



<http://www.diva-portal.org>

This is the published version of a paper published in *Quality Management in Health Care*.

Citation for the original published paper (version of record):

Andersson, A-C., Ainalem, I., Berg, A., Janlov, A-C. (2016)

Challenges to improve inter-professional care and service collaboration for people living with psychiatric disabilities in ordinary housing.

Quality Management in Health Care, 25(1): 44-52

<http://dx.doi.org/10.1097/QMH.0000000000000076>

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Open Access article

Permanent link to this version:

<http://urn.kb.se/resolve?urn=urn:nbn:se:hj:diva-30048>

Challenges to Improve Inter-Professional Care and Service Collaboration for People Living With Psychiatric Disabilities in Ordinary Housing

Ann-Christine Andersson, PhD, MSc, RN; Ingrid Ainalem, MSc, RN; Agneta Berg, PhD, RNT; Ann-Christin Janlöv, PhD, MSc, RN

The aim of this study was to describe health care- and social service professionals' experiences of a quality-improvement program implemented in the south of Sweden. The focus of the program was to develop inter-professional collaboration to improve care and service to people with psychiatric disabilities in ordinary housing. Focus group interviews and a thematic analysis were used. The result was captured as themes along steps in process. (I) Entering the quality-improvement program: *Lack of information about the program, The challenge of getting started, and Approaching the resources reluctantly*. (II) Doing the practice-based improvement work: *Facing unprepared workplaces, and Doing twice the work*. (III) Looking back—evaluation over 1 year: *Balancing theoretical knowledge with practical training, and Considering profound knowledge as an integral part of work*. The improvement process in clinical practice was found to be both time and energy consuming, yet worth the effort. The findings also indicate that collaboration across organizational boundaries was broadened, and the care and service delivery were improved.

Key words: health care, inter-professional collaboration, improvement methodology, psychiatric disability, social service, thematic analysis

Author Affiliations: The Jönköping Academy for Improvement of Health and Welfare, Jönköping University, Jönköping (Dr Andersson), Centre for Innovation and Improvement (CII), Region Skåne, Malmö (Dr Ainalem), School of Health and Society, Kristianstad University, Kristianstad (Drs Berg and Janlöv), and University West, Trollhättan (Dr Berg), Sweden.

Correspondence: Ann-Christine Andersson, PhD, MSc, RN, The Jönköping Academy for Improvement of Health and Welfare, Jönköping University, Jönköping, Sweden (contact@ann-christine.se, ann-christine.andersson@ju.se)

The authors declare no conflicts of interest.

The authors thank the Research Platform for Collaboration for Health, Kristianstad University and the Research Board Kristianstad University for funding. We also thank the participants in the study and Språkservice for revising the English.

This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License 4.0 (CCBY-NC-ND), where it is permissible to download and share the work provided it is properly cited. The work cannot be changed in any way or used commercially.

Author contribution: Three authors (A.C.J., I.A., A.B.) conducted analyses independently of each other and then discussed the evolving structure of codes as subthemes and themes in the transcripts, moving back and forth between these, reflecting on relations and levels, and finally agreeing on a preliminary structure. A fourth author (A.C.A.) critically reviewed the themes in relation to the codes, and after a joint discussion all the authors agreed on the final themes. Two authors (A.C.J., A.B.) are professionally experienced psychiatric nurses with research experience in the field. The other 2 authors are professionally experienced in quality-improvement work; one is a strategic organizational developer (I.A.), and the other holds a PhD in quality technology (A.C.A.).

Funding: This research was funded by the Research Platform for Collaboration for Health, Kristianstad University and the Research Board Kristianstad University.

Ethical approval: Ethical considerations related to the study followed the Swedish law for human research (<http://www.codex.uu.se>). All professionals were invited to participate, received written and oral information about the study, and thereafter gave informed consent to be interviewed.

To improve health care and social services to vulnerable groups, such as people with severe psychiatric disorders living in ordinary housing, there is a need to find more efficient ways for inter-professional collaboration. This is a challenge in Sweden since the responsibility of providing care and social services for those people is shared between county councils or regions ($n = 21$) and municipalities ($n = 290$) as a result of Sweden's 1995 mental health care reform.¹ This deinstitutionalization meant that municipalities became legally obligated to offer social support, housing, and activities for people with psychiatric disabilities,² while county councils were to retain responsibility for health care.³ The shared legal responsibility has increased the pressure on professionals from different organizations to cooperate to offer the best care and service.⁴ It is vital to establish continuity in care and service between caregivers of these different organizations, not least since people with psychiatric disabilities often have several care and service needs. This article describes professionals' experiences of a 1-year quality-improvement program meant to develop inter-professional collaboration between organizations.

