldelser for "Sundhedsvidenskabelig forskning i Region Syddanmark" nr. 2008-58-0035 findes i fortegnelsen over anmeldte behandlinger på Datatilsynets hjemmeside: www.datatilsynet.dk.

Persondataloven kan læses/hentes på Datatilsynets hjemmeside under punktet "Lovgivning".

Advarsel – ved brug af Excel, PowerPoint m.v.

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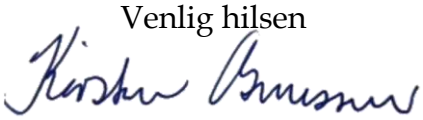
Den dataansvarlige skal til enhver tid sikre sig, at dokumenter og andre præsentationer, som publiceres eller på anden måde gøres tilgængelig for andre på internettet, usb-nøgle eller på andet elektronisk medie, ikke indeholder personoplysninger.

Der skal vises særlig agtpågivenhed i forbindelse med brug af grafiske præsentationer i Excel og PowerPoint, da de uforvarende kan indeholde indlejrede persondata i form af regneark, tabeller mv. Præsentationer, der gøres tilgængelig på internettet, skal derfor omformateres til Portable Digital Format (PDF), da dette fjerner eventuelle indlejrede Excel-tabeller.

Venlig hilsen



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Appendix III, "The Committee of Multipractice Studies in General Practice"

UDVALGET FOR MULTIPRAKSISUNDERSØGELSER

PRAKTISERENDE LÆGERS ORGANISATION

dsam
Dansk Selskab for Almen Medicin

2. oktober 2017

Kære Maiken Hjuler Persson

Vedr. MPU 25-2017 PÅ FORKANT - Belysning af de sundhedsprofessionelles vinkel for styrket tværsektoriel indsats omkring ældre borgere

På baggrund af indstilling fra forskningsleder Jens Søndergaard, Forskningsenheden for Almen Praksis, Syddansk Universitet har MPU-udvalget vurderet projektet og anbefaler praktiserende læger at deltage.

Du bedes oplyse evt. deltagende praktiserende læger om indholdet af dette brev.

Vurderingen vil blive offentliggjort på DSAM's hjemmeside, www.dsam.dk, se under Forskning – Multipraksisudvalget – MPU-projekter.

MPU modtager gerne et eksemplar af eventuelle publikationer af undersøgelsen.

Med venlig hilsen

Hans Christian Kjeldsen
Formand for MPU
Ekstern lektor, ph.d., praktiserende læge

Stockholmsgade 55, st.
2100 København Ø
T: 7070 7431 dsam@dsam.dk
www.dsam.dk

Appendix IV, "Number of people aged ≥65 years"

Folketal den 1. i kvartalet

køn	område	alder	2021K2
I alt	Region Syddanmark	65 år	15469
I alt	Region Syddanmark	66 år	14927
I alt	Region Syddanmark	67 år	14870
I alt	Region Syddanmark	68 år	14480
I alt	Region Syddanmark	69 år	13418
I alt	Region Syddanmark	70 år	13766
I alt	Region Syddanmark	71 år	13701
I alt	Region Syddanmark	72 år	14122
I alt	Region Syddanmark	73 år	14460
I alt	Region Syddanmark	74 år	14626
I alt	Region Syddanmark	75 år	14419
I alt	Region Syddanmark	76 år	12939
I alt	Region Syddanmark	77 år	11741
I alt	Region Syddanmark	78 år	10699
I alt	Region Syddanmark	79 år	9714
I alt	Region Syddanmark	80 år	8475
I alt	Region Syddanmark	81 år	8066
I alt	Region Syddanmark	82 år	7233
I alt	Region Syddanmark	83 år	6775
I alt	Region Syddanmark	84 år	5901
I alt	Region Syddanmark	85 år	5177
I alt	Region Syddanmark	86 år	4577
I alt	Region Syddanmark	87 år	3876

I alt	Region Syddanmark	88 år	3354
I alt	Region Syddanmark	89 år	2838
I alt	Region Syddanmark	90 år	2434
I alt	Region Syddanmark	91 år	1912
I alt	Region Syddanmark	92 år	1679
I alt	Region Syddanmark	93 år	1272
I alt	Region Syddanmark	94 år	1033
I alt	Region Syddanmark	95 år	773
I alt	Region Syddanmark	96 år	555
I alt	Region Syddanmark	97 år	396
I alt	Region Syddanmark	98 år	282
I alt	Region Syddanmark	99 år	175
I alt	Region Syddanmark	100 år	122
I alt	Region Syddanmark	101 år	58
I alt	Region Syddanmark	102 år	31
I alt	Region Syddanmark	103 år	18
I alt	Region Syddanmark	104 år	13
I alt	Region Syddanmark	105 år	4
I alt	Region Syddanmark	106 år	4
I alt	Region Syddanmark	107 år	0
I alt	Region Syddanmark	108 år	0
I alt	Region Syddanmark	109 år	0
I alt	Region Syddanmark	110 år	0
I alt	Region Syddanmark	Subtotal	270384

19-5-2021 Danmarks Statistik , © www.statistikbanken.dk/FOLK1A

Appendix V: "General literature search" (Updated may-sept. 2021)

Database	Search string and facets	Hits (Date)
PubMed	**Facet 1 'Healthcare Professionals':** Search: **(((Healthcare professionals) OR (Personel, Health)) OR (Health Care Providers)) OR (Health Care Provider)) OR (Provider, Health Care)) OR (Providers, Health Care)) OR (Healthcare Providers)) OR (Healthcare Provider)) OR (Provider, Healthcare)) OR (Providers, Healthcare)) OR (Healthcare Workers)) OR (Healthcare Worker)) OR (Caregivers)) OR (Caregiver)) OR (Carers)) OR (Carer)) OR (Care Givers)) OR (Care Giver)) OR (Medical Staff)) OR (Staffs, Medical)) OR (Medical Staffs)) OR (Staff, Medical)) OR (Hospital Personnel)) OR (Nurses)) OR (Nurse Practitioners)) OR (Family Nurse Practitioners)) OR (Nurse Specialists)) OR (Nurse Clinicians)) OR (Nurses, Community Health)) OR (Nurses, Public Health)) OR (Staffs, Nursing)) OR (Nursing Staffs)) OR (Staff, Nursing)) OR (Physicians)) OR (General practitioners)) OR (General Practitioner)) OR (Practitioner, General)) OR (Practitioners, General)) OR (Physicians, General Practice)) OR (General Practice Physician)) OR (General Practice Physicians)) OR (Physician, General Practice)) OR (Practice Physicians)) OR (Geriatrician)) OR (Gerontologists)) OR (Gerontologist)** Filters: **in the last 10 years, English** ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "professionals"[All Fields]) OR "healthcare professionals"[All Fields] OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("personnel"[All Fields] AND "health"[All Fields]) OR "personnel health"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("health"[All Fields] AND "care"[All Fields] AND "providers"[All Fields]) OR "health care providers"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("health"[All Fields] AND "care"[All Fields] AND "provider"[All Fields]) OR "health care provider"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("provider"[All Fields] AND "health"[All Fields] AND "care"[All Fields]) OR "provider health care"[All Fields]) OR (("provide"[All Fields] OR "provided"[All Fields] OR "provider"[All Fields] OR "provider s"[All Fields] OR "providers"[All Fields] OR "provides"[All Fields] OR "providing"[All Fields]) AND ("delivery of health care"[MeSH Terms] OR ("delivery"[All Fields] AND "health"[All Fields] AND "care"[All Fields]) OR "delivery of health care"[All Fields] OR ("health"[All Fields] AND "care"[All Fields]) OR "health care"[All Fields])) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "providers"[All Fields]) OR "healthcare providers"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "provider"[All Fields]) OR "healthcare provider"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("provider"[All Fields] AND "healthcare"[All Fields]) OR "provider	**803,090** (100821)

