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# MOBILE HOMECARE TEAMS – HOW TO LEAD AND ORGANIZE?

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**ABSTRACT**
The societal development of an ageing population in Sweden poses significant challenges to maintaining high-quality healthcare. As the population ages, there is an increased incidence of multiple illnesses, necessitating increased medical and health-promoting interventions without a corresponding growth of resources. These health conditions require comprehensive and continuous care, which places significant challenges on existing healthcare systems which are already stretched thin.

To meet these challenges the ambition is to transform the healthcare structure to what is defined as person-centered and integrated care. This concept emphasizes the importance of bringing healthcare services closer to where patients live. This not only enhances accessibility, but also ensures that care is more personalized and responsive to the immediate needs of patients.

Home care allows patients to remain in a familiar and comfortable environment, which can significantly improve their quality of life. It also enables them to maintain a higher degree of independence and control over their daily lives. People who are cared for at home are often more satisfied and experience greater well-being compared to those who are cared for in hospitals. By shifting the locus of care from hospitals to community settings or patients' homes, there are expectations to improve patient satisfaction and quality of life.

However, conducting assessments of the condition of older patients in a home setting is challenging. It requires healthcare workers to make accurate and timely decisions based on limited information and often without the immediate support of a hospital infrastructure.

To succeed in this shift in the locus of care, there are expectations for the digital transformation of healthcare and the implementation of e-health solutions to improve healthcare for providers and patients. Digital transformation involves the integration of digital technologies into all areas of healthcare, fundamentally changing how care is delivered and managed. E-health solutions, such as telemedicine, electronic health records, collaboration tools, and mobile health


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applications, can streamline processes, improve communication, and enhance the quality of care.

One core challenge is when healthcare that is traditionally performed in hospitals is moved to patients' homes, more advanced care must also move out. This care must be performed by medically competent personnel who can handle the complexities of home care. Following this, when personnel to a varying extent move out, the conditions for leading this personnel group change. Hence, leadership in this context involves managing remote teams, ensuring quality and consistency of care, and providing ongoing training and support for dispersed team members.

The project's purpose was to develop strategies and guidelines for the operational management and governance of digital transformation. This facilitated person-centered and integrated care for those in need, using mobile teams supported by digital tools in their work. By leveraging technology, there were expectations to improve the efficiency and effectiveness of home care, ensuring that patients received the right care at the right time.

The study was designed as a qualitative case study in two organizations, Vårdbolaget Tiohundra and Region Kronoberg, and performed by two research partners, Linnaeus University and Lund University. The empirical data collection consisted of in total five workshops with stakeholders from both Vårdbolaget Tiohundra and Region Kronoberg. Two one-hour rich picture workshops with stakeholders from Region Kronoberg such as managers, physicians and ambulance staff plus one one-hour rich picture workshops with an experienced home health care team from Vårdbolaget Tiohundra, all three workshops with the aim of creating a problematization of mobile home care. Followed by document studies of guidelines and policy documents and 17 qualitative semi structured interviews guided by themes from the rich picture workshops and policy documents. The duration of the was interviews approximately 50-60 minutes, all recorded, transcribed and uploaded to a team based QDA-tool. Data was analyzed through qualitative data analysis based on the organization's problems and possible solutions, as well as various theoretical perspectives and current research. After the analysis of workshops and interviews one workshop each was held with Vårdbolaget Tiohundra and Region Kronoberg to present, validate and challenge the findings. These two workshops were used as a member check and filter when doing the last round of analysis of the empirical data.

The findings showed that the core issue at hand is that the care of the older and frail patients cuts across organizational boundaries in the health care system. Challenges were identified in the form of different views on what good and integrated care means among actors in different organizational units. Another significant challenge was deficiencies in accessibility and communication between the actors. To meet these challenges, guidelines have been drawn up based on the specific conditions of the owners of the needs.

The collaboration of multiple stakeholders is considered crucial for success. Collaborative care models, where different healthcare professionals work together as a team, have been shown in prior studies and confirmed in this study, to improve patient outcomes and satisfaction. These models require robust systems for communication, coordination, and management to ensure that all team members are aligned and working towards common goals.

The findings from the study reveal that coordination of activities as well as self-managing and autonomous work teams were identified as success factors for the governance and management of mobile teams in home healthcare. This was possible by A; a thorough operationalization of the vision of "person-centered and integrated care" into measurable objectives that can be anchored jointly by the actors involved in the care of the elderly and frail patient, B; improved accessibility and communication between the actors and improved communication between digital information systems, and C: self-organizing and autonomous mobile teams.

Expected effects: A self-organizing and flexible adaptable organization with clear strategies and improved communication between organizational units.

**Keywords**: person-centered and integrated care, mobile home care team, eHealth