In Sweden, managements' responsibility for providing and improving care service and cooperation is defined in national health care regulations,⁵ and quality-improvement programs have become frequent

Q Manage Health Care
Vol. 25, No. 1, pp. 44–52

Copyright © 2016 Wolters Kluwer Health, Inc. All rights reserved.

DOI: 10.1097/QMH.000000000000076

components of both Swedish health care and social services.⁶ Those initiatives are often seen as a way to overcome the financial strain that public organizations face,⁷ as well as a means of bridging gaps in care and services between different caregivers.⁵

To realize improvement ideas, both professional knowledge and profound knowledge is required. Profound knowledge is needed to know how to improve processes and systems in health care and social service.⁸ Profound knowledge consists of systems understanding, evidence-based knowledge, knowledge of measurements and variations, and change management/psychology,⁹ and can develop the professionals' ability to identify and bridge the gaps between what we know and what we do.^{8,10} This was the aim of the development of the Breakthrough Series Collaborative methodology¹¹ that has been used frequently in (Swedish) care and service settings, perhaps because of its collaborative and bridging intentions. In the southern region of Sweden, the Centre for Innovation and Improvement (CII)¹² is working on development and improvement in accordance with the systematic policy of quality and patient safety within care and service,⁵ often by using the Breakthrough Model for Improvements. The CII policy involves a long-term, patient-oriented process that is characterized by a preventive mindset and methodology, is open to continuous improvement, and involves decisions firmly grounded in facts; in addition, the process is cooperative by nature.

To improve care and services for psychiatrically disabled people in ordinary housing, it is vital that the different organizations—including hospitals, primary care facilities, and social services—work together across their organizational boundaries. Cooperation between professionals despite organizational affiliation are preconditions for improvement, and collaborative quality-improvement programs can be used to improve care on an organizational level¹³ and to close the gap between current practice and ideal performance.¹⁴ Improvement programs can also be used to create practical learning that can improve care and services.¹⁰ A Swedish evaluation study of a collaborative program showed both improvements and confirmed significant engagement in improvement work.¹⁵

There are ongoing improvement initiatives based on profound knowledge within Swedish health care and social services⁶ but, as far as we know, they are not focused on collaboration between municipalities, county councils, and regions. Therefore, the objective of this study was to describe experiences reported by inter-professional participants in a 1-year quality-improvement program aimed at improving care and services for people living with psychiatric disabilities in ordinary housing, through collaboration between organizations.

METHODS

Design, settings, and participants

The research used a qualitative descriptive approach employing focus group interviews, followed by a the-

matic analysis, to grasp the professionals' experiences of the quality-improvement program. The study was conducted in 6 municipalities in Sweden's southern region, which all vary in size, structure, and number of inhabitants. The municipalities' populations ranged from 7000 to 80 000 inhabitants.¹⁶ In total, 54 professionals participated in the program while 46 participated in the interviews. They represented many different professions and specialties, including county council psychiatry, community psychiatry, home help service, and primary care (see Table 1). Six multi-professional teams, each consisting of 6-11 professionals, were formed. The participating professionals were selected by their managers to represent the care and service actors involved in multi-professional collaboration within their respective communities. Ethical considerations related to the study followed the Swedish law for human research (<http://www.codex.uu.se>).

The improvement program

The CII improvement program was aimed to improve collaboration between the different participating organizations and was conducted in 2010. Before the program started, facilitators met with first- and second-line managers in the municipalities. The municipalities were informed about the program, its design, and its content and were asked to select professionals from the main care and service facilities in each community to form and participate in a community team. The importance of the managers' involvement in the program, as well as their support for it, was stressed.

This program (see Figure 1) was based on the Breakthrough Series Collaborative methodology.¹¹ Participants divided into teams participated in 5 learning seminars and were trained in the different components of profound knowledge⁹ by facilitators ($n = 4$) from the CII. Each team was assigned a facilitator who was fully acquainted with the theory of improvement and with all the improvement process tools that compose the programs. The program extended over a 10-month period and consisted of a number of learning seminars interspersed with periods of homework. The learning seminars focused on the basic elements underlying an improvement process and used a systematic methodology based on Deming's PDSA model (plan, do, study, act).¹⁷ To stimulate exchange of knowledge, individuals worked both in their own teams and in cross-team groups.

