

Case Study:

The Mobile Emergency Team for the Elderly in Uppsala



Based on Gustav Klimt, Tree of Life, Stoclet Frieze, Lebensbaum, 1905

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Table of Contents

Executive Summary	2
Introduction	2
Care Integration	2
Urgent Care	2
Staffing	3
Care Coordination.....	4
Summary of the Swedish Association of Local Authorities and Regions Final Report on the Mobile Emergency Team for the Elderly, 2013	6
Results.....	7
How Does It Work?.....	7
Care Coordination.....	8
Objectives and Evaluation	9
Organization	10
Benefits	11
Areas for Improvement.....	11
Cost Calculation of the Mobile Team for the Elderly.....	13
Group Interview with the Mobile Emergency Team.....	15

Executive Summary

Introduction

The Mobile Emergency Team (Mobile Team) consists of two physicians and two nurses. At any one time, one physician and one nurse make home visits to the elderly in Uppsala Municipality. The Mobile Team is a leading example of integrated elder care in Sweden. The team coordinates its work with that of ambulance services, Uppsala University Hospital, the telephone healthcare advisory line, primary healthcare clinics, municipal nurses in home healthcare teams, and homecare organizations. The Mobile Team started operations in 2011, with financial support from the Swedish Association of Local Authorities and Regions.

Care Integration

The team becomes involved with patients through several different avenues: Nurses who work in homecare organizations contact the team when they need a second opinion on a patient. Employees at care homes for the elderly contact the team for advice. And ambulance personnel coordinate their efforts with the Mobile Team. Sometimes, the ambulance staff realizes that the team can deliver urgent care at home. When the ambulance staff arrives at the home of an individual, they can call the Mobile Team.

The Mobile Team centers on the needs of the patient. The objective of the Mobile Team is to offer urgent care at home to people over the age of sixty five. Many older patients visit emergency rooms at hospitals for urgent but non life threatening care that can be treated at home. Often, these patients must wait for hours at emergency rooms because their infections are not as pressing as the illnesses of other patients seeking emergency care.

Urgent Care

The Mobile Team performs urgent care right in patients' homes. The team measures glucose, takes blood tests, tests urine, and performs electrocardiograms in the home. The team can treat patients with a range of drugs at home. They measure blood flow in arteries to assess if the blood circulation provides enough

blood to the legs and to the brain. Blood circulation to all tissue is necessary to avoid stroke.

The Mobile Team treats patients with Pari Boy, an inhaler, if patients experience difficulty breathing. The team also treats minor wounds. When a patient needs treatment at the hospital, the Mobile Team coordinates with the ambulance service to arrange transport.



Pari Boy Inhaler

Many older patients need support at home from multiple caregivers. The team coordinates care with these caregivers, including professional homecare providers. If a patient visits the emergency room for an illness that can be treated at home, a Mobile Team municipal nurse who works at the hospital emergency room informs the patient about the Mobile Team. If possible, the municipal nurse informs the patient's caregivers of the treatment that the team can offer at home. If a patient needs urgent care a second time, the caregivers and the patient know about the team.

Staffing

The Mobile Team includes a nurse from the municipality and a doctor from the county. Sometimes, the municipal nurse needs assistance from the doctor to treat patients at home. In turn, the doctor often relies on the expertise of the municipal nurse about the full care plan for a particular patient. For example, the municipal nurse coordinates the work of the Mobile Team with the work of homecare teams. The Mobile Team and homecare teams work together to ensure that patients obtain the support they need to stay at home and recover. Both the healthcare and the social care needs of the patient are assessed. Many times, doctors assess healthcare needs in isolation. Homecare teams assess social care needs. The Mobile Team can help provide for these needs by increasing communication between caregivers.

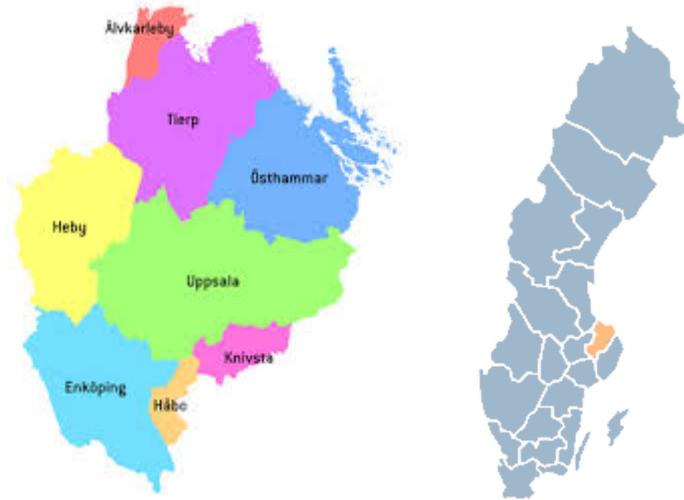
The quality of healthcare delivered to a patient depends to a large extent on the quality of communication between caregivers. This is particularly true for older patients with complex needs. The municipal nurse in the team can update homecare providers on new treatment and new medications. Sometimes, the communication between doctors from the county and homecare providers can become delayed. Since the Mobile Team only recruits nurses with experience from municipal care organizations, the nurses in the team are familiar with the channels of communication in the municipality. This familiarity speeds up communication and creates added value to patients that obtain care from different caregivers.

The Mobile Team is a critical link in the integrated healthcare chain in Uppsala Municipality. The neighboring municipalities are examining the possibility of establishing similar mobile teams.

The combination of the medical expertise of the doctor from the county and of the network and the experience of the municipal nurse renders the Mobile Team more effective than its constituent parts. Integrated care requires that different care providers collaborate. Different healthcare providers must acknowledge each other. They must understand each other's abilities and limitations.

Care Coordination

Healthcare professionals cannot become experts in isolation. High quality healthcare at home and the timely transfer of information to homecare organizations improve patient experiences and patient outcomes. The best healthcare at home will not, in itself, prevent the patient from falling ill a second time. A patient may need help cooking or remembering to take her medication. If the homecare team is not informed or fails to help the patient take her medication, the patient may soon fall ill again. This is just one example of the interdependencies of integrated care models. Each care provider depends on other care providers. Patients depend on multiple care providers.



The enlarged map to the left shows where Uppsala Municipality is located in Uppsala County. The map on the right shows the location of Uppsala County in Sweden.

Summary of the Swedish Association of Local Authorities and Regions Final Report on the Mobile Emergency Team for the Elderly, 2013¹

The Mobile Team began as a pilot project in September 2011. The Swedish Association of Local Authorities and Regions funded the Mobile Team. The Mobile Team became a permanent unit in January 2014. The objective of the Mobile Team is to offer urgent care in the home to people over the age of sixty five. The long run objective is to create integrated structures of healthcare and social care in Uppsala Municipality.

