Within an integrated home health care model

– Registered nurses’, physicians’, patients’ and their next of kin’s perspectives

Lina Emmesjö
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Abstract

**Background:** Many older patients receive health care from several different healthcare organizations, which may lead to uncertainty about the responsibility for their healthcare needs. Integrated care has been argued to aid the healthcare system by addressing the challenge of the complex care needs of older patients with multiple health problems. Previous research has stated that integrated care models often have been developed with a focus on a single diagnosis, which risks overlooking the extensive and complex care needs of older patients. Prior research has also expressed the need to deepen knowledge about how integrated care models influence health care professionals, patients and their next of kin. Moreover, it is important to understand how the COVID-19 pandemic affected integrated care models which may expand knowledge about integrated home health care in crisis situations.

**Aim:** To study expectations, perceptions and experiences of an integrated home health care model from the perspective of registered nurses, physicians, patients and their next of kin.

**Method:** Data for the four studies were collected about the mobile integrated care model with a home health care physician (MICM) through semi-structured interviews with registered nurses, physicians, patients and their next of kin. Data for two studies were also collected through field notes. The data were analyzed using qualitative content analysis, phenomenography and thematic analysis.

**Findings:** The registered nurses and physicians expressed that the MICM was the best way to work in home health care. For patients and their next of kin, a sense of relief occurred when being admitted to the MICM. The healthcare professionals experienced increased continuity of care after the implementation of the MICM. Although many patients and their next of kin also experienced such continuity, others did not. Registered nurses and physicians expressed that the lack of continuous home visits during the COVID-19 pandemic negatively influenced the building and maintaining of relationships with patients. It was important for both patients and their next of kin that the healthcare professionals viewed older persons as being more than patients and that they were able to talk
about other things beyond health care. Differences in the prioritization of the MICM were expressed by the registered nurses and physicians based on the prioritization of the individual primary healthcare center. Moreover, registered nurses, patients and their next of kin detected differences in the health care provided based on the ability of the individual physician. Furthermore, differences were found when comparing healthcare organizations, where the patients in MICM had benefit of receiving health care in the home but lacking access to medical equipment. Teamwork was the dreamwork of the MICM. The most prominent collaborations were between the registered nurses and the physicians, who were described as working well together. Although teamwork with other healthcare professionals in the MICM was apparently rare, it was regarded as being significant in the provision of the high-quality care for which the MICM aimed. Teamwork was also adversely impacted by the COVID-19 pandemic, with telephone and video communications often leading to miscommunication. The MICM structure influenced patient participation both positively and negatively. Many patients and their next of kin expressed that they had been provided the opportunity to participate in their health care in the MICM. However, others depicted the structure of the MICM as hierarchical and felt like they were on the bottom of this hierarchy. Providing health care within the homes of patients, one part of the MICM structure, allowed for patient participation and for addressing issues beyond health care itself. This was especially important during the COVID-19 pandemic as healthcare professionals became the only persons with whom patients met in their home. The physicians and registered nurses stated that being in patients’ homes gave them unique insights into their lives. The patients and their next of kin were relieved that they did not have to travel as much for their health care as they received much of it in their homes.

**Conclusions:** The emphasis on person-centered care in the MICM was evident in the perceptions of the healthcare professionals about the patients and their next of kin, whom they viewed as persons, not simply recipients of health care. Differences were found in the health care provided in the MICM and in comparison, to other healthcare organizations which did not align with the person-centered care ethics. However, providing health care to patients in their own home benefited the provision of person-centered care – the value base of the MICM.
The MICM was created with the goal of implementing individually tailored and coherent health care with increased continuity. The healthcare professionals viewed individual medical healthcare plans as co-created with each patient, and yet no patient could recall participating in this co-creation. The coherency of the MICM was regarded as having been improved by teamwork between the registered nurse and the home healthcare physician. Collaborations with other healthcare professionals rarely occurred and should be improved in the future. Participants reported varying experiences of continuity in the MICM, which influenced the possibility of building relationships. Providing continuity with a home healthcare physician for patients is therefore preferable.