	healthcare"[All Fields]) OR (("provide"[All Fields] OR "provided"[All Fields] OR "provider"[All Fields] OR "provider s"[All Fields] OR "providers"[All Fields] OR "provides"[All Fields] OR "providing"[All Fields]) AND ("delivery of health care"[MeSH Terms] OR ("delivery"[All Fields] AND "health"[All Fields] AND "care"[All Fields]) OR "delivery of health care"[All Fields] OR "healthcare"[All Fields] OR "healthcare s"[All Fields] OR "healthcares"[All Fields])) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "workers"[All Fields]) OR "healthcare workers"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "worker"[All Fields]) OR "healthcare worker"[All Fields]) OR ("caregiver s"[All Fields] OR "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "caregiver"[All Fields] OR "caregiving"[All Fields]) OR ("caregiver s"[All Fields] OR "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "caregiver"[All Fields] OR "caregiving"[All Fields]) OR ("caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "carer"[All Fields] OR "carers"[All Fields] OR "carer s"[All Fields]) OR ("caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "carer"[All Fields] OR "carers"[All Fields] OR "carer s"[All Fields]) OR ("caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR ("care"[All Fields] AND "givers"[All Fields]) OR "care givers"[All Fields]) OR ("caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR ("care"[All Fields] AND "giver"[All Fields]) OR "care giver"[All Fields]) OR ("medical staff"[MeSH Terms] OR ("medical"[All Fields] AND "staff"[All Fields]) OR "medical staff"[All Fields]) OR ("medical staff"[MeSH Terms] OR ("medical"[All Fields] AND "staff"[All Fields]) OR "medical staff"[All Fields] OR ("staffs"[All Fields] AND "medical"[All Fields]) OR "staffs medical"[All Fields]) OR ("medical staff"[MeSH Terms] OR ("medical"[All Fields] AND "staff"[All Fields]) OR "medical staff"[All Fields] OR ("medical"[All Fields] AND "staffs"[All Fields]) OR "medical staffs"[All Fields]) OR ("medical staff"[MeSH Terms] OR ("medical"[All Fields] AND "staff"[All Fields]) OR "medical staff"[All Fields] OR ("staff"[All Fields] AND "medical"[All Fields]) OR "staff medical"[All Fields]) OR ("personnel, hospital"[MeSH Terms] OR ("personnel"[All Fields] AND "hospital"[All Fields]) OR "hospital personnel"[All Fields] OR ("hospital"[All Fields] AND "personnel"[All Fields])) OR ("nurse s"[All Fields] OR "nurses"[MeSH Terms] OR "nurses"[All Fields] OR "nurse"[All Fields] OR "nurses s"[All Fields]) OR ("nurse practitioners"[MeSH Terms] OR ("nurse"[All Fields] AND "practitioners"[All Fields]) OR "nurse practitioners"[All Fields]) OR ("family nurse practitioners"[MeSH Terms] OR ("family"[All Fields] AND "nurse"[All Fields] AND "practitioners"[All Fields]) OR "family nurse practitioners"[All Fields]) OR ("nurse specialists"[MeSH Terms] OR ("nurse"[All Fields] AND "specialists"[All Fields]) OR "nurse specialists"[All Fields]) OR ("nurse clinicians"[MeSH Terms] OR ("nurse"[All Fields] AND "clinicians"[All Fields]) OR "nurse clinicians"[All Fields]) OR ("nurses, community health"[MeSH Terms] OR ("nurses"[All Fields] AND "community"[All Fields] AND "health"[All Fields]) OR "community health nurses"[All Fields] OR ("nurses"[All Fields] AND "community"[All Fields] AND "health"[All Fields]) OR "nurses community health"[All Fields]) OR ("nurses, public health"[MeSH Terms] OR ("nurses"[All Fields] AND "public"[All Fields] AND "health"[All Fields]) OR "public health nurses"[All Fields] OR ("nurses"[All Fields] AND "public"[All Fields] AND "health"[All Fields]) OR "nurses public health"[All Fields]) OR ("nursing staff"[MeSH Terms] OR ("nursing"[All Fields] AND "staff"[All Fields]) OR "nursing staff"[All Fields] OR ("staffs"[All Fields] AND "nursing"[All Fields]) OR "staffs nursing"[All Fields]) OR ("nursing	

	staff"[MeSH Terms] OR ("nursing"[All Fields] AND "staff"[All Fields]) OR "nursing staff"[All Fields] OR ("nursing"[All Fields] AND "staffs"[All Fields]) OR "nursing staffs"[All Fields]) OR ("nursing staff"[MeSH Terms] OR ("nursing"[All Fields] AND "staff"[All Fields]) OR "nursing staff"[All Fields] OR ("staff"[All Fields] AND "nursing"[All Fields]) OR "staff nursing"[All Fields]) OR ("physician s"[All Fields] OR "physicians"[MeSH Terms] OR "physicians"[All Fields] OR "physician"[All Fields] OR "physicians s"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("general"[All Fields] AND "practitioner"[All Fields]) OR "general practitioner"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("practitioner"[All Fields] AND "general"[All Fields]) OR "practitioner general"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("practitioners"[All Fields] AND "general"[All Fields]) OR "practitioners general"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("physicians"[All Fields] AND "general"[All Fields] AND "practice"[All Fields]) OR "physicians general practice"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("general"[All Fields] AND "practice"[All Fields] AND "physician"[All Fields]) OR "general practice physician"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("general"[All Fields] AND "practice"[All Fields] AND "physicians"[All Fields]) OR "general practice physicians"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("physician"[All Fields] AND "general"[All Fields] AND "practice"[All Fields]) OR "physician general practice"[All Fields]) OR (("practicability"[All Fields] OR "practicable"[All Fields] OR "practical"[All Fields] OR "practicalities"[All Fields] OR "practicality"[All Fields] OR "practically"[All Fields] OR "practicals"[All Fields] OR "practice"[All Fields] OR "practice s"[All Fields] OR "practiced"[All Fields] OR "practices"[All Fields] OR "practicing"[All Fields]) AND ("physician s"[All Fields] OR "physicians"[MeSH Terms] OR "physicians"[All Fields] OR "physician"[All Fields] OR "physicians s"[All Fields])) OR ("geriatrician s"[All Fields] OR "geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "geriatrician"[All Fields]) OR ("geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "gerontologist"[All Fields] OR "gerontologists"[All Fields]) OR ("geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "gerontologist"[All Fields] OR "gerontologists"[All Fields])) AND ((y_10[Filter]) AND (english[Filter]))	
PubMed	**<u>Facet 2 'Interdisciplinary/Intersectoral Collaboration':</u>** Search: **(Interprofessional Collaboration) OR (Interdisciplinary Collaboration) OR (Intersectoral Collaboration) (Transdisciplinary Collaboration)** Filters: **in the last 10 years, English**	**17,949** (100821)