The team consists of a nurse and a doctor. The team advises municipal nurses and visits patients in their homes. Target patients are people over the age of sixty five who need urgent care.

Administrators in Uppsala Municipality conducted a pilot study between September 2011 and December 2013. Patient questionnaires showed that the majority of patients felt satisfied with the Mobile Team. Nurses in the municipality expressed satisfaction with the support from the Mobile Team. The Mobile Team was able to treat over eighty percent of the patients at home.

Patients reach the Mobile Team through municipal nurses or through the healthcare information line. The Team also delivers healthcare to elderly patients residing in nursing homes. The nursing home staff can call the team. Ambulance personnel also contact the Mobile Team.

The Mobile Team handled just under six patients per day during the pilot study. Eighty one percent of those patients obtained urgent care at home. One percent of patients went directly to a geriatric ward after the Mobile Team had assessed their needs. The Mobile Team referred eighteen percent of patients to the emergency room at Uppsala University Hospital. Eighty five percent of the patients who went to the emergency room were admitted to hospital.

Uppsala Municipality and Uppsala County finances the Mobile Team. The Mobile Team is a project to improve the integration of healthcare for the elderly.

In January 2014, Uppsala County Council decided to turn the pilot project into a permanent service. Uppsala County is the formal employer of the members of the

Mobile Team. Uppsala Municipality covers forty percent of the costs. Uppsala County pays for sixty percent of the costs.

Results

Fewer older patients visited the emergency room at Uppsala University Hospital after the establishment of the Mobile Team. A visit to the emergency room costs the Uppsala University Hospital 2,500 Swedish kronor (350 US dollars). The county bears this cost.

The total yearly cost of the Mobile Team is 3.5 million Swedish kronor (five hundred thousand US dollars). Uppsala County saves around 2.5 million Swedish kronor (350 US dollars) on reduced outpatient treatments of the elderly.

The largest savings are in the area of reduced hospitalizations of the elderly. Estimates from 2012 indicate that Uppsala County saves over nine million Swedish kronor (1.2 million US dollars) annually on inpatient treatments because of the Mobile Team.

Without the Mobile Team, an estimated 460 patients would have traveled to Uppsala University Hospital for treatment during the pilot phase. These 460 patients are avoidable inpatients, patients who can avoid a stay in hospital with treatment or social care assistance at home. Two hundred thousand people live in Uppsala Municipality.

How Does It Work?

Patients cannot contact the Mobile Team on their own. Patients can call the healthcare information line,² the national advisory line for healthcare. The healthcare information line can refer patients to the Mobile Team. Referral to the Mobile Team means that the Mobile Team will visit the patient at home.

Patients can call municipal nurses or nurses in homecare organizations. These nurses contact the Mobile Team for advice or to schedule an unplanned visit to patients who need urgent care.

The nurse describes the patient's symptoms to the team doctor and nurse. The Mobile Team and the municipal nurse decide on the best treatment for the

patient. Either the patient obtains a home visit or the patient can go to the emergency room.

If the municipal nurse can treat the patient, the Mobile Team physician advises the municipal nurse remotely on the correct treatment. Most nurses in the municipality express satisfaction with the support of the Mobile Team.

Initially, residents over the age of sixty five living at home with homecare or with home healthcare could obtain referral to the Mobile Team. During the pilot phase, the Mobile Team decided to include residents in Uppsala Municipality over the age of sixty five who lack homecare or home healthcare as well. The Mobile Team further expanded its coverage. Nurses in nursing homes can call the Mobile Team for advice or for visits to nursing homes.

Nursing home employees sometimes direct residents to the emergency room. If nursing home personnel always had a doctor to ask for advice, more residents could obtain treatment in the nursing home instead of in the hospital. Nursing home staff may need to change the dosage of insulin to a patient. If a nurse can call a doctor about the correct dosage, the nurse can administer the insulin shot in the nursing home. There are many similar situations where the remote support of a doctor makes a large difference to the patient.

Care Coordination

The pilot phase showed that some older patients come to the emergency room because they lack support at home. A significant number of older patients end up in emergency rooms for nonmedical reasons. These patients come to the emergency room because they have social care needs. Some patients need non urgent care but do not know where else to turn.

A municipal coordinator³ works in the emergency room at Uppsala University Hospital. The municipal coordinator identifies patients that need help at home. The idea of the embedded municipal coordinator arose during the pilot project. The municipal coordinator works with the elderly who can leave the emergency room without emergency care. The municipal coordinator examines the needs of the patient when she arrives at the emergency room. The municipal coordinator connects the patient to social care organizations and to municipal nurses. The municipal coordinator also informs the patients about the Mobile Team, which they can reach through the healthcare information line by dialing 1177.

The three most common causes of visits by the elderly to the emergency room were a fall or injury, general weakness, and difficulty breathing. During the pilot study, sixty percent of all patients over the age of sixty five could return home after meeting with the municipal coordinator in the emergency room. The patients who returned home after meeting with the municipal coordinator obtained no emergency healthcare. Four percent of the patients who returned home obtained increased homecare. Five percent of the patients obtained homecare. Twenty one percent of the patients obtained a place in a municipal care home. Five percent of the patients needed a care plan to stay at home. Sixty five percent of the patients needed no help. The patients who needed no help obtained information about available municipal assistance.

The healthcare information line can contact the Mobile Team. Patients call the healthcare information line and describe their symptoms. The staff of the healthcare information line calls the Mobile Team.

In November 2012, the Mobile Team invited three primary care providers as partners. Primary care providers direct patients to emergency rooms when they are unable to treat the patient in the primary care clinic. Few primary care providers called the Mobile Team during the pilot project. All primary care providers in Uppsala Municipality have access to the advice of the Mobile Team. These partnerships could be developed further. Primary care centers could use the Mobile Team more often.

Objectives and Evaluation

The objective of the Mobile Team was to establish an organization of physicians and nurses for urgent visits in the homes of patients. The project leader, Marianne Rutqvist, states that the Mobile Team meets this objective. The second objective of the Mobile Team was to offer support to other care organizations. This objective was fulfilled as well. Nurses in the emergency service, in nursing homes, in ambulance services, and in municipal home healthcare contact the Mobile Team.

The third objective of the Mobile Team was to develop routines for the frail elderly to reduce wait times in emergency rooms. The way to reduce wait times is to establish a direct path for older patients to specialist physicians.

Referral to specialists is an area that needs improvement. Only one percent of the patients of the Mobile Team had a direct path to a geriatrician at Uppsala University Hospital.

The Mobile Team has developed clear routines for direct paths to the geriatric ward. The geriatric ward at Uppsala University Hospital has limited capacity. This lack of space causes obstacles for older patients. The geriatric ward directs patients back to the emergency room because of this shortage.

The Readiness Alert⁴ complements the work of the Mobile Team. The Readiness Alert answers nurses' question during evenings, nights, and weekends.