The work described in this thesis was conducted during the COVID-19 pandemic, with one study focusing on experiences of registered nurses and physicians in a crisis situation. The findings of this study, and the thesis as a whole, provided unique insights into integrated care models in crisis situations, which the healthcare system may face in similar or different ways in the future. The MICM was upheld as the best way to work in home health care, especially as patients and their next of kin regarded the model as making their daily lives easier. The suggested improvements can therefore guide the development of an already appreciated integrated care model, as well as other integrated care models and to prepare them for future crisis situations.

**Keywords**: home health care, home healthcare physician, municipality nursing, integrated care, person-centered care, semi-structured interviews, field notes, qualitative content analysis, phenomenography, thematic analysis
Svensk sammanfattning


Syfte: Att studera förväntningar, uppfattningar och erfarenheter av en integrerad hemsjukvårdsmodell utifrån sjuksköterskors, läkares, patienters och närståendes perspektiv.

Metod: För att besvara syftet användes induktiva kvalitativa designer. Kontexten för avhandlingen var vårdmodellen Mobil Närvård med hemsjukvårdsläkare (MICM).

Delstudie I: Syftet var att beskriva sjuksköterskors erfarenheter av att arbeta och ge vård i vårdmodellen Mobil Närvård med hemsjukvårdsläkare. Data för delstudie I insamlades genom semistrukturerade intervjuer. I delstudien deltog 18 sjuksköterskor som arbetade i hemsjukvården i kommuner där MICM implementerats. Data analyserades genom kvalitativ innehållsanalys.

Delstudie II: Syftet var att beskriva hemsjukvårdsläkares uppfattningar av att arbeta och ge vård i vårdmodellen Mobil Närvård med hemsjukvårdsläkare,
samt uppfattningar av deltagande och utformning av vården. Data för delstudie II insamlades genom semistrukturerade intervjuer. I delstudien deltog 16 hemsjukvårdsläkare anställda på vårdcentral som arbetade i den mobila närvårdsmodellen. Fenomenografisk analys användes för att analysera data.


Resultat: Sjuksköterskorna och hemsjukvårdsläkarna framförde att MICM var det bästa sättet att arbeta i hemsjukvården, och att de inte ville gå tillbaka till att arbeta som de gjort innan. Patienterna och deras närstående framförde att deras liv hade förenklats sedan de började få vård av hälso- och sjukvårdspersonalen i MICM. Att bygga relationer mellan hälso- och sjukvårdspersonalen och patienten samt dennes närstående beskrevs av alla grupper som viktigt inom MICM. Kontinuitet i hälso- och sjukvården och att se patienten som en person blev byggestenar för att bygga relationen. Sjuksköterskorna och hemsjukvårdsläkarna beskrev en ökad kontinuitet i hälso- och sjukvården sedan implementeringen av MICM. Ökad kontinuitet i hälso- och sjukvården framfördes även av flera av patienterna och deras närstående, medan andra erfor bristande kontinuitet. Hemsjukvårdsläkarna och sjuksköterskorna uttryckte även en bristande
möjlighet att besöka patienterna under COVID-19 pandemin vilket skapade svårigheter i byggandet av relationer med patienterna.

Det uttrycktes skillnader i den hälso- och sjukvård som gavs mellan de kommuner som implementerat MICM. Skillnaderna beskrevs av sjuksköterskor och hemsjukvårdsläkare vara baserade på de organisatoriska prioriteringarna som gjordes av de enskilda vården och, enligt sjuksköterskorna, patienterna och de närstående, den enskilda hemsjukvårdsläkarens förmåga att ge vård som omfattade hela patienten. Vidare beskrev hemsjukvårdsläkare, patienter och närstående skillnader i den vården som gavs i MICM i jämförelse med andra hälso- och sjukvårdsorganisationer, som primärvården. Det beskrevs av hemsjukvårdsläkarna hur patienter i MICM fick mer resurser än andra grupper av patienter. Andra hemsjukvårdsläkare, patienter och närstående beskrev hur resurser som medicinteknisk utrustning saknades i MICM som patienter i primärvården hade tillgång till.