Since the design aimed to collaboratively improve psychiatric health care and social services for users with psychiatric disabilities, each team identified, formulated, and then worked on improving areas of joint activity—in other words, on establishing continuity of care. The improvement ideas varied, from increasing the use of individual care-plans and following national guidelines, to setting goals like "Increase cooperation between county council psychiatry, municipal community psychiatry, and social service—to decreasing long hospital stays and increasing quality of life" (Table 2). The outcomes of the improvement teams also differed; one team used measurements (VAS) and could show

Table 1. Demographic Characteristics of the Professionals in the Focus Groups (N = 46)

	Group 1 (n = 9)	Group 2 (n = 12)	Group 3 (n = 9)	Group 4 (n = 5)	Group 5 (n = 5)	Group 6 (n = 6)
Gender (man/woman)	1/8	2/10	3/6	3/2	2/3	0/6
Age	29-55	32-62	32-55	26-55	38-65	29-63
Municipal psychiatric service						
Registered psychiatric nurse			1			
Licensed mental practical nurse	6	1		1	1	1
Social worker			2	1	1	2 ^a
Social educationalist		2	1			1
Municipal home help service						
Social worker						
Home help aid		1				
Licensed practical nurse		3				
County council psychiatry						
Registered psychiatric nurse			1	1	1	
Registered nurse	1	1	1		1	1
Licensed mental practical nurse	1	2	1	2	1	
Social worker			1			
Treatment educationalist		1	1			
Primary care						
Registered primary care nurse						
Registered nurse	1	1				1 ^a

^aAn additional management position.

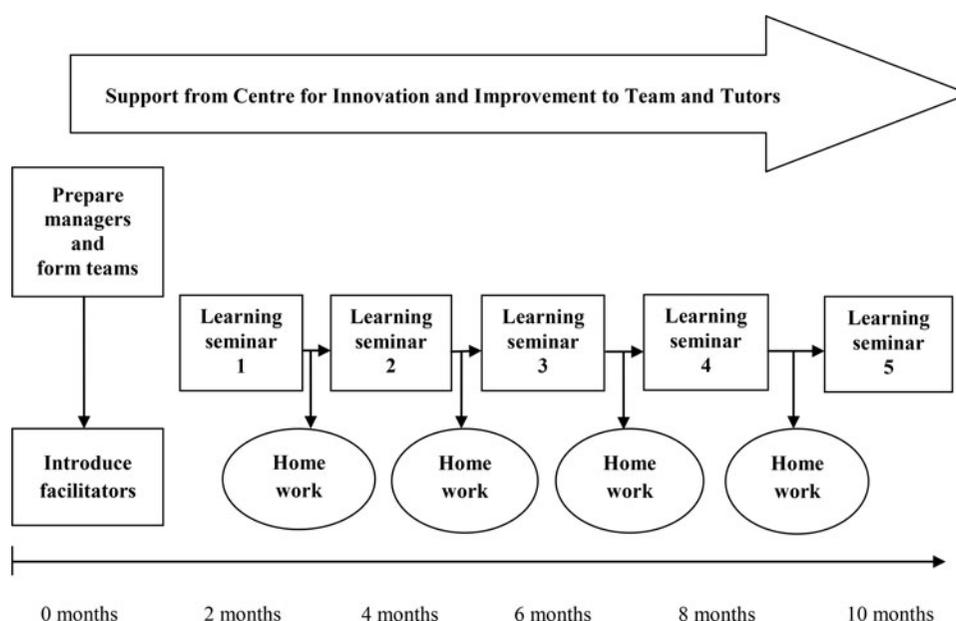


Figure 1. The Centre for Innovation and Improvement’s improvement programs.

Table 2. Improvement Idea/Goal and Outcome Related to Clients' Care and Service

Team	Improvement Idea/Goal	Outcome
1	(Poor cooperation despite shared responsibility) Increase cooperation between county council psychiatry, municipal community psychiatry, and social service in order to decrease long hospital stays and increase quality of life of these clients.	1a. Increased cooperation between the care- and service levels. Established networks and contacts across boundaries. 1b. Increased quality of life by 50% for clients hospitalized for long periods of time (VAS ^a).
2	(Cases of compulsory care) Prevent compulsory care for clients with psychiatric disability.	2a. Implemented Case Management as organizational model that led to improved cooperation with other care/service levels. 2b. Established a preventive crisis plan by multi-professional collaboration.
3	(Unclear care plans) Increase the number of documented care plans to 100%.	The base line number of care plans were 56% and 75% when the program was completed (VAS ^a).
4	(Unstable life- and care situation) Improve quality of life by Case Management—by providing a Case Manager to coordinate the care/service for 5 clients.	4a. Implemented Case Management as an organizational model. 4b. Improved clients' quality of life by providing a Case Manager (VAS ^a).
5	(Not following National guidelines due to poor cooperation) Increase cooperation between county council psychiatry and municipal community psychiatry, and social service.	5a. Formed a collaborative professional team between county council psychiatry and municipal community psychiatry, which initiated physical activities for clients. 5b. Formed cooperation/collaboration regarding shared responsibility for clients.
6	(Lack of meaningful activities/work) Increase number of possibilities for transitional work for clients.	Cooperation between county council psychiatry, municipal community psychiatry, and assessing social worker led to transitional work for 4 clients.