	((("interprofessional"[All Fields] OR "interprofessionalism"[All Fields] OR "interprofessionality"[All Fields] OR "interprofessionally"[All Fields] OR "interprofessionals"[All Fields]) AND ("collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative s"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields])) OR (("interdisciplinary studies"[MeSH Terms] OR ("interdisciplinary"[All Fields] AND "studies"[All Fields]) OR "interdisciplinary studies"[All Fields] OR "interdisciplinary"[All Fields]) AND ("collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative s"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields])) OR ("intersectoral collaboration"[MeSH Terms] OR ("intersectoral"[All Fields] AND "collaboration"[All Fields]) OR "intersectoral collaboration"[All Fields]) OR ("Transdisciplinary"[All Fields] AND ("collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative s"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields])) OR ("Transdisciplinary"[All Fields] AND ("coordinate"[All Fields] OR "coordinated"[All Fields] OR "coordinately"[All Fields] OR "coordinates"[All Fields] OR "coordinating"[All Fields] OR "coordination"[All Fields] OR "coordinations"[All Fields] OR "coordinative"[All Fields] OR "coordinatively"[All Fields] OR "coordinator"[All Fields] OR "coordinator s"[All Fields] OR "coordinators"[All Fields])) OR (("interprofessional"[All Fields] OR "interprofessionalism"[All Fields] OR "interprofessionality"[All Fields] OR "interprofessionally"[All Fields] OR "interprofessionals"[All Fields]) AND ("coordinate"[All Fields] OR "coordinated"[All Fields] OR "coordinately"[All Fields] OR "coordinates"[All Fields] OR "coordinating"[All Fields] OR "coordination"[All Fields] OR "coordinations"[All Fields] OR "coordinative"[All Fields] OR "coordinatively"[All Fields] OR "coordinator"[All Fields] OR "coordinator s"[All Fields] OR "coordinators"[All Fields])) OR (("interdisciplinary studies"[MeSH Terms] OR ("interdisciplinary"[All Fields] AND "studies"[All Fields]) OR "interdisciplinary studies"[All Fields] OR "interdisciplinary"[All Fields]) AND ("coordinate"[All Fields] OR "coordinated"[All Fields] OR "coordinately"[All Fields] OR "coordinates"[All Fields] OR "coordinating"[All Fields] OR "coordination"[All Fields] OR "coordinations"[All Fields] OR "coordinative"[All Fields] OR "coordinatively"[All Fields] OR "coordinator"[All Fields] OR "coordinator s"[All Fields] OR "coordinators"[All Fields]))) AND ((y_10[Filter]) AND (english[Filter]))	
PubMed	**<u>Facet 3 'Older Adults in Acute Hospitalisations:</u>** Search: **((((((((((Older Adults) OR (Older People)) OR (Aged)) OR (Elderly)) OR (Old)) OR (Old People)) OR (Old Adults)) AND (Acute Hospitalisation)) OR (Acute Admission)) OR (Acute Care)) OR (Critical Care)) OR (Clinical Care Trajectory)) OR (Acute Trajectory)** Filters: **in the last 10 years, English**	**389,308** (100821)

	((("aged"[MeSH Terms] OR "aged"[All Fields] OR ("older"[All Fields] AND "adults"[All Fields]) OR "older adults"[All Fields] OR (("older"[All Fields] OR "olders"[All Fields]) AND ("people s"[All Fields] OR "peopled"[All Fields] OR "peopling"[All Fields] OR "persons"[MeSH Terms] OR "persons"[All Fields] OR "people"[All Fields] OR "peoples"[All Fields])) OR ("aged"[MeSH Terms] OR "aged"[All Fields]) OR ("aged"[MeSH Terms] OR "aged"[All Fields] OR "elderly"[All Fields] OR "elderlies"[All Fields] OR "elderly s"[All Fields] OR "elderlys"[All Fields]) OR "Old"[All Fields] OR ("Old"[All Fields] AND ("people s"[All Fields] OR "peopled"[All Fields] OR "peopling"[All Fields] OR "persons"[MeSH Terms] OR "persons"[All Fields] OR "people"[All Fields] OR "peoples"[All Fields])) OR ("Old"[All Fields] AND ("adult"[MeSH Terms] OR "adult"[All Fields] OR "adults"[All Fields] OR "adult s"[All Fields]))) AND (("acute"[All Fields] OR "acutely"[All Fields] OR "acutes"[All Fields]) AND ("hospital s"[All Fields] OR "hospitalisation"[All Fields] OR "hospitalization"[MeSH Terms] OR "hospitalization"[All Fields] OR "hospitalising"[All Fields] OR "hospitality"[All Fields] OR "hospitalisations"[All Fields] OR "hospitalised"[All Fields] OR "hospitalizations"[All Fields] OR "hospitalized"[All Fields] OR "hospitalize"[All Fields] OR "hospitalizing"[All Fields] OR "hospitals"[MeSH Terms] OR "hospitals"[All Fields] OR "hospital"[All Fields]))) OR (("acute"[All Fields] OR "acutely"[All Fields] OR "acutes"[All Fields]) AND ("admission"[All Fields] OR "admissions"[All Fields])) OR ("acute care"[Journal] OR ("acute"[All Fields] AND "Care"[All Fields]) OR "acute care"[All Fields]) OR ("critical care"[MeSH Terms] OR ("critical"[All Fields] AND "Care"[All Fields]) OR "critical care"[All Fields]) OR (("ambulatory care facilities"[MeSH Terms] OR ("ambulatory"[All Fields] AND "Care"[All Fields] AND "facilities"[All Fields]) OR "ambulatory care facilities"[All Fields] OR "clinic"[All Fields] OR "clinic s"[All Fields] OR "clinical"[All Fields] OR "clinically"[All Fields] OR "clinicals"[All Fields] OR "clinics"[All Fields]) AND "Care"[All Fields] AND ("trajectories"[All Fields] OR "trajectory"[All Fields] OR "trajectory s"[All Fields])) OR (("acute"[All Fields] OR "acutely"[All Fields] OR "acutes"[All Fields]) AND ("trajectories"[All Fields] OR "trajectory"[All Fields] OR "trajectory s"[All Fields]))) AND ((y_10[Filter]) AND (english[Filter]))	
PubMed	**<u>Facet 4 'Coordination of Care':</u>** Search: **((((((Care Coherence) OR (Care Quality)) OR (Care Continuum)) OR (Care Integration)) OR (Integrated Care)) OR (Care Coordination)) OR (Transitional Care) AND ((y_10[Filter]) AND (english[Filter])) AND ((y_10[Filter]) AND (english[Filter])) AND ((y_10[Filter]) AND (english[Filter]))** Filters: **in the last 10 years, English** Filters: **in the last 10 years, English** ((("Care"[All Fields] AND ("coherence"[All Fields] OR "coherences"[All Fields] OR "coherencies"[All Fields] OR "coherency"[All Fields] OR "coherent"[All Fields] OR "coherently"[All Fields])) OR ("quality of health care"[MeSH Terms] OR ("quality"[All Fields] AND "health"[All Fields] AND "Care"[All Fields]) OR "quality of health care"[All Fields] OR ("Care"[All Fields] AND "quality"[All Fields]) OR "care quality"[All Fields]) OR ("continuity of patient care"[MeSH Terms] OR ("continuity"[All Fields] AND "patient"[All Fields] AND "Care"[All Fields]) OR "continuity of patient care"[All Fields] OR ("Care"[All Fields] AND "continuum"[All Fields]) OR "care continuum"[All Fields]) OR ("Care"[All Fields] AND ("integrability"[All Fields] OR "integrable"[All Fields] OR	**3,165,979** (100821)