Results from patient questionnaires indicate that patients are satisfied with the Mobile Team. Patients evaluated the Mobile Team according to "safety of care," "fast treatment," "good service," and "too much care."

Results from a questionnaire of nurses in Uppsala Municipality show that municipal nurses appreciate the support of the Mobile Team. Nurses in homecare evaluated the Mobile Team according to "improved work environment," "improved patient safety," and "improved organization."

Thirty five of thirty seven ambulance nurses contact the Mobile Team. Ambulance staff can send the Mobile Team to patients they consider treatable at home. Thirty five ambulance nurses reported that the Mobile Team improves the quality of care for patients. Over seventy percent of the nurses are satisfied with the team.

Ambulance nurses evaluated the Mobile Team according to "medical and social competence," "reduced pressure on emergency rooms and ambulances," "reduction in patient suffering due to treatment at home," and "room for improvement in the Mobile Team."

Organization

The Mobile Team is located in the Elder care unit.⁵ The Elder care unit provides healthcare at home to patients over the age of sixty five, to people who cannot travel to hospitals, and to those who suffer from long term illnesses.

The Mobile Team and the elder care unit hired nurses jointly during the pilot phase. This optimized the use of human resources.

The project leader of the Mobile Team was hired in February 2011. Two physicians and one nurse were hired in June 2011. One more nurse was hired in August 2011. The Mobile Team became operational in September 2011. The Mobile Team treats patients from Monday to Friday, between eight am and five pm.

The Mobile Team measures glucose, takes blood tests, tests urine, and performs electrocardiograms in the home. The team can treat patients with a range of drugs at home. The team measures blood flow in the arteries to assess whether the blood circulation is providing enough blood to the legs and to the brain. Blood circulation to all tissue is necessary to avoid stroke, for example.

The Mobile Team treats patients with Pari Boy, an inhaler, if patients experience difficulty breathing. The team also treats minor wounds. When a patient needs treatment at hospital, the Mobile Team coordinates with the ambulance service to arrange transport.

After a preliminary assessment by the team, the patient can obtain treatment at home. Alternatively, the patient can obtain care at the geriatric clinic of the Uppsala University Hospital or she can visit the emergency service at Uppsala University Hospital.

Benefits

The Mobile Team guides the patients to the right care provider. The Mobile Team reduces travel for the elderly. Patients and healthcare personnel report difficulty navigating the various care organizations.

Relatives of the elderly feel safer with the Mobile Team. The team reduces the pressure on relatives to care for the elderly. The Mobile Team reduces the pressure on the emergency room and on the ambulance service. The Mobile Team improves communication between different care organizations.

Areas for Improvement

Uppsala County aims to negotiate an agreement with Uppsala Municipality. The agreement should shorten the guaranteed time to delivery of homecare. A resident in Uppsala Municipality has the right to obtain homecare twenty four hours after the municipality grants the person homecare. If the elderly in emergency rooms could obtain homecare within a few hours, some patients could return home immediately. This process will spare patients the wait in emergency rooms. This will help patients who need social care or simpler assistance at home.

The Mobile Team could extend its range of services. The Mobile Team could conduct follow up visits at home. The team could develop partnerships with specialist wards as well.

Cost Calculation of the Mobile Team for the Elderly

Budget 2014 US Dollars	Total	Municipality	County
<i>Salary – Doctors</i>	<i>208,420</i>		<i>208,420</i>
<i>Salary - Nurses</i>	<i>131,000</i>	<i>131,000</i>	
<i>Salary - Secretaries</i>			
<i>Administration</i>	<i>14,900</i>	<i>7,450</i>	<i>7,450</i>
<i>Personnel Costs</i>	<i>5,360</i>	<i>2,680</i>	<i>2,680</i>
<i>Rent</i>	<i>17,860</i>	<i>8,930</i>	<i>8,930</i>
<i>Medical Services</i>	<i>4,160</i>	<i>2,080</i>	<i>2,080</i>
<i>Medical Supplies</i>	<i>9,520</i>	<i>4,760</i>	<i>4,760</i>
<i>Medications</i>	<i>1,190</i>	<i>0</i>	<i>1,190</i>
<i>Information Technology</i>			
<i>Telecommunications</i>	<i>8,800</i>	<i>4,400</i>	<i>4,400</i>
<i>Car, Rental, and Maintenance</i>	<i>11,900</i>	<i>5,950</i>	<i>5,950</i>
<i>Information</i>			
<i>Office Supplies</i>	<i>3,560</i>	<i>1,780</i>	<i>1,780</i>
Total Cost	416,670	169,030	247,640
Share of Total Cost		40.6%	59.4%

All numbers are quoted in US dollars⁶

Out of the 1,445 patient visits of the Mobile Team in 2012, eighty five percent, or 1,228 individuals, were treated at home following the visit of the team.⁷ Fifteen percent, or 217 individuals, were sent to the emergency room at Uppsala University Hospital. Out of those fifteen percent who visited Uppsala University Hospital, eighty five percent were hospitalized.

An estimated seventy five percent of those who received care at home would have travelled to the emergency room, if the Mobile Team had not been available. Out of these 921 patients, only sixty percent were hospitalized. This amounts to 553 individuals over the pilot period.

The daily estimated cost of a stay in the internal medicine ward is eight hundred US dollars. The estimated average hospital stay per patient is five days.

Group Interview with the Mobile Emergency Team



From the left: Magnus Gyllenspetz, Christina Mörk (doctors), Angela Edman, Pia Ekeroth (nurses)
Photographer: Magnus Laupa.

Keywords: Care coordination, urgent care, healthcare at home, transitional care, embedded staff, marketing, users versus patients, support for nurses, patient turf

Interviewer: Sofia Widén

Participants: Two nurses, two physicians, and the project leader of the Mobile Team

Sofia Widén (SW): Could you please tell me a little bit about the background of the Mobile Team?

Physician: Mobile doctors who visit patients at home have existed in Uppsala since the turn of the twenty first century. Dr. Mats Hellkvist worked in the countryside here in Uppsala. Several of us in the Mobile Team worked with Dr. Hellkvist when he was active. The patients loved Dr. Hellkvist. When a patient needed his help, Dr. Hellkvist visited them at home. Dr. Hellkvist carried basic healthcare equipment. Our equipment is much more advanced. We continue the work of Dr. Hellkvist. The Mobile Emergency Team was one of nineteen projects in the national program, Better Life for the Most Sick Elderly,⁸ which ran from 2010 to 2014 with the aim of improving the life of the elderly. The Mobile Team employs two doctors and two nurses.

In 2006, the elder care unit⁹ opened in Uppsala. Doctors at the elder care unit deliver healthcare in patients' homes. Patients who belong to the elder care unit and who are unable to travel to the hospital qualify for home healthcare. Older patients who suffer from multiple diseases can choose to belong to the elder care unit instead of belonging to a primary care center. Most people in Sweden are listed at a primary healthcare center. That clinic obtains taxpayers funding to provide healthcare. The elder care unit is part of the primary care system.