^aVAS (Visual Analogue Scale) was used in the assessments.

that their improvement increased quality of life 50 percentages for clients with long hospitalization periods. Others implemented a Case Management model that led to improved cooperation with other care/service levels, while still others formed a collaborative professional team by county council psychiatry and municipal community psychiatry, which initiated physical activities for clients (Table 2).

Interviews

Focus group interviews¹⁸ were chosen to capture the inter-professional teams' experiences through discussions about the program. An interview guide was used that started with an overarching question: *Could you please tell me about your experiences participating in this improvement program?* Further questions concerned learning in profound knowledge, facilitators, and the barriers, aims, goals, and outcomes involved in the program. Overall, participants were active and engaged in the discussions. AB and ACJ moderated 3 interviews each. The professionals were interviewed in relation to the last learning seminar (October 2010), which lasted between 75 and 100 minutes, and were tape recorded and verbatim transcribed. All professionals were invited to participate, received written and oral information about the study, and gave informed consent to be interviewed.

Data analyses

A thematic analysis by Braun and Clarke was used.¹⁹ The process is described in terms of 6 phases: (1) familiarizing oneself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming the themes, and (6) produc-

ing the report. The analysis started with reading and rereading the transcripts to become familiar with the data and to note ideas. Thereafter, we identified meaningful units from the text that related to the aim of the study. These were coded; similar codes were grouped into subthemes, which ultimately formed the themes. Through the analysis, our understanding of the data in terms of a process grew. Three authors (A.C.J., I.A., A.B.) conducted analyses independently of each other and then discussed the evolving structure of codes as subthemes and themes in the transcripts, moving back and forth between these, reflecting on relations and levels, and finally agreeing on a preliminary structure. A fourth author (A.C.A.) critically reviewed the themes in relation to the codes, and after a joint discussion, all the authors agreed on the final themes. Quotations from the focus group interviews were marked FG 1-6, and participants were marked in order, P 1-11.

RESULT

The professionals' experiences of the 1-year quality-improvement program were captured through the focus groups interviews as themes along steps in a process. (I) Entering the quality-improvement program: *Lack of information about the program, The challenge of getting started, and Approaching the resources reluctantly.* (II) Doing the practice-based improvement work: *Facing unprepared workplaces, and Doing twice the work.* (III) Looking back—evaluation over 1 year: *Balancing theoretical knowledge with practical training, and Considering profound knowledge as an integral part of work.*

Entering the quality-improvement program

Lack of information about the program

A prominent feature in all group discussions was complaints about lack of information about the program, its content, and what participation entailed. The duration and extent of the program was unknown to most of the professionals, including that it would run over 1 year and that it included 5 learning seminars and lessons and group meetings between the seminars. As a result, many participants entered the program without knowing what it was all about. The professionals' motivations for participating in the improvement program varied; most in the groups expressed interest in or curiosity about new care methods as a reason for participation. Most of them were open minded and looked forward to the program, voicing positive expectations, while some expressed reluctance or even resistance regarding participation. The participants had been either selected or asked to take part by their managers. As discussed (FG6):

P1: I just got a letter informing me that I should be at this place. Yes, I had chosen to do this anyhow // P7: When our manager presented it—I have always been eager for collaboration and cooperative work [others agree]. I was on another job when I received the letter welcoming me to a group on improvement work. I thought, "What is this?" [laughter from all]. ... I had no clue then, and the first meeting was soon. // P4: No, I didn't have a clue either.