	"integral"[All Fields] OR "integrally"[All Fields] OR "integrals"[All Fields] OR "integrant"[All Fields] OR "integrants"[All Fields] OR "integrate"[All Fields] OR "integrated"[All Fields] OR "integrates"[All Fields] OR "integrating"[All Fields] OR "integration"[All Fields] OR "integrational"[All Fields] OR "integrations"[All Fields] OR "integrative"[All Fields] OR "integratively"[All Fields] OR "integrator"[All Fields] OR "integrators"[All Fields])) OR ("int j integr care"[Journal] OR ("integrated"[All Fields] AND "Care"[All Fields]) OR "integrated care"[All Fields]) OR ("Care"[All Fields] AND ("coordinate"[All Fields] OR "coordinated"[All Fields] OR "coordinately"[All Fields] OR "coordinates"[All Fields] OR "coordinating"[All Fields] OR "coordination"[All Fields] OR "coordinations"[All Fields] OR "coordinative"[All Fields] OR "coordinatively"[All Fields] OR "coordinator"[All Fields] OR "coordinator s"[All Fields] OR "coordinators"[All Fields])) OR ("transitional care"[MeSH Terms] OR ("transitional"[All Fields] AND "Care"[All Fields]) OR "transitional care"[All Fields])) AND ("2011/08/11 00:00":"3000/01/01 05:00"[Date - Publication] AND "english"[Language]) AND ("2011/08/11 00:00":"3000/01/01 05:00"[Date - Publication] AND "english"[Language]) AND ("2011/08/11 00:00":"3000/01/01 05:00"[Date - Publication] AND "english"[Language])) AND ((y_10[Filter]) AND (english[Filter]))	
PubMed	**Combined search string, Facet 1 AND Facet 2 AND Facet 3 AND Facet 4:** Search: **((Healthcare professionals) OR (Personnel, Health)) OR (Health Care Providers)) OR (Health Care Provider)) OR (Provider, Health Care)) OR (Providers, Health Care)) OR (Healthcare Providers)) OR (Healthcare Provider)) OR (Provider, Healthcare)) OR (Providers, Healthcare)) OR (Healthcare Workers)) OR (Healthcare Worker)) OR (Caregivers)) OR (Caregiver)) OR (Carers)) OR (Carer)) OR (Care Givers)) OR (Care Giver)) OR (Medical Staff)) OR (Staffs, Medical)) OR (Medical Staffs)) OR (Staff, Medical)) OR (Hospital Personnel)) OR (Nurses)) OR (Nurse Practitioners)) OR (Family Nurse Practitioners)) OR (Nurse Specialists)) OR (Nurse Clinicians)) OR (Nurses, Community Health)) OR (Nurses, Public Health)) OR (Staffs, Nursing)) OR (Nursing Staffs)) OR (Staff, Nursing)) OR (Physicians)) OR (General practitioners)) OR (General Practitioner)) OR (Practitioner, General)) OR (Practitioners, General)) OR (Physicians, General Practice)) OR (General Practice Physician)) OR (General Practice Physicians)) OR (Physician, General Practice)) OR (Practice Physicians)) OR (Geriatrician)) OR (Gerontologists)) OR (Gerontologist) AND ((y_10[Filter]) AND (english[Filter]))) AND (((((((Interprofessional Collaboration) OR (Interdisciplinary Collaboration)) OR (Intersectoral Collaboration)) OR (Transdisciplinary Collaboration)) OR (Transdisciplinary Coordination)) OR (Interprofessional Coordination)) OR (Interdisciplinary Coordination) AND ((y_10[Filter]) AND (english[Filter])))) AND ((((((((((((Older Adults) OR (Older People)) OR (Aged)) OR (Elderly)) OR (Old)) OR (Old People)) OR (Old Adults)) AND (Acute Hospitalisation)) OR (Acute Admission)) OR (Acute Care)) OR (Critical Care)) OR (Clinical Care Trajectory)) OR (Acute Trajectory) AND ((y_10[Filter]) AND (english[Filter])))) AND (((((((Care Coherence) OR (Care Quality)) OR (Care Continuum)) OR (Care Integration)) OR (Integrated Care)) OR (Care Coordination)) OR (Transitional Care) AND ((y_10[Filter]) AND (english[Filter])) AND ((y_10[Filter]) AND (english[Filter])) AND ((y_10[Filter]) AND (english[Filter])) AND ((y_10[Filter]) AND (english[Filter]))))** Filters: **in the last 10 years, English**	**1238** (100821)

	(("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "professionals"[All Fields]) OR "healthcare professionals"[All Fields] OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("personnel"[All Fields] AND "health"[All Fields]) OR "personnel health"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("health"[All Fields] AND "Care"[All Fields] AND "providers"[All Fields]) OR "health care providers"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("health"[All Fields] AND "Care"[All Fields] AND "provider"[All Fields]) OR "health care provider"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("provider"[All Fields] AND "health"[All Fields] AND "Care"[All Fields]) OR "provider health care"[All Fields]) OR (("provide"[All Fields] OR "provided"[All Fields] OR "provider"[All Fields] OR "provider s"[All Fields] OR "providers"[All Fields] OR "provides"[All Fields] OR "providing"[All Fields]) AND ("delivery of health care"[MeSH Terms] OR ("delivery"[All Fields] AND "health"[All Fields] AND "Care"[All Fields]) OR "delivery of health care"[All Fields] OR ("health"[All Fields] AND "Care"[All Fields]) OR "health care"[All Fields])) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "providers"[All Fields]) OR "healthcare providers"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "provider"[All Fields]) OR "healthcare provider"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("provider"[All Fields] AND "healthcare"[All Fields]) OR "provider healthcare"[All Fields]) OR (("provide"[All Fields] OR "provided"[All Fields] OR "provider"[All Fields] OR "provider s"[All Fields] OR "providers"[All Fields] OR "provides"[All Fields] OR "providing"[All Fields]) AND ("delivery of health care"[MeSH Terms] OR ("delivery"[All Fields] AND "health"[All Fields] AND "Care"[All Fields]) OR "delivery of health care"[All Fields] OR "healthcare"[All Fields] OR "healthcare s"[All Fields] OR "healthcares"[All Fields])) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "workers"[All Fields]) OR "healthcare workers"[All Fields]) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "worker"[All Fields]) OR "healthcare worker"[All Fields]) OR ("caregiver s"[All Fields] OR "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "caregiver"[All Fields] OR "caregiving"[All Fields]) OR ("caregiver s"[All Fields] OR "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "caregiver"[All Fields] OR "caregiving"[All Fields]) OR ("caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "carer"[All Fields] OR "carers"[All Fields] OR "carer s"[All Fields]) OR ("caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "carer"[All Fields] OR "carers"[All Fields] OR "carer s"[All Fields]) OR ("caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR ("Care"[All Fields] AND "givers"[All Fields]) OR "care givers"[All Fields]) OR ("caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR ("Care"[All Fields] AND "giver"[All Fields]) OR "care giver"[All Fields]) OR ("medical staff"[MeSH Terms] OR	