Dr. Hellkvist started his work in the elder care unit. In the beginning, he kept his patient journal notes manually. Dr. Hellkvist digitized his patient journals in the 1990s. I began working with him at the elder care unit. When Dr. Hellkvist retired in 2009, the elder care unit continued his work.

The county council reimburses the elder care unit by fixed appropriations. Fixed appropriations cover costs of care for older patients with complex needs better than other reimbursement models.

There are different healthcare reimbursement models. In our region, primary care centers are reimbursed by capitation and visitation fees. A capitation system allocates a fixed sum of money for each patient per year. Capitation is used for primary care centers in Uppsala.

The fixed sum of money varies with the age and health of each patient. About seventy percent of the primary care center costs are reimbursed by capitation.

To stimulate primary care centers to offer more treatment to patients with complex needs, payers use a visitation model. The primary care center is paid for each visit. Thirty percent of all primary care is reimbursed by a per visit model.

Capitation models do not suit patients with complex needs. Older patients may need to see their doctor on repeated occasions. Capitation does not encourage healthcare providers to offer patients repeated visits. This payment structure can disadvantage older patients with complex needs.

In 2011, Uppsala Municipality and Uppsala County applied for a grant from the Swedish Association of Local Authorities and Regions. As part of a national effort to improve healthcare to the elderly, the Swedish Association of Counties and Municipalities gave Uppsala Municipality and Uppsala County twelve million Swedish kronor (1.7 million US dollars) to establish the Mobile Emergency Team for the Elderly (Mobile Team). We called the pilot group the “Mobile Elderly Unit.” When we became a permanent team, we took the name, the Mobile Emergency Team for the Elderly.

Nurse: The purpose of the team is to deliver urgent care to patients at home.¹⁰ The Mobile Team makes unplanned urgent care visits. The elder care unit manages planned visits to patients at home. The Mobile Team coordinates the efforts of different social care and healthcare providers.

We intended for the team to be an emergency team around the clock. After careful consideration, we decided to make it a mobile service from Monday to Friday between eight am and five pm. We looked at studies of emergency rooms. Data on patient visits to emergency rooms showed that most elderly patients visit the emergency room during the day. We figured that the costs of a mobile healthcare team with around the clock readiness would outweigh the benefits.

SW: Which patients qualify for your services?

Nurse: We spent a lot of time discussing criteria. Remember that patients do not contact us. A nurse screens the patients.

We wanted a municipal nurse to filter patients for us just like nurses or secretaries talk to patients in hospitals. We thought about using checklists for municipal nurses. We considered different criteria. In the end, we abandoned the

idea of checklists. If the patient is over sixty five, and if she is unable to travel to a primary care center or to a hospital, she qualifies for our services.

SW: What type of diseases do you treat?

Physician: We treat almost anything. Sometimes, we treat serious conditions. We treat patients with chronic obstructive pulmonary disease who have difficulties breathing. We treat wounds. We also visit patients who suffer from minor infections.

We treat patients after falls, minor infections, different types of pneumonia, and patients who experience difficulty breathing. We treat cystitis, usually caused by infections of the bladder. We also perform surgical sutures. We treat minor wounds. We treat infections that do not require intravenous antibiotics. We bring an inhaler for patients who suffer from chronic obstructive pulmonary disease. The inhaler helps patients to take their medication. The medication eases the breathing process.

Nurse: Patients who visit emergency rooms for urgent care may need to wait. Emergency care personnel always prioritize the most ill patients. We visit the patient at home. The patient does not need to wait.

Older patients sometimes wait for eight hours or longer for treatment in a hospital. The hospital nurse or the doctor gives the patient a short treatment after the long wait and sends the patient back home. Some patients return home before they obtain care. It can be physically and mentally demanding to wait in the emergency room. Some patients suffer during the wait.

A frail older patient who sits in the emergency room for eight hours may contract additional illnesses. The patient may not eat for eight hours. This can affect blood sugar levels. This means that doctors must treat patients for conditions the patients did not have when they first arrived at the emergency room.

If we visit the patient at home, the patient does not need to travel to the emergency room. The emergency room can allocate resources to those who need emergency care. Relatives do not need to go with the patient to the emergency room. Typically, caregivers accompany patients to the emergency room. When a caregiver goes with a patient to the emergency room, that caregiver cannot care

for other patients. We produce value for patients, relatives, and other caregivers. We reduce suffering and discomfort.

We also deliver care in nursing homes. A nursing home employs a couple of nurses. The nurses call us for advice. At times, these nurses work alone. They can ask us to visit the elderly. We can guide them if we think that a patient needs to go to the emergency room.

Before we established the Mobile Team, municipal nurses had to direct patients to the emergency room unless a doctor visited the patient. This system increased the workload of the emergency room. Few doctors were able to visit the patient at home. Now, nurses know that we can visit the patient so they don't need to send the patient to the emergency room.

We listen to municipal nurses who describe the symptoms of the patient to us. The nurse at the healthcare information line can also contact us. Sometimes, we deliver advice over the telephone without visiting the patient. One purpose of the Mobile Team is to support municipal nurses who lack the support of other doctors. Doctors at primary care centers help municipal nurses, but sometimes this support is minimal. If a nurse needs to change the dosage of insulin for a diabetic patient, we can guide the nurse over the telephone. This advice can be valuable for the nurse who cannot reach other doctors.

SW: What is the philosophy of the Mobile Team?

Physician: Our work centers around the needs and the desires of the patients. A patient who waits in an emergency room for eight hours never wants to experience a long wait again. Our philosophy is to make it easy for patients. Many patients want to obtain treatment at home. We offer patients a choice.

We must persuade some patients to travel to the emergency room. Some patients dislike the emergency room. These patients do not go there even though they need emergency care. This can be the result of their past experience with long wait times at the emergency room. We want the option to direct patients straight to specialist wards, such as a geriatric ward.

Nurse: We managed to negotiate an agreement with Uppsala University Hospital to earmark a few beds for our patients in the geriatric ward. This agreement only worked in theory. There were never spare beds for our patient in

the geriatric ward. The hospital cut resources to the geriatric ward. These shortages make it difficult to direct patients straight to the specialist geriatrician.

It would be a great advantage for us to direct patients, whom we know need specialist care, straight to a geriatrician. We prefer to offer patients who need to lie down in a bed the option to do so instead of sitting in emergency rooms.

We established the elderly ward. Now we direct patients straight to the elderly ward instead and circumvent the problem with the geriatrics ward at Uppsala University Hospital.

If a patient cannot stay at home with healthcare at home and social care services, we offer the patient a place at the elderly ward. We try to keep patients here for no more than a week. It is a short term ward. Some patients stay for longer.