The challenge of getting started

The first day of the first seminar was spent primarily setting up each group to work with the tasks; this meant more or less group processing. All groups revealed their difficulties beginning their tasks—defining a problem, formulating a goal, executing a plan, and following up. They appeared unprepared for the extra work they would have to do. Clearly, the groups had to address different preexisting conditions before they could focus on the tasks. In all the groups, time was needed for members to get to know one another. However, 2 groups stood out from the others. In one, the professionals did not know one another or the responsibilities and functions at all; in this group, a great deal of time was dedicated to presentations and clarifications, and this slowed their work process significantly. The other group constituted members who were quite familiar with one another who therefore could begin collaborating and focusing on their tasks more quickly than the other groups. Some interviews showed complaints about the incomplete sprawling constellation of the groups themselves—probably because the groups were meant to represent all the involved service providers in each municipality, psychiatric county council, and primary care facility. (This plan in some cases failed, since representatives of primary care providers and social service care managers often were absent.) Excerpt (FG1):

P6: It was difficult, because we were from different places, to get the group together and choose a mutual area for improvement. // P1: When we met ... we hardly knew why we were there and how we were connected to each other ... we had big problems with this in the beginning. Or as (FG6): In our group it has been easier. I mean, it's worked faster because there are only a few of us and we know each other ... but we were vulnerable when someone was missing.

Approaching the resources reluctantly

The first learning seminar appeared to motivate most groups to get started—especially a lecture about a case that succeeded, thanks to a new way of thinking and cooperating. The facilitators of each group were mostly regarded as supportive during the work sessions. It took time to grasp the improvement thinking, identify an improvement area, make the improvement area tangible, decide upon a goal, and then map it and decide how to measure it. Professionals could call for better facilitation. The facilitation was considered important, and the characteristics that participants emphasized as necessary in facilitators were being trustworthy, inspiring, and enthusiastic, having the ability to moderate without being disruptively commanding, and being able to create an open and permissive climate. At the study's end, in retrospect, most professionals smiled at the high-flying goals that they had initially articulated but that had necessarily changed several times.

An initial reluctance regarding the tools was evident, as was a slow discovery of the advantages of systematic use of such methods, including reflective group dialogues. One group strongly indicated that its members saw no use in them at all; indeed, most professionals had little experience working with assessment tools in daily practice. Eventually, in spite of the resistance, they learned to use the tools for mapping care situations and assessments. However, applying those tools in daily practice in their workplaces was a challenge. Several tools were mentioned as particularly valuable during the improvement work. Systemic meetings were viewed as very useful, as was the PDSA (plan, do, study, act) cycle. Other tools that were considered helpful were measurement methods, process mapping, SWOT, systemic meetings, and the fish-bone technique. Excerpt (FG3):

P2: The facilitators were helping by not directing too much at the start. You have to discover yourself that, OK, we can't bring down those stars. One must dare to fail. // P4: But, we used the VAS scale and asked users if they were satisfied with their daily activities. It actually showed that some were not. Then we worked on that.

Doing practice-based improvement work

Facing unprepared workplaces

When starting the improvement process, the importance of preparation in the workplaces became

distressfully evident. The professionals became clear of how vital it is to involve managers, coworkers, and psychiatrically disabled people in the improvement process. Management's involvement and support was stressed by all groups as a precondition for successful improvement: managers must be engaged and supportive, and they need to have taken measures ahead of time to facilitate the improvement work; for instance, they should ease the participating professionals' ordinary workloads. Few professionals stated that their managers had done so. Instead, group discussions commonly described an unprepared workplace and uninterested or unsupportive managers. One group described a manager who behaved as if he had issued an order—improvement work was to be conducted by others. A new type of managers was deemed necessary: one that would provide support both throughout the improvement process and after the program's completion. All groups described having difficulty awakening coworkers' interest at the workplace. Coworkers' resistance to change as a whole and to improvement work in particular was experienced as a barrier. Improvement work was particularly neglected by professionals who held legitimate power. The psychiatrically disabled people were mainly described as curious about and positive regarding involvement in the work; only a few were negative or reluctant. Preparedness was also associated with different conditions in larger and smaller communities. Smaller communities were dependent on the larger communities' care and service, and had a smaller supply of services. Excerpt (FG3):

P1: There has been less support from the employer than was expected. // P10: Well, it sounded so good when we started—"Oh yes, it is a priority"—but the reality, what the management actually did, was very different [others agree]. // P6: I would say that it was the information before . . . that was not clear enough.