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	("general"[All Fields] AND "practice"[All Fields] AND "physician"[All Fields]) OR "general practice physician"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("general"[All Fields] AND "practice"[All Fields] AND "physicians"[All Fields]) OR "general practice physicians"[All Fields]) OR ("general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("physician"[All Fields] AND "general"[All Fields] AND "practice"[All Fields]) OR "physician general practice"[All Fields]) OR (("practicability"[All Fields] OR "practicable"[All Fields] OR "practical"[All Fields] OR "practicalities"[All Fields] OR "practicality"[All Fields] OR "practically"[All Fields] OR "practicals"[All Fields] OR "practice"[All Fields] OR "practice s"[All Fields] OR "practiced"[All Fields] OR "practices"[All Fields] OR "practicing"[All Fields]) AND ("physician s"[All Fields] OR "physicians"[MeSH Terms] OR "physicians"[All Fields] OR "physician"[All Fields] OR "physicians s"[All Fields])) OR ("geriatrician s"[All Fields] OR "geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "geriatrician"[All Fields]) OR ("geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "gerontologist"[All Fields] OR "gerontologists"[All Fields]) OR ("geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "gerontologist"[All Fields] OR "gerontologists"[All Fields])) AND ("2011/08/11 00:00":"3000/01/01 05:00"[Date - Publication] AND "english"[Language]) AND ((((("interprofessional"[All Fields] OR "interprofessionalism"[All Fields] OR "interprofessionality"[All Fields] OR "interprofessionally"[All Fields] OR "interprofessionals"[All Fields]) AND ("collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative s"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields])) OR (("interdisciplinary studies"[MeSH Terms] OR ("interdisciplinary"[All Fields] AND "studies"[All Fields]) OR "interdisciplinary studies"[All Fields] OR "interdisciplinary"[All Fields]) AND ("collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative s"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields])) OR ("intersectoral collaboration"[MeSH Terms] OR ("intersectoral"[All Fields] AND "collaboration"[All Fields]) OR "intersectoral collaboration"[All Fields]) OR ("Transdisciplinary"[All Fields] AND ("collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative s"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields])) OR ("Transdisciplinary"[All Fields] AND ("coordinate"[All Fields] OR "coordinated"[All Fields] OR "coordinately"[All Fields] OR "coordinates"[All Fields] OR "coordinating"[All Fields] OR "coordination"[All Fields] OR "coordinations"[All Fields] OR "coordinative"[All Fields] OR "coordinatively"[All Fields] OR "coordinator"[All Fields] OR "coordinator s"[All Fields] OR "coordinators"[All Fields])) OR (("interprofessional"[All Fields] OR "interprofessionalism"[All Fields] OR "interprofessionality"[All Fields] OR "interprofessionally"[All Fields] OR "interprofessionals"[All Fields]) AND ("coordinate"[All Fields] OR "coordinated"[All Fields] OR "coordinately"[All Fields] OR "coordinates"[All	

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	("healthcare"[All Fields] AND "providers"[All Fields]) OR "healthcare providers"[All Fields] **Healthcare Provider:** "health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "provider"[All Fields]) OR "healthcare provider"[All Fields] **Provider, Healthcare:** "health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("provider"[All Fields] AND "healthcare"[All Fields]) OR "provider, healthcare"[All Fields] **Providers,:** "provide"[All Fields] OR "provided"[All Fields] OR "provider"[All Fields] OR "provider's"[All Fields] OR "providers"[All Fields] OR "provides"[All Fields] OR "providing"[All Fields] **Healthcare:** "delivery of health care"[MeSH Terms] OR ("delivery"[All Fields] AND "health"[All Fields] AND "care"[All Fields]) OR "delivery of health care"[All Fields] OR "healthcare"[All Fields] OR "healthcare's"[All Fields] OR "healthcares"[All Fields] **Healthcare Workers:** "health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "workers"[All Fields]) OR "healthcare workers"[All Fields] **Healthcare Worker:** "health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "worker"[All Fields]) OR "healthcare worker"[All Fields] **Caregivers:** "caregiver's"[All Fields] OR "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "caregiver"[All Fields] OR "caregiving"[All Fields] **Caregiver:** "caregiver's"[All Fields] OR "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "caregiver"[All Fields] OR "caregiving"[All Fields] **Carers:** "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "carer"[All Fields] OR "carers"[All Fields] OR "carer's"[All Fields] **Carer:** "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR "carer"[All Fields] OR "carers"[All Fields] OR "carer's"[All Fields] **Care Givers:** "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR ("care"[All Fields] AND "givers"[All Fields]) OR "care givers"[All Fields] **Care Giver:** "caregivers"[MeSH Terms] OR "caregivers"[All Fields] OR ("care"[All Fields] AND "giver"[All Fields]) OR "care giver"[All Fields] **Medical Staff:** "medical staff"[MeSH Terms] OR ("medical"[All Fields] AND "staff"[All Fields]) OR "medical staff"[All Fields] **Staffs, Medical:** "medical staff"[MeSH Terms] OR ("medical"[All Fields] AND "staff"[All Fields]) OR "medical staff"[All Fields] OR ("staffs"[All Fields] AND "medical"[All Fields]) OR "staffs, medical"[All Fields] **Medical Staffs:** "medical staff"[MeSH Terms] OR ("medical"[All Fields] AND "staff"[All Fields]) OR "medical staff"[All Fields] OR ("medical"[All Fields] AND "staffs"[All Fields]) OR "medical staffs"[All Fields] **Staff, Medical:** "medical staff"[MeSH Terms] OR ("medical"[All Fields] AND "staff"[All Fields]) OR "medical staff"[All Fields] OR ("staff"[All Fields] AND "medical"[All Fields]) OR "staff, medical"[All Fields] **Hospital Personnel:** "personnel, hospital"[MeSH Terms] OR ("personnel"[All Fields] AND "hospital"[All Fields]) OR "hospital personnel"[All Fields] OR ("hospital"[All Fields] AND "personnel"[All Fields]) **Nurses:** "nurse's"[All Fields] OR "nurses"[MeSH Terms] OR "nurses"[All Fields] OR "nurse"[All Fields] OR "nurses's"[All Fields]	

	Nurse Practitioners: "nurse practitioners"[MeSH Terms] OR ("nurse"[All Fields] AND "practitioners"[All Fields]) OR "nurse practitioners"[All Fields] **Family Nurse Practitioners:** "family nurse practitioners"[MeSH Terms] OR ("family"[All Fields] AND "nurse"[All Fields] AND "practitioners"[All Fields]) OR "family nurse practitioners"[All Fields] **Nurse Specialists:** "nurse specialists"[MeSH Terms] OR ("nurse"[All Fields] AND "specialists"[All Fields]) OR "nurse specialists"[All Fields] **Nurse Clinicians:** "nurse clinicians"[MeSH Terms] OR ("nurse"[All Fields] AND "clinicians"[All Fields]) OR "nurse clinicians"[All Fields] **Nurses, Community Health:** "nurses, community health"[MeSH Terms] OR ("nurses"[All Fields] AND "community"[All Fields] AND "health"[All Fields]) OR "community health nurses"[All Fields] OR ("nurses"[All Fields] AND "community"[All Fields] AND "health"[All Fields]) OR "nurses, community health"[All Fields] **Nurses, Public Health:** "nurses, public health"[MeSH Terms] OR ("nurses"[All Fields] AND "public"[All Fields] AND "health"[All Fields]) OR "public health nurses"[All Fields] OR ("nurses"[All Fields] AND "public"[All Fields] AND "health"[All Fields]) OR "nurses, public health"[All Fields] **Staffs, Nursing:** "nursing staff"[MeSH Terms] OR ("nursing"[All Fields] AND "staff"[All Fields]) OR "nursing staff"[All Fields] OR ("staffs"[All Fields] AND "nursing"[All Fields]) OR "staffs, nursing"[All Fields] **Nursing Staffs:** "nursing staff"[MeSH Terms] OR ("nursing"[All Fields] AND "staff"[All Fields]) OR "nursing staff"[All Fields] OR ("nursing"[All Fields] AND "staffs"[All Fields]) OR "nursing staffs"[All Fields] **Staff, Nursing:** "nursing staff"[MeSH Terms] OR ("nursing"[All Fields] AND "staff"[All Fields]) OR "nursing staff"[All Fields] OR ("staff"[All Fields] AND "nursing"[All Fields]) OR "staff nursing"[All Fields] **Physicians:** "physician's"[All Fields] OR "physicians"[MeSH Terms] OR "physicians"[All Fields] OR "physician"[All Fields] OR "physicians's"[All Fields] **General practitioners:** "general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] **General Practitioner:** "general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("general"[All Fields] AND "practitioner"[All Fields]) OR "general practitioner"[All Fields] **Practitioner, General:** "general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("practitioner"[All Fields] AND "general"[All Fields]) OR "practitioner, general"[All Fields] **Practitioners, General:** "general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("practitioners"[All Fields] AND "general"[All Fields]) OR "practitioners, general"[All Fields] **Physicians, General Practice:** "general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("physicians"[All Fields] AND "general"[All Fields] AND "practice"[All Fields]) OR "physicians general practice"[All Fields] **General Practice Physician:** "general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("general"[All Fields] AND "practice"[All Fields] AND "physician"[All Fields]) OR "general practice physician"[All Fields] **General Practice Physicians:** "general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general	