SW: Can you offer the same treatment at the elderly ward as specialist physicians can offer at the geriatric ward?

Physician: We cannot do X-rays or ultrasound examinations. We cannot deliver test results as quickly. We do not have access to different specialist physicians. We must diagnose the patient before we offer her a place in the elderly ward. Yesterday, the managers announced that they will expand the elderly ward from thirteen places to twenty eight.

Some patients fall and break legs. The orthopedic doctors contact us when the patient can move to the elderly ward from the orthopedic ward at the hospital. The patient recovers here. We plan the transition back home for the patient. We examine the patient's network. Who can help the patient back home? We assess what each patient needs.

A nurse and a doctor at the elderly ward make a personal health plan for each patient.¹¹ We assess what kind of homecare and social care the patient needs at home. We look at the support of relatives. We try to gather as much information about the patient as we can.

For patients who need extra support, we hold a care plan meeting.¹² A support agent¹³ from the municipality, a representative from the patient's primary care center, relatives, and our physician meet with the patient. The representatives formulate a care plan for the patient. The representatives outline what kind of

healthcare and social care the patient needs. These meetings resemble care plan meetings at the hospital. Not everyone who ought to attend the planning meeting can attend the meetings.

Nurse: We recently began to conduct follow up visits in the homes of patients of the elderly ward. We assess if follow up visits benefit the patient. Today, we do not know the value of follow up visits for patients. This is a new routine. We must evaluate this routine.

We believe that follow up visits at home help patients because they give us an opportunity to check how the patient manages at home. We can check if the patient follows her medical prescription plan.

The Municipal Law stipulates that it is the responsibility of the municipal nurses to check up on the patient at home. Uppsala Municipality is in charge of home healthcare. However, we know that coordination between healthcare teams and homecare teams fails from time to time. Follow up visits benefit patients when communication between different care providers fails. During a follow up visit, we can analyze how well information has been communicated to homecare teams. For patients who have no help at home, we can assess if they need help.

We coordinate our efforts with the home healthcare teams of the elder care unit. The elder care unit conducts planned healthcare visits to patients. Sometimes, a home healthcare team greets the patient at home when we discharge them from the elderly ward. We try to update the nurse in the municipal home healthcare team on our treatment.

SW: Do you use a different patient record system compared with the municipal nurses?

Nurse: Cosmic¹⁴ is our patient journal system. The municipality uses a separate system. We cannot share patient journals online. We fax the journals to each other. We can communicate via an older system called Prator. We use Prator to send simpler messages to the municipality.

A new meta system will allow counties and municipalities to upload information to a shared platform. The new National Patient Overview¹⁵ is under development. We need compatible communications systems. Municipal care organizations will be able to access healthcare records. Yet, healthcare professionals in the county

will not be able to access patient records of the municipality. The National Patient Overview is not a system that shares information symmetrically.

National medical records systems are being developed. However, this process has been underway for several years. We see few concrete results.

Since we know that the patient journal systems are incompatible, we have started to conduct follow up visits. Some of our patients have no contact with nurses from the municipality. These are patient who lack home healthcare and homecare from the municipality. For these patients, the follow up visit are important.

As a former municipal nurse, I know that municipal caregivers lack important information because they cannot access the patient record in Cosmic. Patient records contain large amounts of information.

SW: What are some of the benefits of the Mobile Team?

Nurse: We meet the patient in her home environment. This gives us advantages. The doctor takes his or her shoes off in the hallway. We meet the patient on equal terms. We are on patient turf. Traditionally, doctors always knew what was best for the patient. I think we take a different approach. We listen to the patient.

We also gauge a holistic picture of the patient's situation. At home, patients are perhaps more honest about their issues. We meet patients when they are more relaxed. This helps us diagnose the patients. We also see what aids the patient may need at home. This captures our philosophy. We meet the patient at her home and on her terms.

We have met patients who contact us for back pain. Later, we have discovered that the patient suffers from cancer. We feel that we make a difference.

Doctor: We continue the philosophy of Dr. Hellkvist.

In the United States and the Netherlands, doctors travel much more than they do in Sweden. However, mobile teams, including a doctor and a nurse, are rare in the United States and in the Netherlands. Our strength lies in the teamwork.

SW: How is a team different from a doctor who works alone?

Doctor: The nurse drives the car while I read the patient record. I am prepared to meet the patient when we arrive. I am informed.

When someone contacts us, we communicate in the car via Bluetooth. The nurse and the doctor in the car listen to the description of the patient in the car. Both members of the team understand the patient.

Furthermore, the Mobile Team nurse has worked in the municipality. This means that the nurse is familiar with the routines of the other administration. Doctors in Sweden work in the county administration. There are different routines and different cultures in these two layers of government. Doctors from the county may not know what type of healthcare information nurses in homecare teams need. The doctor and the nurse complement each other.

Nurse: The team helps us to coordinate efforts across administrations. The Mobile Team nurse understands how nurses in homecare services operate. The Mobile Team nurse has been in the position of municipal nurses before.

We understand what kind of questions nurses who work in homecare may have. We see the patient from their perspective. The nurses' perspective differs from the perspective of doctors, at times.

When the team arrives at the patient's home, the doctor can conduct tests. The nurse can analyze the test results. The team is more efficient than the single doctor. Four eyes see more than two eyes. Four ears hear more than two ears.

SW: How does the municipal administration differ from the county administration?

Nurse: The Healthcare Law¹⁶ governs the work of the county. County employees focus on patients and on healthcare. County personnel discuss patients as patients. The municipality is governed by the Municipal Law and the Social Care Law.¹⁷ Employees in the municipality focus on social care needs. Municipal employees refer to the patients as "users" or "customers."

The legal basis instructs how employees in the two administrations view people and their needs. The legal text is the foundation for routines. The legal text creates different understandings of the individual. The two legal bases inform the culture and the routines of each administration.

We sometimes realize that municipal employees fail to comprehend the healthcare needs of patients. Understandably, the municipality is in charge of homecare and social care. They focus on social needs.

In the 1990s, Ädelreformen, or the Noble Reform in English, changed elder care in Sweden. Care for the elderly became a municipal responsibility. Previously, elder care was a county responsibility, along with healthcare. The view of the individual shifted from “patients” to “users,” in certain nursing homes.

Nurses in some elderly wards became consultants, servicing a number of wards. The separation of social care needs and healthcare needs changed how people approached patients. Patients were not viewed as people with illnesses. Patients were viewed as healthy individuals with social care needs. Ädelreformen changed the view of the individual.

Nurse: I work in the emergency room at Uppsala University Hospital as the municipal coordinator. The county employs me. I coordinate the needs of older patients with the municipal administration. I am also a member of the Mobile Team. I am a bridge between different care providers. I help patients to contact homecare providers for support at home.