Doing twice the work

The improvement work would be done in parallel with participants' ordinary work. This was when the challenge of applying what they had learned and knew became noticeable. The lessons produced the stress of planning, taking measurements, studying measurements, writing up results, and meeting deadlines related to the program. Applying tools and measurements in practice involved learning, which took time. All professionals experienced this as a time strain due to the requirement that they work on their "lessons" at group meetings between the learning seminars in order to collaborate on their improvement goal. In addition, an organizational tiredness was expressed, which resulted from other ongoing projects, parallel training sessions, and sick leaves. Coworkers had to take over elements of participants' ordinary work duties since absent staff weren't being replaced. "*My colleagues have been worth their weight in gold, working understaffed*" (FG2, P6). Consequently, the professionals felt guilty

because coworkers' workload had increased, which risked negatively influencing their attitude toward the program. Another issue was the lack of continuity in the workplace and for the psychiatrically disabled people. Most appreciated participating in the improvement activity; however, some refused to collaborate. On the whole, the improvement process in clinical practice was viewed as time and energy consuming, but worth the effort. Excerpt (FG1):

P5: I think a desire to work this way has been expressed [others agree]. But . . . then there is a weariness in the organization; there are so many projects going on all the time . . . And how to set aside time? // P3: Yes, and if you have patients, time must be devoted. It's not something you do in between. It takes time. // P5: Yes, otherwise the patients could suffer, and then the improvement work would suffer.

Looking back—Evaluation after 1 year

Balancing theoretical knowledge with practical training

When the professionals were asked to reflect on what profound knowledge is and how to define it, cautious comments revealed a lack of theoretical understanding of profound knowledge. It seemed difficult to grasp, whereas practice-based explanations seemed more accessible. Few professionals clarified profound knowledge as a systematic way of working by using tools, setting goals, and finding new methods and possibilities. A common reflection was that profound knowledge involves cooperation and collaboration—and that getting to know one another, along with colleagues' functions and responsibilities, therefore is important for improving psychiatric care and service. One group stressed this as a necessity. It was also mentioned that the improvement work had increased both their own and doctors' involvement. Excerpt (FG5):

P1: We are still learning . . . it is like traveling . . . across borders. We learn about other functions. // P6: Yes, I have learned so much in this program, and I think it's useful knowledge because it isn't merely theoretical knowledge.

Considering profound knowledge as an integral part of work

The participants generally found the program to be sufficiently well designed. Discussions concluded that participants had gained new, useful knowledge and insights through the program and through the actual improvement work by implementing it in their workplaces. Suggestions were made that all coworkers should have been invited to the program to excite their interest and thereby ease and strengthen the improvement work. When reflecting on initial aims versus achieved goals and results, most group discussions emphasized a need to work long term and to value small steps in the right direction. However, all the participants

were very proud of their achieved improvement results. Overall, the participating professionals received positive feedback from the psychiatrically disabled people and from their networks. Those directly involved in the improvement efforts were perceived in very positive ways because they learned new approaches, a step further toward personal growth and greater involvement in the community. Excerpt (FG3);

P1: Changes through the improvement work? Seeing the potential in all individuals . . . there is potential for change in every individual and an opportunity for change . . . [others agree]. Ignore the obstacles [others agree], and see opportunities. // P2: Yes, nowadays, we see possibilities in every problem. And, I would go so far as to say that because of the way we worked together . . . we even saved his life. // P5: Mmm, this is the first time in a long time I've felt that [a program] is something that can stay alive.

Having to work in groups that represented different health care and service providers in the community and having a common focus on improving care for psychiatrically disabled persons were seen as very fruitful. The work in one group was described as having brought the professionals together, facilitating knowledge about one another's work, responsibilities, and mandates. In this way, assignments in the future could be handled faster and more effectively. As a whole, comments indicated that it now was easier to reach out to each other because now, as a result of this collaborative work, they knew about the facilities. Some had worked together so well during the program that they planned to meet regularly after its conclusion to keep the improvement work alive. Continuing the group's collaboration was viewed as important. Plans were made to organize further collaboration meetings at the various workplaces to facilitate even greater learning and understanding of each organization's function. The plans also included inviting new collaborative partners. The need to support one another in order to keep the improvement work alive was stressed. Discussion (FG5):

P7: This program has produced many side effects that have been valuable [and], important for the future. // P2: and, this particular interaction with new channels makes it very convenient to assist the individual. // P10: Yes . . . changes that lead to improvements are valuable, so that we don't simply change without evaluating. I think that I'll probably work on improvements not only through this concept.

DISCUSSION

This study describes professionals' experience of a 1-year quality-improvement program intended to develop inter-professional collaboration and improve the care and services provided to people with psychiatric disabili-

ties across organizational boundaries. The results are presented according to themes throughout a process, illuminating the challenges and barriers that arose both at its beginning and during the improvement program; but the results also to some extent reflect participants' retrospective evaluations of their improvement journey. Improvements and changes overall can be seen as ongoing journeys that should never end.^{11,17} Therefore, the participants' statements that they wished to maintain the established collaboration can themselves be seen as improvement.