	practitioners"[All Fields] OR ("general"[All Fields] AND "practice"[All Fields] AND "physicians"[All Fields]) OR "general practice physicians"[All Fields] **Physician, General Practice:** "general practitioners"[MeSH Terms] OR ("general"[All Fields] AND "practitioners"[All Fields]) OR "general practitioners"[All Fields] OR ("physician"[All Fields] AND "general"[All Fields] AND "practice"[All Fields]) OR "physician, general practice"[All Fields] **Practice:** "practicability"[All Fields] OR "practicable"[All Fields] OR "practical"[All Fields] OR "practicalities"[All Fields] OR "practicality"[All Fields] OR "practically"[All Fields] OR "practicals"[All Fields] OR "practice"[All Fields] OR "practice's"[All Fields] OR "practiced"[All Fields] OR "practices"[All Fields] OR "practicing"[All Fields] **Physicians:** "physician's"[All Fields] OR "physicians"[MeSH Terms] OR "physicians"[All Fields] OR "physician"[All Fields] OR "physicians's"[All Fields] **Geriatrician:** "geriatrician's"[All Fields] OR "geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "geriatrician"[All Fields] **Gerontologists:** "geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "gerontologist"[All Fields] OR "gerontologists"[All Fields] **Gerontologist:** "geriatricians"[MeSH Terms] OR "geriatricians"[All Fields] OR "gerontologist"[All Fields] OR "gerontologists"[All Fields] **y_10[Filter]:** "last 10 years"[dp] **english[Filter]:** english [LA] **Interprofessional:** "interprofessional"[All Fields] OR "interprofessionalism"[All Fields] OR "interprofessionality"[All Fields] OR "interprofessionally"[All Fields] OR "interprofessionals"[All Fields] **Collaboration:** "collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative's"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields] **Interdisciplinary:** "interdisciplinary studies"[MeSH Terms] OR ("interdisciplinary"[All Fields] AND "studies"[All Fields]) OR "interdisciplinary studies"[All Fields] OR "interdisciplinary"[All Fields] **Collaboration:** "collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative's"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields] **Intersectoral Collaboration:** "intersectoral collaboration"[MeSH Terms] OR ("intersectoral"[All Fields] AND "collaboration"[All Fields]) OR "intersectoral collaboration"[All Fields] **Collaboration:** "collaborate"[All Fields] OR "collaborated"[All Fields] OR "collaborates"[All Fields] OR "collaborating"[All Fields] OR "collaboration"[All Fields] OR "collaborations"[All Fields] OR "collaborative"[All Fields] OR "collaborative's"[All Fields] OR "collaboratively"[All Fields] OR "collaboratives"[All Fields] OR "collaborator"[All Fields] OR "collaborators"[All Fields] **Coordination:** "coordinate"[All Fields] OR "coordinated"[All Fields] OR "coordinately"[All Fields] OR "coordinates"[All Fields] OR "coordinating"[All Fields] OR "coordination"[All Fields] OR "coordinations"[All Fields] OR "coordinative"[All Fields] OR "coordinatively"[All Fields] OR "coordinator"[All Fields] OR "coordinator's"[All Fields] OR "coordinators"[All Fields]	

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	Acute: "acute"[All Fields] OR "acutely"[All Fields] OR "acutes"[All Fields] **Trajectory:** "trajectories"[All Fields] OR "trajectory"[All Fields] OR "trajectory's"[All Fields] **y_10[Filter]:** "last 10 years"[dp] **english[Filter]:** english [LA] **Coherence:** "coherence"[All Fields] OR "coherences"[All Fields] OR "coherencies"[All Fields] OR "coherency"[All Fields] OR "coherent"[All Fields] OR "coherently"[All Fields] **Care Quality:** "quality of health care"[MeSH Terms] OR ("quality"[All Fields] AND "health"[All Fields] AND "care"[All Fields]) OR "quality of health care"[All Fields] OR ("care"[All Fields] AND "quality"[All Fields]) OR "care quality"[All Fields] **Care Continuum:** "continuity of patient care"[MeSH Terms] OR ("continuity"[All Fields] AND "patient"[All Fields] AND "care"[All Fields]) OR "continuity of patient care"[All Fields] OR ("care"[All Fields] AND "continuum"[All Fields]) OR "care continuum"[All Fields] **Integration:** "integrability"[All Fields] OR "integrable"[All Fields] OR "integral"[All Fields] OR "integrally"[All Fields] OR "integrals"[All Fields] OR "integrant"[All Fields] OR "integrants"[All Fields] OR "integrate"[All Fields] OR "integrated"[All Fields] OR "integrates"[All Fields] OR "integrating"[All Fields] OR "integration"[All Fields] OR "integrational"[All Fields] OR "integrations"[All Fields] OR "integrative"[All Fields] OR "integratively"[All Fields] OR "integrator"[All Fields] OR "integrators"[All Fields] **Integrated Care:** "Int J Integr Care"[Journal:__jid101214424] OR ("integrated"[All Fields] AND "care"[All Fields]) OR "integrated care"[All Fields] **Coordination:** "coordinate"[All Fields] OR "coordinated"[All Fields] OR "coordinately"[All Fields] OR "coordinates"[All Fields] OR "coordinating"[All Fields] OR "coordination"[All Fields] OR "coordinations"[All Fields] OR "coordinative"[All Fields] OR "coordinatively"[All Fields] OR "coordinator"[All Fields] OR "coordinator's"[All Fields] OR "coordinators"[All Fields] **Transitional Care:** "transitional care"[MeSH Terms] OR ("transitional"[All Fields] AND "care"[All Fields]) OR "transitional care"[All Fields] **y_10[Filter]:** "last 10 years"[dp] **english[Filter]:** english [LA] **y_10[Filter]:** "last 10 years"[dp] **english[Filter]:** english [LA] **y_10[Filter]:** "last 10 years"[dp] **english[Filter]:** english [LA] **y_10[Filter]:** "last 10 years"[dp] **english[Filter]:** english [LA]	

Appendix VI, "Example of initial information via e-mail, Study I"

Kære XX.

Jeg kontakter dig vedrørende Projektet "På FORKANT", hvoraf jeg er en ud af tre ph.d. studerende. Måske har du allerede hørt om projektet, hvor Christian Backer Mogensen er hovedansvarlig?
Projektet fokuserer på tværsektorielt og tværfagligt samarbejde omkring ældre akutindlagte borgere og på sammenhæng i deres behandlingsforløb. Jeg belyser i den forbindelse de sundhedsprofessionelles perspektiv.
Første fase af mit studie indebærer individuelle interviews med sundhedsprofessionelle. Derfor henvender jeg mig hermed til dig.