The concept of a municipal coordinator at the county hospital (Uppsala University Hospital) is not new. The concept has not been put to use lately. We embed a member of the Mobile Team in the emergency room at the hospital to integrate care for the elderly. We persuaded the emergency service of the need for a municipal coordinator.

Different healthcare providers use different terminology. Employees in different areas sometimes focus on their own responsibilities. I improve the communication between the emergency room and the municipal care organizations.

Some nurses and doctors in the emergency room lack a comprehensive understanding of social care organizations. One person in the emergency room stated that a patient obtained homecare and lived in a nursing home. These two services are incompatible. Yet, the emergency room and the municipal care organizations treat the same patients. Patients rely on integrated care channels.

Employees in the emergency room do not always know whom to call in the municipal administration to obtain information about a patient. Support agents in the municipal administration decide what assistance patients obtain at home.

I call the support agents. I explain what I think the patient needs. My understanding of the role of the support agent is an advantage that other healthcare workers may not possess. Those who work in the municipality understand the importance of a support agent. The support agent is the link between individuals and social care providers. Employees in the county may have no understanding of the role of the support agent.

Many older patients visit the emergency room because they lack support at home. A patient may not have eaten properly. If we can serve meals, this person may not become a patient again. In the beginning, the emergency room personnel did not appreciate the importance of my job. Today, I feel that I am an important part of the emergency room. The emergency room personnel now appreciate my work. Emergency rooms lack the direct communication channels to the municipality that I have because I have worked in the municipality.

The Mobile Team examined the needs of patients in the emergency room during the pilot phase. We went to the emergency room for a few days. When we assessed patients, we concluded that our Mobile Team could treat four out of five elderly patients in their homes.

SW: How do you incorporate new ideas into your work?

Nurse: We develop new ideas continuously. We negotiate an agreement with the municipality for shorter wait times for homecare. We aim to have a four hour rule for homecare. The rule means that a patient who qualifies for homecare ought to obtain that care within four hours. We measure the time from decision to delivery of care.

If we see a patient in the emergency room that lacks support at home, we want to offer homecare instead of care in the emergency room. In some cases, this is sufficient to help patients. Implementation of the four hour rule will reduce the time in the emergency room.

We also try to encourage use of safety alarms to prevent unnecessary visits to the emergency room. This is a safety alarm that patients have at home. Patients who

visit the emergency room for urinary catheterization issues can use the alarm to obtain help at home. If we can introduce a routine for these patients to carry an alarm, we can reach their homes and treat these patients more quickly. Blockage of the catheter is a common problem. When a person presses the alarm, it alerts the safety line.¹⁸ Staff at the safety line can contact us so that we can travel to the patient. Alarms can help us to integrate care further.

Some patients dislike the alarm systems. Some patients do not use the alarm.

Doctor: Patients must pay for the alarm. The cost is a barrier for some. Some alarms are connected to landline telephones. Patients with mobile telephones cannot use those alarms. We must develop alarms with new technologies.

Alarms are sometimes perceived as problematic, from the perspective of patient privacy. A person who obtains an alarm must give up a key to her house so that a nurse or a person from the alarm company can enter the house in case of emergency. Patients who do not use this alarm often end up in emergency rooms when a municipal nurse or the Mobile Team could have treated the person at home. Alarms can increase the safety of patients at home.

SW: What aspects of the Mobile Team are you most proud of?

Nurse: We put ideas into practice. We developed the idea of a municipal coordinator in the emergency room. We try to increase the usage of alarms. We want to shorten the wait time for homecare. We are improving the Mobile Team. We solve problems. We cooperate with nursing homes, with ambulance services, and with municipal nurses. We cooperate with the advisory line and with the emergency room.

Sofia: Would you say that your collaboration works equally well with different healthcare bodies?

Nurse: Our collaboration with the ambulance services in Uppsala Municipality works well. They have a clear structure for different responsibilities. There is a manager, a vice manager, and eighty ambulance employees. Everyone knows that the Mobile Team exists and the ambulance service has low staff turnover. The managers of the ambulance service informed the staff about our capabilities when we established the team.

SW: Can you please describe how you work together with ambulance staff?

Doctor: The ambulance staff calls us. If they are to visit a patient we can treat, they call us.

Ambulance staff can call our municipal coordinator in the emergency room. Our municipal coordinator looks to see if the patient obtains homecare or home healthcare. Our municipal coordinator contacts the municipal homecare organization to arrange homecare for patients that need help at home but currently lack formal assistance.

We can improve our collaboration with the healthcare information line. The staff of the healthcare information line follows checklists. For example, if a patient reports difficulty breathing, the staff of the healthcare information line must direct the patient to the emergency room. We can treat patients with breathing difficulty at home. We can ask more questions than the healthcare information line. Checklists do not bind us. Through follow up questions, we can gain a better understanding of the patient. At times, the follow up questions help us discern if the patient needs urgent care or emergency care. We want to improve our accuracy in determining whom we can treat at home.

There is a clause in the healthcare information line manual that allows staff to make independent judgments about patients. Healthcare information line staff can call and obtain advice from the Mobile Team. We coordinate our efforts by discussing the needs of patients. We could develop this further, in the future. Some patients request the Mobile Team.

Doctor: The healthcare information line staff listens to what the patient reports. The patient sometimes reports illnesses incorrectly. If a patient reports that she is experiencing great pain, the healthcare information line may direct the patient to the emergency room. If the doctor from the Mobile Team checks the patient journals, he or she may figure out what the real problem is.

A few weeks ago, a patient reported that she was in great pain. When I checked her patient records, I saw that the patient had a history of overconsumption of painkillers. The patient's general practitioner had ordered a rationing of painkillers for this patient. This illustrates the importance to us of shared patient records.

SW: What other caregivers do you work with?

Nurse: Our most important partners are the district nurses. We would like to improve the relationship with district nurses. If a patient contacts his primary care clinic, the nurse who talks to the patient could call us. It is easier for the nurse to call an ambulance that picks up the patient. It is easier for the nurse to direct the patient to the emergency room. If the nurse wants the Mobile Team to visit the patient, the nurse must call us. After this, the nurse must call the patient. The nurse must coordinate with relatives of the patient to inform them about the Mobile Team. In the long run, the district nurse can benefit from greater coordination with the Mobile Team.

In the short term, it takes away time from the other tasks of the district nurse. We understand that district nurses work under pressure. There is high turnover of district nurses. Primary care centers lack personnel.

The district nurses who contact the Mobile Team are satisfied with our work. The same district nurses contact us on repeated occasions. The clinics that incorporate us in their routines see the benefits for the patient.

The county public primary care clinics have strong lateral organization. Nurses and doctors are more likely to contact the Mobile Team if managers inform them about us. We have reached out on multiple occasions to the primary care clinics. We would like the primary clinics to do a better job of informing their personnel about our work.