All participants expressed a strong intention to improve the care and the daily-life situations of psychiatrically disabled people. This intention has been expressed in other studies exploring collaborative methods in different (health) care settings.¹⁵ The challenge to delivering good continuous care was identified as the administrative gap between the regions and the municipalities. The varying leadership and legislation for care and services for persons with psychiatric disability are often seen as significant challenges.²⁰ Therefore, collaborative improvement programs are useful and important, a view that the participants also shared. Table 2 shows the improvement ideas and outcome after 1 year. Over the course of the program, the improvement ideas and the goals shifted, and so did the outcomes. All teams had nonetheless, in spite of the challenge of sharing responsibility for providing care and social services, managed to establish collaboration between the different organizations—an important first step for improvements.

An odd finding in this study is that so many of the participants claimed they did not know anything about the improvement program they were joining before it began. Why were they there and why had they not learned beforehand what was expected of them? One possible explanation is that they were selected by management. All the managers were informed about the program before it started—but when selecting participants, why did the managers not pass that information along? Strandberg et al have shown that the outcome of improvement collaboration is more successful if participants freely volunteer to participate rather than if managers select them.²¹ On the other hand, in this case, some selected participants were better able or had already begun to work toward more collaboration across boundaries. But the question remains: Why did the managers who selected the participants not inform them about the program? Did the managers understand the purpose and possible benefits of this initiative, and did they themselves feel that they had enough support? Understanding the possible benefits, and also to create measurements showing that the improvements are successful, must be important to managers, who have to deal with personnel absence and other (initial) costs resulting from participation in the program. A study investigating managers' views of a county council-wide improvement program found that managers seldom had measurements or data that could confirm whether such improvement initiatives were positive and yielded results—measurements and

data that, one supposes, would be quite valuable to the managers.²²

The participants stated that the CII facilitators had been supportive throughout the program. However, some participants who called for better and increased facilitation stated that goals and measurements were hard to decide on; so was grasping the new ideas about profound knowledge. These professionals lacked a theoretical understanding of the concept. Batalden and Davidoff claim that improvement work must become a natural part of daily work.⁸ Therefore, this element of understanding and learning is important. Participants in this study did not consider the improvement work to be integrated. Instead, they indicated having to do twice the work and lacked the time needed to implement the improvement work. This made them feel guilty vis-à-vis their coworkers. Another study found that lack of time could be compensated for by having supportive management; if the staff felt they had permission to engage in improvement work and if improvement work was considered important by management, this balanced the negative feeling of time pressure.¹⁵ Incorporating improvement work as a natural part of daily work will probably involve a longer journey, and it demands active involvement at every level in an organization.⁸ Yet another barrier was coworker resistance. Change processes always encounter resistance, and researchers emphasize the importance of involving important stakeholders in order to facilitate the work.²¹

Quality improvement has been emphasized in nursing education lately,^{23,24} and our study shows that collaboration between professions in health and social care organizations presupposes that all professionals need such skills in order to improve care across boundaries. The Breakthrough Series Collaborative methodology emphasizes that reflection on and sharing of new knowledge is important,¹¹ and could be one way to incorporate new practice into an organization. Teamwork is also seen as important, and the participants in this study described the inter-professional teams as one of the more fruitful parts of this work. They learned about one another's functions and organizations, and this will likely have a positive impact on care quality. Quality improvement work exposes the tension between (inter-)professionals and systems,²³ which the participants in our study confirmed. Some teams planned to continue meeting and even to invite other partners to the table, thereby further promoting collaboration. Some of them had received positive responses from the psychiatrically disabled people in their care—feedback that, given that the efforts made a visible difference, constituted strong motivation to continue their work. Participants mentioned the importance of keeping the improvement work alive, implying a need for additional studies; improvements are not implemented once, it needs to be a part of a constant, on-going, long-term process.²⁵

CONCLUSIONS

All the participants expressed an overall intention to improve the care and daily life of psychiatrically disabled

people. At the same time, the challenges of working in inter-professional teams across organizational boundaries were highlighted. The findings indicate that when caregivers and service providers learn about their colleagues' functions and organizations, this knowledge has a positive impact on care, improving the patient's journey across organizational boundaries. Another important consideration for those who are organizing such improvement programs is that providing managers with information about the program did not improve the participants' preparation for or understanding of the program and its methodology. Organizers and facilitators need to consider alternative ways of preparing both managers and participants.