Har du tid og lyst til at deltage i et individuelt interview af ca. 1 times varighed?
Du kan følge nedenstående link, hvis du ønsker at læse mere en projektet.

Ellers ser jeg frem til at høre fra dig.

Venlig hilsen

Maiken Hjuler Persson
Ph.d-studerende, Cand.Scient.San.Publ., Jordemoder.
Lærings- og Forskningshuset, Fokuseret forskningsenhed for Akutmedicin, Sygehus Sønderjylland.
Institut for Sundhedstjenesteforskning, Syddansk Universitet.

Læs mere om projektet her:
http://www.sdu.dk/da/om_sdu/institutter_centre/ist_sundhedstjenesteforsk/forskning/sundhedsfremme/ph,-d-,d,-d-,-projekter/maiken+hjuler+persson

Appendix VII, "Interview guide. Study I"

Rammen:

- Rammen for interviewet vil være i et for informanten kendt miljø. Varighed estimeres til ca. en time. Deltagelse forudsætter skriftligt samtykke afgivet efter mundtlig og skriftlig information om projektet og deltagelse heri. PL aflønnes efter konsulenttaksten (131,47 kr./modul a' ti min.).

Indledning:

- Kort præsentation af UT

Formål:

- At undersøge fagprofessionelles opfattelse af og erfaring med tværsektorielt og tværprofessionelt samarbejde samt sammenhæng i patientforløb for ældre borger +75, der indlægges akut. Projektet bidrager til generering af nye guideline mhp. At styrke samarbejdet på tværs af sektorer og professioner og skabe større sammenhæng i patientforløbene.

Forløb:

- Interviewet er bygget op over **2 temaer**, som jeg gerne vil have dig til at byde ind på. Det første tema omhandler tværsektorielt og tværfagligt samarbejde omkring ældre borgere +75, der indlægges akut. Andet tema omhandler sammenhæng i forløbene med ældre borgere, der indlægges akut.
- Jeg stiller så vidt muligt åbne spørgsmål, og der er ikke noget rigtigt eller forkert svar, da jeg gerne vil belyse dine synspunkter som fagperson. Muligvis stiller jeg nogle supplerende spørgsmål undervejs, men primært er det dig, som kommer til at dele ud af din erfaring.

Håndtering af data:

- Båndoptagelse og håndskrevne noter, støtte til hukommelse, hjælp til dataanalyse
- Data håndteres fortroligt og anonymiseres, når analyse præsenteres (Du vil formentlig kunne genkende dig selv og dine synspunkter.)
- Bidrager til en international artikel
- Tavshedspligt

<u>Spørgsmål (demografi), Indledning:</u>

Navn og profession?
Hvor lang tid har du været ansat i sundhedsvæsenet? (Kommunalt, regionalt)
Hvad er din nuværende funktion?
Hvor længe har du haft din nuværende funktion?

<u>Spørgsmål, tværsektorielt og tværfagligt samarbejde:</u>

Hvad forstår du ved **tværsektorielt** samarbejde omkring ældre borgere, der indlægges akut?
Hvad forstår du ved **tværfagligt** samarbejde omkring ældre borgere, der indlægges akut?

Hvem ser du som dine vigtigste samarbejdspartnere i relation til tværfagligt og tværsektorielt samarbejde?
Hvordan tror du, dine samarbejdspartnere (Hospital, Kommune PL) ser dig/Din faggruppe/profession og din funktion?
Hvordan ser du din egen rolle i forhold til tværsektorielt og tværfagligt samarbejde omkring en ældre borger, der indlægges akut?
Hvad bidrager til et velfungerende samarbejde på tværs af sektor- og faggrænser?
Hvilke barrierer kan der være?
Hvad er vigtigt for dig for at samarbejdet før under og efter akutindlæggelse af den ældre borger kan styrkes/fungere?

Spørgsmål, sammenhængende patientforløb:
Hvad er et "sammenhængende patientforløb" for den akutindlagte ældre borger?
Hvad bidrager til et sammenhængende patientforløb før, under og efter akutindlæggelse af ældre borgere?
Hvilke barrierer kan der være for sammenhæng i et forløb?
Hvordan ser du din egen rolle i forhold til at skabe sammenhæng i et patientforløb, hvor en ældre borger indlægges akut?
Hvem har ansvaret for at forløbet bliver sammenhængende?
Har borgeren nogen andel i at påvirke sammenhængen i forløbet? (Er der forskel på borgere/patienter)

Har de pårørende nogen andel i at påvirke sammenhængen i forløbet? (Er der forskel på pårørende-indflydelse) (Sparsomt netværk? Ændrer det kravene til dig som sundhedsprofessionel?)

Afrunding:
Er der noget, vi ikke har været inde på, som du synes er særlig relevant, og som du vil tilføje?

Afslutning:
- Tak for din deltagelse.
- Hvordan har det været at deltage i interviewet?

Appendix VIII, "Check-list"

Checklist for negotiation of access	
1	Establish contact with necessary permission givers
2	Have an outline of your study ready
3	Clear any official permissions at all levels or channels
4	Consider relevant gate-keepers Consider potential sensitive issues or areas
5	Discuss study outline with likelihoods (Any blind angles?)
6	Be prepared to modify your plans

Based on Box ATP.1 (Robson, C., 2002, "Real world research: a resource for social scientists and practitioner-researchers", p 379.)

Appendix IX, "Written Information, Study II"

Kære _____

Mit navn er Maiken Hjuler Persson. Jeg er i gang med en ph.d. uddannelse, hvor jeg undersøger, hvordan praktiserende læger, sygehus og kommune samarbejder.
Formålet med mit projekt er at få viden om, hvordan et forløb *før*, *under* og *efter* en akut indlæggelse af ældre (på 65 år eller derover) kan forbedres.

Konkret kan din deltagelse komme til at betyde:

- At jeg er til stede, når du har kontakt med f.eks. læger og sygeplejersker under din indlæggelse. Det vil sige, at jeg opholder mig som en ekstra person i lokalet

- At du giver mig lov til at ringe til din egen læge, hjemmepleje, visitator og evt. fysioterapeut eller andre sundhedsfaglige personer, der er involveret i dit forløb, for at høre om hans/hendes oplevelse af samarbejdet omkring din indlæggelse

- At du giver mig lov til at deltage efter din udskrivelse, hvis du har nye kontakter med eksempelvis egen læge eller sygehus. Jeg vil derfor gerne have lov at ringe til dig cirka 1 uge, 2 uger og 1 måned efter din udskrivelse for at følge op

Mit studie er en del af et projekt, der hedder På FORKANT i Syd, som bl.a. er støttet af Region Syddanmark, de fire sønderjyske kommuner (Aabenraa, Haderslev, Tønder og Sønderborg) og Syddansk Universitet.
Hvis du har lyst, kan du læse mere i den vedlagte folder. (Generel information omkring På FORKANT i Syd vedlægges[17]).
Du vil naturligvis indgå anonymt i studiet, ligesom din deltagelse eller dit afslag ikke vil få nogen form for betydning for din pleje og behandling.
Det er vigtigt for mig, at din deltagelse på alle måder bliver en god oplevelse.
Jeg fortæller dig gerne mere om projektet, hvis du oplever et behov for dette.