Municipal social care organizations are not governed by equally strong lateral organization. Information from managers does not always reach the staff on the floor.

It is difficult for us to establish coordination with primary care centers. District nurses at primary care centers change jobs frequently. If one nurse quits, he or she may not inform the successor of the Mobile Team. Some district nurses may be unfamiliar with our routines.

We want a nurse to assess the needs of the patient before we visit the patient. Some patients call their doctors multiple times every day. If our doctor answers all the phone calls from these patients, our doctor cannot treat patients. We want a nurse in another organization to screen the patient. We talk to the nurse, who describes the patient.

We reach out to all managers of primary care centers in our region. Three out of thirty managers invited us to hold informational sessions about the Mobile Team. We have reached out to the managers of home healthcare in each region. We would like more primary clinic managers to inform their staff about our work. We rely on other organizations to contact us. That is how we integrate care.

The Mobile Team depends on the work of other healthcare providers. We need a nurse to assess the patient's needs before we pay the patient a visit. If the primary care center nurse sends the patient to the hospital emergency room, we can do little to help the patient at home.

SW: What do you consider to be your greatest challenges?

Doctor: Outreach. Everyone knows about emergency rooms. Many citizens know about the advisory line. The elderly know what number to dial for an ambulance. Very few know about the Mobile Team. We hand out a brochure about our work to patients and relatives, but we only reach a fraction of our target patients.

The coordination with municipal nurses and care organizations is a great challenge. Care organizations work according to a different incentive structure than healthcare providers. They are guided by a different culture. Homecare teams are paid to deliver social care. Nurses in the homecare organization are under pressure to care for a growing number of older citizens at home. The nurses must educate assistant nurses to perform certain tasks.

Sometimes, the workload of municipal nurses exceeds their capacity. The municipality provides cleaning and helps older patients with the groceries, the cooking, and a range of other services. Their focus is not on healthcare.

Assistant nurses help the municipal nurses. The assistant nurses often lack the relevant training in healthcare. If an educated nurse treats a patient for a wound, the patient may recover in two weeks. If an inexperienced assistant nurse treats the wound, the patient may recover in two months. The cost of materials increases with the treatment period. We need to improve the training of municipal staff. Municipalities focus on education of assistant nurses now. This is a positive trend.

As we described, we need to improve our collaboration with primary care clinics. Many patients contact their general practitioner for urgent care. We would like to reach these patients. We know that it is difficult to establish new ways of working. Other organizations can benefit if they contact us. We treat the same patients.

A few years ago, Uppsala University Hospital tried to establish a unit for urgent care. The urgent care unit performed our function at the hospital. After some time, managers closed it because few people visited the unit. It is always difficult to embed new units in established organizations. Out of habit, most people traveled to the emergency room.

Nurse: We can help patients that live far from the hospital. A lady used her alarm system to call us. The lady was healthy but was experiencing difficulty breathing. I had ordered an ambulance to take her to the emergency room. We could help this lady at home. We were there for twenty minutes and prescribed Furex, a medication, for her problem. This patient did not need to travel forty kilometers to the hospital emergency room. This patient was happy.

SW: How do you spread information about your work?

Nurse: We have tried to contact the local newspapers. Newspapers focus on other types of news. In the summer, local newspapers reported about our work.

We distribute a brochure to patients and to relatives. We contact managers and nurses in nursing homes. Far from every nurse in our region understands what kind of care we can deliver.

Nurses in nursing homes can contact us instead of taking a resident to the emergency room. An assistant nurse must accompany residents who are ill to the emergency room. Most people in nursing homes cannot travel alone because they suffer from illnesses such as dementia and Alzheimer's disease. The assistant nurse can care for other residents while we treat the patient. We communicate directly with nurses in nursing homes. In this way, there are no barriers to communication.

SW: Are there mobile teams elsewhere in Sweden?

Doctor: There are mobile doctors in other places. Doctors and nurses from overseas and from other regions study our team.

There is a mobile geriatrics team in the south of Sweden. This team departs from the local hospital. The geriatrics team is not as focused on integrating the care of different organizations. Patients need to be over the age of seventy five. Patients must suffer from multiple diseases to qualify for home healthcare in the south of Sweden.

Nurse: There is a private urgent care team in Uppsala. They work in the evenings and overnight. The difference between that team and our work lies in the follow up work. We can ensure that a municipal nurse visits the patient after we have left. The private urgent care team makes one visit. If the patient suffers from dehydration or fails to take her medication, that patient may need to go to hospital soon after the home visit. We need to coordinate efforts to reduce avoidable inpatients.

Politicians want to establish similar teams in other municipalities in Uppsala County. There are eight municipalities in this county. There is only the one mobile team in Uppsala Municipality. We cannot travel the entire county. We could travel to Tierp, the neighboring municipality. The municipal board of Tierp turned down our offer to treat patients in their municipality. Tierp did not want to incur the costs of our work. The cost was not huge, but many municipalities struggle financially.

Nurse: It is a great success that the Mobile Elderly Unit became the permanent Mobile Team.

SW: Why did the politicians decide to keep the Mobile Team?

Doctor: The Mobile Team cuts costs. We proved, with statistical data, that it is cheaper to treat the elderly at home. If we make three visits per day, we save costs for the county council. It is expensive to send ambulances to patients. Emergency care in hospital is expensive.

We also improve one standard of evaluation, avoidable inpatients.¹⁹ Avoidable inpatients refer to the number of patients who end up in the hospital when they could have avoided a hospital stay. An older patient who lacks homecare and ends up in hospital because she has not been able to cook for herself is an avoidable inpatient. This is an important standard of evaluation for managers and politicians. There are several advantages for the patient and for the

healthcare system if people who can avoid hospital stays do so. The elderly with weak immune systems can contract additional infections during a hospital stay. Complications like these cause immense suffering. The elderly who stay at home are at lower risk of care related infections.

Nurse: We collected statistics during the trial period. We went to every meeting in the municipal administration. We went to every county council meeting. We made sure that we were visible. We gained an understanding of the decision making processes in both administrations.

Uppsala County covers sixty percent of the costs. Uppsala County wanted to keep the Mobile Team. They read our reports, including the cost benefit calculations.

The municipality covers forty percent of our costs. The municipality does not save any costs directly with the Mobile Team. However, nurses in the municipality gain support from us. Our support improves their situation. Their work environment improves. In the long run, this can save costs for the municipality if nurses stay on longer in the municipality. Nurses in the municipality often work alone without support.

Some politicians also studied how the Mobile Team helps the patients. The decision was not only based on an economic calculation.

Politicians in the municipality pay attention to questions related to the elderly. In the county, the elderly are not always prioritized. Uppsala University Hospital decreased the number of emergency beds in the geriatric ward. There is a trend to keep older patients at home. This trend is great because many older patients want to stay at home. Politicians allocate resources to initiatives that keep older patients out of the hospital.

