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Cooperation in a complex care network
The case of Cognitive Rehabilitation

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Abstract. Rehabilitation services have become increasingly important with the expansion of chronical illness cases. In this position paper I present an empirical study of the cognitive rehabilitation process of people suffering from cognitive impairments after an Acquired Brain Injury (ABI) in Norway. A discussion of the empirical understanding of the organisation of work and the care network that support the person in rehabilitation is presented. Finally, a proposition for using articulation work at the care network level to improve care services is provided.

Introduction

Nowadays the call for integrated services and integrated care is strong in many countries. The situation is the same in Norway, where health directives require close collaboration among care providers and enhancement of a person's active participation in shared decision making in their treatment (Kasper et al., 2017). Health services still have to change to accommodate these requirements. A country level study in Norway of cooperation between services when patients are discharged from hospital and return to their municipalities, finds that those who need health care and follow-up from several parts of the health service are not seeing the health service "hanging together" (CARE & NICE, 2015).

The continuation of care and a smooth transition among different healthcare settings becomes relevant in the case of chronically ill patients. In this paper, I

present the rehabilitation process of people who have had an ABI and suffer cognitive impairments. Empirical data were collected in a specialist hospital and in a medical competence center that offers rehabilitation services for people from seven municipalities and has an ongoing innovative rehabilitation project. The process is very dynamic, with many carers involved in supporting a person to improve individual life situations that have been influenced by the injury (LOVDATA, 2019). I discuss how work is organised in rehabilitation and finally conclude with some implications for the care network.

Data Collection

As stated in the law (LOVDATA, 2019), in Norway. a person in need will receive rehabilitation services in the municipality s/he lives and if needed can get rehabilitation services in a specialist hospital which operates in her/his region or at a country level. The rehabilitation journey varies from one person to another and not all get a hospitalisation period in specialist institutions. I conducted research at Sunnaas Rehabilitation Hospital which is Norway's largest specialist hospital in rehabilitation (Sunnaas, 2017)) and operates both on a regional and country level. I did non-participant observations at Sunnaas's Cognitive Unit. Moreover, the way rehabilitation services are organised in each municipality in Norway varies significantly. Indre Østfold Medical Competence Centre is currently carrying on an innovation project in rehabilitation (Fuglerud et al., 2018). The project aims to offer better rehabilitation services by integrating all the carers necessary to support the "person" (an essential concept for the project - as one of the interviewees said "*at the hospital there are patients, here in the municipalities we have persons, which besides the illness also have a life"*). Moreover, they aim to unify services in the 7 municipalities and have as well a national transfer value. Hence, I conducted a semi-structured interview with two project initiators to get an understanding of their way of working and as well learn from their expertise on how rehabilitation services are organized in the municipalities. In this paper, I will use the term patient only for the hospital setting and person for all the other cases.

The practice of cognitive rehabilitation

Wilson et al. (2009) defines cognitive rehabilitation as: *"a process whereby people with brain injury work together with health service professionals and others to remediate or alleviate cognitive deficits arising from a neurological insult"*. The primary goal of cognitive rehabilitation is to ameliorate injury related deficits in order to maximise safety, daily functioning, independence and quality of life (Haskins et al., 2012). The person's involvement in decision making

regarding his/her rehabilitation is crucial for the rehabilitation to succeeded (Wilson et al., 2009).

At the hospital, the patient is supported by a multidisciplinary rehabilitation team. The presence and influence of each of the team members in rehabilitation varies based on the patient. The team is composed of a neurologist, psychologist, nurse, occupational therapist, physiotherapist, speech therapist and social worker. In the hospital, the patient and her/his kin are also considered part of the team and contributing to care. The team supports the patient to define realistic and attainable personal goals for improvement. The goals target specific patient's life areas that have been influenced after the injury. Further, the team and the patient make a treatment plan based on predefined rehabilitation goals. Bratteteig and Wagner (2013) use the term formal carers for healthcare professionals and informal cares for kin and others involved in home care. Thus, in their terms, in the specialist hospital there is an extensive "care network" (Bratteteig & Wagner, 2013; Consolvo et al., 2004) composed of many formal carers as listed above and also the kin as informal carers.

To assure the continuation of rehabilitation in municipalities, the multidisciplinary team members try to establish all the needed links with the local carers in the municipality where the patient lives, while the patient is still in the hospital. However, this process is not easy. Usually aligning work requires time and there are variations in the work organisation or resources available in each municipality. Thus, requiring different strategies of cooperation among the hospital and the respective municipalities. In most cases, further reassessment and repetition of work are done. Both the hospital and the municipalities state that there are limitations in the continuation of work although they work on the same recovery goals.

In the local communities, other carers support the person. This involves formal carers such as rehabilitation specialists in local settings, local private rehabilitation centres, the person's General Practitioner/family doctor and Sunnaas outpatient clinic. The informal carers such as the kin and others for ex., the employer, colleagues, NAV (Norway's institution of Labor and Welfare administration) etc|, have as well an important role in the person rehabilitation. In Indre Østfold, the innovation rehabilitation project helps coordinate all the carers mentioned previously to provide the needed support for the person. Similar to the hospital, they use the goal setting model and make a rehabilitation plan for the person.

Both a specialised treatment and a continuation of the rehabilitation in her/his local community provide "a full package" of rehabilitation for the person. Thus, repeated efforts and miscoordination must be overcome so that the person can benefit from an integrated care network in both settings.

The organisation of work in rehabilitation and implications for the care network

The case of cognitive rehabilitation involves various formal and informal carers. To achieve better results from rehabilitation, it is essential that all carers cooperate. The carers work independently of each other, and the work is distributed. The formal carers at the hospital work in the same place and have easy access to each other. However, they should coordinate activities with the other formal carers in the municipality which should be the ones to continue the rehabilitation therapies started at the hospital. Moreover, cooperation of formal carers with informal carers is essential both at the hospital and municipalities. These characteristics of multiple actors, interdependent and distributed are what Schmidt and Bannon (1992) define as cooperative work. However, in cooperative work it is essential that cooperative workers divide, allocate, schedule, mesh, interrelate etc. their distributed individual activities. Strauss (1985) defines this supra type of work needed in any division of labour among different cooperating actors as "articulation work". Schmidt (2002) defines articulation work as "*the work to make cooperative work work"*.

In the situation described above, all the carers belonging to the hospital care network get involved in defining the patient goals, the treatment plan, and the tasks through which the treatment is operationalised. Thus, they do articulation work only among each other. The same happens in the municipalities where articulation work is done among the carers belonging to the municipality care network. However, these are not two distinct care networks. The informal carers fall within both settings even though the division of labour for them varies based on the setting. For example, in the home, they have more work responsibilities (Bratteteig & Wagner, 2013). Moreover, the formal carers in the hospital and municipality create connections with each other in order to coordinate their work. This because the recovery goals of the person are the same both when s/he gets treatment at the hospital or in the municipalities.

So, *"How can we organise work to support the person's needs? That should be the question"* said one of the interviewers in the municipality. Further, she adds that "*it is important to get away from the linear way of thinking…we can collaborate directly with the hospital, use hospital competence as part of the team…be together in the beginning and then decide what kind of rehabilitation should happen*". The quote argues that articulation of work and division of labour should not be enclosed within care settings. Articulation work should be at the level of the integrated care network at the beginning of the rehabilitation. Establishment of the care plan by sitting together with the person, kin, specialist hospital representatives and municipality rehab specialist can divide the work in a way that closes the gaps in services and ensure the highest possible performance for the recovery goals.

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