Venlig hilsen
Maiken Hjuler Persson
Ph.d.-studerende
Mail: Maiken.Hjuler.Persson@rsyd.dk
Tlf.: 23 88 57 84

[17] See http://www.sygehussonderjylland.dk/wm499408

Appendix X, "Information, Study III"

Kære interviewdeltager

Tak for dit positive tilsagn om deltagelse i fokusgruppe.
Mit navn er Maiken Hjuler Persson. Jeg er i gang med en ph.d. uddannelse, hvor jeg undersøger, hvordan praktiserende læger, sygehus og kommune samarbejder.
Formålet med mit projekt er at få viden om, hvordan et forløb *før*, *under* og *efter* en akut indlæggelse af ældre kan forbedres.
Mit studie er en del af projekt 'På FORKANT i Syd', som bl.a. er støttet af Region Syddanmark, Hospital Sønderjylland, de fire sønderjyske kommuner (Aabenraa, Haderslev, Tønder og Sønderborg) og Syddansk Universitet.
Hvis du har lyst, kan du læse mere via flg. Link:
http://www.sygehussonderjylland.dk/wm499408
Selve interviewet foregår **d. XX-XX-2019** kl. **13-15**. i **mødelokale A1 i Lærings- og Forskningshuset, Kresten Philipsens vej 15F, 6200 Aabenraa**.
Der er fri parkering (Se vedhæftede kort) lige udenfor indgangen (P-F), alternativt kan P-huset (P-B) eller P-A benyttes.
Der er ingen forberedelse til dagen. Selve interviewet tager udgangspunkt i en case, der er genereret på baggrund af mine tidligere interviews og observationer, som du skal drøfte sammen med andre sundhedsprofessionelle. Du deltager sammen med sundhedsprofessionelle fra henholdsvis sygehus, almen praksis og kommune. Med jeres viden kan I bidrage til at belyse, hvor og hvordan et patientforløb kan styrkes. På dagen vil der skulle udfyldes samtykkeerklæringer på din deltagelse.
Du er velkommen til at kontakte mig, hvis du har spørgsmål. Er du mod forventning forhindret, beder jeg dig kontakte mig snarest.
Jeg glæder mig til at møde dig.

Venlig hilsen

Maiken Hjuler Persson
Ph.d.-studerende
Mail: Maiken.Hjuler.Persson@rsyd.dk
Tlf.: 23 88 57 84

Appendix XI, "Consent form, Study I-III"

(S1)

Informeret samtykke til deltagelse i et sundhedsvidenskabeligt forskningsprojekt.

Forskningsprojektets titel: "På FORKANT i Syd – Belysning af de sundhedsprofessionelles vinkel for styrket tværsektoriel indsats omkring ældre borgere, der indlægges akut"

Erklæring fra forsøgspersonen:

Jeg har fået skriftlig og mundtlig information og jeg ved nok om formål, metode, fordele og ulemper til at sige ja til at deltage.

Jeg ved, at det er frivilligt at deltage, og at jeg altid kan trække mit samtykke tilbage uden at miste mine nuværende eller fremtidige rettigheder til behandling.

Jeg giver samtykke til, at deltage i forskningsprojektet, og har fået en kopi af dette samtykkeark samt en kopi af den skriftlige information om projektet til eget brug.

Forsøgspersonens navn: _____

Adresse:_____

Tlf.:_____

Dato: _____ Underskrift: _____

Jeg giver mit samtykke til, at jeg efter min deltagelse må kontaktes i projektperioden, hvis der er behov for yderligere oplysninger:

Ja _____ (sæt x) Nej _____ (sæt x)

Ønsker du at blive informeret om forskningsprojektets resultat samt eventuelle konsekvenser for dig?:

Ja _____ (sæt x) Nej _____ (sæt x)

Erklæring fra den, der afgiver information:

Jeg erklærer, at forsøgspersonen har modtaget mundtlig og skriftlig information om projektet.

Efter min overbevisning er der givet tilstrækkelig information til, at der kan træffes beslutning om deltagelse i projektet.

Navnet på den, der har afgivet information: Maiken Hjuler Persson

Dato: _____ Underskrift: _____

Appendix XII, "Supplementary material, Study I-III":

Forsøgspersoners rettigheder i et sundhedsvidenskabeligt

Forskningsprojekt

Som deltager i et sundhedsvidenskabeligt forskningsprojekt skal du vide, at:

- din deltagelse i forskningsprojektet er helt frivillig og kun kan ske efter, at du har fået både skriftlig og mundtlig information om forskningsprojektet og underskrevet samtykkeerklæringen.
- du til enhver tid mundtligt, skriftligt eller ved anden klar tilkendegivelse kan trække dit samtykke til deltagelse tilbage og udtræde af forskningsprojektet. Såfremt du trækker dit samtykke tilbage påvirker dette ikke din ret til nuværende eller fremtidig behandling eller andre rettigheder, som du måtte have.
- du har ret til at tage et familiemedlem, en ven eller en bekendt med til informationssamtalen.
- du har ret til betænkningstid, før du underskriver samtykkeerklæringen.
- oplysninger om dine helbredsforhold, øvrige rent private forhold og andre fortrolige oplysninger om dig, som fremkommer i forbindelse med forskningsprojektet, er omfattet af tavshedspligt.
- opbevaring af oplysninger om dig, herunder oplysninger i dine blodprøver og væv, sker efter reglerne i lov om behandling af personoplysninger og sundhedsloven.
- der er mulighed for at få aktindsigt i forsøgsprotokoller efter offentlighedslovens bestemmelser. Det vil sige, at du kan få adgang til at se alle papirer vedrørende din deltagelse i forsøget, bortset fra de dele, som indeholder forretningshemmeligheder eller fortrolige oplysninger om andre.
- der er mulighed for at klage og få erstatning efter reglerne i lov om klage- og erstatningsadgang inden for sundhedsvæsenet. Hvis der under forsøget skulle opstå en skade kan du henvende dig til Patienterstatningen, se nærmere på www.patienterstatningen.dk.

De Videnskabsetiske Komiteer for Region Hovedstaden (6 komiteer)
Tlf.: +45 38 66 63 95
E-mail: vek@regionh.dk
Hjemmeside: www.regionh.dk/vek

De Videnskabsetiske Komiteer for Region Syddanmark (2 komiteer)
Tlf.: + 45 76 63 82 21
E-mail: komite@rsyd.dk
Hjemmeside: www.regionsyddanmark.dk/komite

Den Videnskabsetiske Komité for Region Nordjylland Tlf.: +45 97 64 84 40
E-mail: vek@rn.dk
Hjemmeside: www.vek.rn.dk

Den Videnskabsetiske Komité for Region Sjælland
Tlf.: +45 93 56 60 00
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De Videnskabsetiske Komiteer for Region Midtjylland (2 komiteer)
Tlf.: +45 78 41 01 83 / +45 78 41 01 82 / +45 78 41 01 81
E-mail: komite@rm.dk
Hjemmeside: www.komite.rm.dk

Den Nationale Videnskabsetiske Komité
Tlf.: +45 72 26 93 70
E-mail: kontakt@nvk.dk
Hjemmeside: www.nvk.dk

Dette tillæg er udarbejdet af det videnskabsetiske komitésystem og kan vedhæftes den skriftlige information om det sundhedsvidenskabelige forskningsprojekt. Spørgsmål til et konkret projekt skal rettes til projektets forsøgsansvarlige. Generelle spørgsmål til forsøgspersoners rettigheder kan rettes til den komité, som har godkendt projektet.

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Appendix XIII, "Room-arrangements, FG 1 and FG 2"