This trend is also problematic because some older patients need to go to hospital. It would be better if an older ill patient got into a bed in a geriatric ward immediately instead of sitting in the emergency room. Now, older patients end up in different wards, including women's and children's wards. There are no beds for these patients. An older patient who suffers from dementia can experience confusion. A ward for children lacks the resources to deal with dementia. Older patients need specialist geriatric care.

The integration of care is incomplete. Yesterday, I heard news about the number of older patients who occupy beds in hospitals when they are ready to go home. The municipality cannot offer homecare and help to these patients. For this reason, the hospital cannot send all older patients home when they are discharged. The municipality must pay for each extra day, from five days after onwards, when the patient is ready to go home.

SW: How do you measure results?

Doctor: Uppsala County and the Swedish Association of Counties and Municipalities track avoidable inpatients and readmissions to hospital after thirty days. It is too early to say whether the Mobile Team and the elder care unit reduce readmissions. We believe we help.

SW: Do you measure door to door time for older patients in emergency rooms? That is, do you measure how much time older patients spend in emergency rooms?

Nurse: Uppsala University Hospital has among the longest wait times in emergency rooms for older patients. This standard is recorded nationally to keep track of hospital performance.

Doctor: Yes, we measure door to door time. We also consider unquantifiable gains such as time for relatives in emergency rooms. Relatives cannot work when they accompany a relative. This is a productivity loss that is difficult to quantify. We reduce the discomfort for relatives.

Nurse: We measure results, but the Mobile Team was not intended to measure results. The Mobile Team solves problems we know exist. That is the idea. Sometimes, we measure things, but we do little about the issues. We solve the problems we know exist. We know that a nurse and a doctor need to visit older patients. We send a nurse and a doctor to the elderly.

We already know of the problems that exist. The Swedish Association of Counties and Municipalities delivers reports. We are familiar with the problems in these reports. The reports reveal little new information about problems.

We reach out to around thirty percent of the elderly that need urgent care. Seventy percent of the elderly that need urgent care travel to the emergency

room. Thirty five percent of those that come to the emergency room travel there independently. Relatives take the remaining thirty five percent to the emergency room. We want to reach all the patients that we can help. That is where the work of Angela, the municipal coordinator in the emergency room, matters. In January 2015, we evaluated the trial project of a municipal coordinator in the emergency room.

We would like to see a change in attitude toward emergency rooms. At times, young people with minor infections come to the emergency room. These people do not need emergency care.

SW: What would you change if you were to establish the Mobile Team elsewhere?

Doctor: I am not sure I would change anything.

Nurse: We incorporate new ideas. When we saw that a municipal coordinator could help patients in the emergency room, we decided to station a nurse from our team there. We try new ideas when one member of the team presents an idea. Now that we are a permanent team, it is perhaps more difficult to incorporate new ideas. We have fixed channels of communication. We have established routines.

We continue to make improvements when we see problems. I recommend that other mobile teams adopt a similar approach.

SW: What challenges did you face when you started the Mobile Team?

Nurse: There was some confusion about who was in charge in the municipality, in the county, and in the labor unions. No one seemed to know who was in charge of specific areas of collaboration. I cannot remember how to navigate in two bureaucracies. I could revisit my notes and describe with whom I had to meet at different points.

I had many meetings with managers of the geriatric ward at Uppsala University Hospital. I am familiar with the way they work. The personnel at the geriatric ward wanted to earmark emergency beds for the patients of the Mobile Team. We negotiated an agreement and it felt great. We all saw the need for this agreement. In practice, the agreement never worked out. The geriatric ward was always full.

The geriatric ward reduced the number of beds by half. Integration of care requires that all steps work.

We completed the project application for funds from the Swedish Association of Municipalities and Regions in two weeks. We started the application on June 1, 2014, and the deadline was June 15, 2014.

Nurse: Some patients resist being told what to do. We understand how these patients feel. These patients may want to go to the emergency room. The staff in the emergency room is friendly. The staff greets the elderly. Even though patients wait for hours and could be treated at home, these patients travel to the emergency room.

Other patients resist carrying alarms at home. If all older patients carry alarms, we can help more patients at home. The alarm connects the patient to a nurse or to a healthcare advisor who then contacts us.

Nurse: Initiatives like the Mobile Team rely on a core group of devoted employees. Reliance on a few devoted people renders the Mobile Team fragile. This is less of a risk now that we have become a permanent team.

SW: How would you describe your greatest opportunities?

Doctor: We could help many more patients. With one car, we can treat many patients at home. That is an opportunity. We could reach more patients. If these patients only knew what kind of healthcare we deliver, we would catch these patients before they went to the emergency room.

We could scale up our operations. If we reached all patients who needed urgent care, we could have two cars. It would still cost less than treating those patients in the hospital.

We could also diversify our activities. I know doctors of patients with heart failure who have talked about using the Mobile Team. We could conduct follow up visits at home to patients with heart failure. Other specialist physicians could use our team for follow up visits if they embraced our work. We could help hospitals and patients.

Nurse: A follow up visit at home often prevents a second hospital stay. The problem with healthcare today is that we intervene when patients are ill. The Mobile Team could prevent illnesses or intervene at early stages.

We could communicate our work in a more effective way. We want to develop a new promotional strategy. People have short memories. You must remind patients, nurses, and healthcare staff about our work on more than one occasion. That is a future opportunity. If more people used our services, we could help more patients.

SW: Thank you all very much for your participation.

Mobile Team: Thank you, Sofia, for all your questions!

¹ Original title: Slutrapport för projekt kring de mest sjuka äldre Mobila hembesöksteamet i Uppsala

² Sjukvårdsrådgivningen 1177

³ Kommunal sjuksköterska

⁴ Beredskapsjouren

⁵ Hemvårdsenheten/Åldrevårdsenheten efter januari 2014

⁶ Bloomberg Currency Converter. SEK to USD 0,1191, February 15, 2015, link [here](#)

⁷ Bilagor till slutrapport, Projekt för de mest sjuka äldre, Mobila hembesöksteamet Uppsala, Appendix

10 – Methodology, Cost Calculation,

⁸ Bättre liv för sjuka äldre, link [here](#)

⁹ Åldrevårdsenheten

¹⁰ Urgent care is a condition that requires immediate care but is not considered life-threatening (Scripps Health Definition)

¹¹ Personlig hälsoplan

¹² Vårdplanering

¹³ Biståndshandläggare

¹⁴ Cambio Cosmic is a patient record system. [Cambio Healthcare Systems](#) delivers comprehensive information technology solutions for healthcare organizations

¹⁵ Nationell Patientöversikt

¹⁶ Hälso- och sjukvårdslagen

¹⁷ Kommunallagen och Socialtjänstlagen

¹⁸ Trygghetsjouren

¹⁹ Undvikbar slutenvård