International Journal of Integrated Care

Wirsell L et al, 2026, The Hub That Connects Care – Seamless Transition from Early Identification of Palliative Care Needs to the End of Life.. International Journal of Integrated Care 26(S2):556 DOI: doi.org/10.5334/ijic.ICIC26556

POSTER ABSTRACT

The Hub That Connects Care – Seamless Transition from Early Identification of Palliative Care Needs to the End of Life.

International Conference on Integrated Care (ICIC26), Birmingham, 13-15 April 2026

Linnéa Wirsell[1], Therese Sverenius[1], Amanda Hellström[1,2], Heidi Hagerman[1,2], Nam-Young Pak[1], Frida Olausson[1]

1: Region Kalmar County, Sweden
2: Linnaeus University, Sweden

Background: This project outlines the development of an integrated palliative care model aimed at strengthening continuity, involvement, and security throughout the entire care process. In Sweden, more than 75% of palliative care is provided within primary care, making early identification and access to a designated contact nurse with specialist expertise essential.

Approach: Patients needing palliative care were identified through referrals to primary care, messages from inpatient care, or the coordination team (SOT). SOT plays an essential role in identifying patients by using data on healthcare contacts, hospital stays, and ambulance use to detect vulnerable patients with complex needs - especially those with chronic conditions like chronic obstructive pulmonary disease (COPD) or heart failure, where the disease trajectory is less predictable than in cancer care. By utilizing statistical tools to analyze electronic health records, patients in need of palliative care can be proactively identified.

Results: During the first visit with the contact nurse, patients receive personalized information and an assessment of symptom burden and support needs. The nurse helps coordinate the patient's care and coordinates contacts with various professionals and specialists required to meet the patient's needs. At the second visit, the assessment of symptom burden and support to families are followed up, and an individual care plan is established.

The third visit includes follow-up according to the care plan and a renewed assessment of symptom burden. There after, subsequent visits are planned based on the patient’s individual needs. During the whole process, the contact nurse and the patient decide if further contact in the form of phone calls is needed.

The palliative outpatient clinic provides patients and families with care visits at the health care centre, telephone support and advice, home visits by RN or physician, support to families, consultations with experts, survivor support and interpreter assistance when needed, as defined by the integrative palliative care model and care plan. In response to our initiative, specialist

outpatient clinics have now begun sending informational referrals when patients transition from curative to palliative care. This enables to ensure continuity of care by engaging the patient early through follow-up visits at the primary health centre.

Implications: The organization of primary care varies by county. In Kalmar County, services are divided between regional and municipal governance. The palliative outpatient clinic functions as a link between these systems, providing support to both patients and their families. As care needs increase, the contact nurse coordinates a transition to municipal home healthcare while maintaining the same physician, thereby promoting continuity and reducing hospital visits.

Established in May 2025, the clinic adopts an integrated palliative care model that encourages early involvement of patients and families to tailor care to individual needs and enhance quality of life. Evaluation of the clinic is planned for 2026, and preliminary outcomes are care utilization data (e.g., health care contacts, emergency visits, care duration, symptoms at enrollment), assessment tools for continuity of care and support, together with qualitative interviews with patients, families, and staff that will explore experiences and factors influencing implementation.