REFERENCES

1. Ministry of Health and Social Affairs. SOU 1992:73, Valfärd och valfrihet: service, stöd och vård för psykiskt störda: slutbetänkande av Psykiatriutredningen. Stockholm, Sweden: Ministry of Health and Social Affairs; 1992 (in Swedish).
2. Ministry of Health and Social Affairs. SFS 2001:453, *Social Services Act*. Stockholm, Sweden: Ministry of Health and Social Affairs; 2001.
3. Ministry of Health and Social Affairs. SFS 1982:763; *Health and Medical Services Act*. Stockholm, Sweden: Ministry of Health and Social Affairs; 1982.
4. The National Board of Health and Welfare. SOSFS 2005:27; *Socialstyrelsens föreskrifter om samverkan vid in- och utskrivning av patienter i slutenvård*. Stockholm, Sweden: The National Board of Health and Welfare; 2005 (in Swedish). <http://www.socialstyrelsen.se/sosfs/2005-27>. Accessed November 28, 2014.
5. The National Board of Health and Welfare. SOSFS 2011:9; *Ledningssystem för systematiskt kvalitetsarbete Socialstyrelsens författningssamling*. Stockholm, Sweden: The National Board of Health and Welfare; 2005 (in Swedish). <http://www.socialstyrelsen.se/ledningssystem>. Accessed November 28, 2014.
6. Swedish Association of Local Authorities and Regions (SALAR) website. <http://www.skl.se/>. Accessed November 28, 2014.
7. Anell A. Swedish health care under pressure. *Health Econ*. 2005;14:237-254.
8. Batalden PB, Davidoff F. What is "quality improvement" and how can it transform healthcare? *Qual Safe Health Care*. 2007;16:2-3.
9. Deming WE. *Out of the Crisis*. Cambridge, MA: MIT Press; 2000.
10. Marshall M, Pronovost P, Dixon-Woods M. Promotion of improvement as a science. *Lancet*. 2013;381:419-421.
11. Institute for Healthcare Improvement. *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement, Innovation Series White Paper*. 2003. <http://www.ihl.org>. Accessed November 28, 2014.
12. Region Skåne 2013, www.skane.se/utvecklingscentrum. Accessed November 28, 2014.
13. Pinto A, Benn J, Burnett S, Parand A, Vincent C. Predictors of the perceived impact of a patient safety collaborative: an exploratory study. *Int J Qual Health Care*. 2011;23(2):173-181.
14. Ting HH, Shojania KG, Montori VM, Bradley EH. Quality improvement: science and action. *Circulation*. 2009;119:1962-1974. <http://circ.ahajournals.org>. Accessed November 28, 2014.
15. Andersson A-C, Idvall E, Perseus K-I, Elg M. Evaluating a breakthrough series collaborative in a Swedish health care context. *J Nurs Care Qual*. 2013;29(2):E1-E10.
16. Statistics Sweden (SCB) 2012. <http://www.scb.se/>. Accessed May 28, 2014.
17. Langley GJ, Moen RD, Nolan KM, Nolan TW, Norman CL, Provost PL. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 2nd ed. San Francisco, CA: Jossey-Bass; San Francisco 2009.

18. Krueger RA, Casey MA. *Focus Groups. A Practical Guide for Applied Research*. 4th ed. Thousand Oaks, CA: Sage Publications; 2009.
19. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101.
20. Janlöv A-C, Berg A. The nurses' voice of working in a newly established community based 24-hours support center for people with psychiatric disabilities. *Open J Nurs*. 2013;3:195-201.
21. Strandberg EL, Ovhed I, Håkansson A, Troein M. The meaning of quality work from the general practitioner's perspective: an interview study. *BMC Fam Pract*. 2006;7(60). doi: 10.1186/1471-2296-7-60.
22. Andersson A-C. Managers' views and experiences of a large-scale county council improvement program: limitations and opportunities. *Qual Manag Health Care*. 2013;22(2):152-160.
23. Cronenwett L, Sherwood G, Barnsteiner J, et al. Quality and safety education for nurses. *Nurs Outl*. 2007;55(3):122-131.
24. Sherwood G. Integrating quality and safety science in nursing education and practice. *J Res Nurs*. 2011;16(3):226-240.
25. Øvretveit J. Making temporary quality improvement continuous: a review of research relevant to the sustainability of quality improvement in health care. 2003. http://www.skf.se/vi_arbetar_med/halsaochvard/. Accessed November 19, 2013.