Att arbeta i team i MICM erfors av hemsjukvårdsläkare och sjuksköterskor som nödvändigt och som det bästa sättet att ge patienterna vård. Deltagare från båda professionerna uttryckte sig vara centrum i MICM. Teamarbetet mellan sjuksköterskor och hemsjukvårdsläkare var det primära och upplevdes av både båda professionerna fungera väl och ha hög kvalité. Både hemsjukvårdsläkarna och sjuksköterskorna erfor att övrig personal i hemsjukvården sällan samarbetade med hemsjukvårdsläkaren. I teamet beskrevs därför hemsjukvårdsläkaren av sjuksköterskorna och hemsjukvårdsläkarna själva delvis som en del av teamet, men också som en konsult eller ”outsider”.

Strukturen i MICM påverkade möjligheten för patienter att vara delaktig i sin egen vård, både positivt och negativt. Flera patienter beskrev att MICM gav en ökad möjlighet att delta i sin egen vård. En del patienter och närstående beskrev MICM som hierarkisk med minskad möjlighet för patienterna att delta i sin hälso- och sjukvård. Däremot beskrev sjuksköterskorna och hemsjukvårdsläkarna att strukturen i MICM, att ge vård i hemmet, ökade patientens möjlighet till delaktighet i sin vård.
Hemmet blev särskilt viktigt under pandemin eftersom patienterna var isolerade i sitt hem och enbart träffade hemsjukvårdspersonalen.

**Slutsats:** Sjuksköterskorna och hemsjukvårdsläkarna framförde att MICM var det bästa arbetssättet i hemsjukvården, och att de inte ville gå tillbaka till att arbeta som de gjorde innan. Patienterna och deras närstående framförde att deras liv hade förenklats sedan de började få vård av hälso- och sjukvårdspersonalen i MICM.

MICM har sin värdegrund i personcentrerad vård. I strävan efter att arbeta personcentrerat framträdde initierande av det personcentrerade partnerskapet i vårdpersonalens förmåga att se personen bortom behovet av hälso- och sjukvård. Att träffa patienten i dennes hem ökade möjligheten till strävan mot personcentrerad vård. Hemmet blev särskilt viktigt under COVID-19 pandemin eftersom patienterna var isolerade i sitt hem och enbart träffade hemsjukvårdspersonalen. Skillnader i den hälso- och sjukvård som gavs i de olika kommunerna möjliggjordes av strukturen i MICM. Skillnader beskrevs även gentemot andra hälso- och sjukvårdsorganisationer, som kan uppfattas inte vara i linje med delar av den personcentrerade etiken. Mer forskning skulle kunna fördjupa kunskapen kring hur strävan efter personcentrerad vård förverkligas inom en integrerad vårdmodell i hemsjukvården.

MICM har målsättningen att skapa individuellt utformade och sammanhängande hälso-och sjukvårdsinsatser i patientens hem med ökad kontinuitet. Den individuellt utformade hälso- och sjukvården påverkades av strukturer i MICM som inverkade på patientens delaktighet. Många patienter beskrev att de kände sig uppmuntrade att delta. Andra beskrev hur de var tvungna att vända sig till hälso- och sjukvårdspersonal lägre ner i hierarkin för att få prata med sjuksköterskorna och hemsjukvårdsläkaren. Det var även patienter och närstående som beskrev en brist på tillgång till information. Att ge patienter tillgång till sina journaler, och den medicinska vårdplanen bör vara en prioritet inom MICM.

Målsättningen att ge sammanhängande vård i MICM erfors förbättras genom teamarbete, vilket beskrevs fungera väl mellan sjuksköterskor och hemsjukvårdsläkare. Det uttrycktes finnas behov av flera hälso- och sjukvårdsprofessioner för att ge den högkvalitativa vård som eftersträvades i MICM, men ett samarbete där flera professioner deltog beskrevs vara ovanligt och skulle kunna förbättras.
framöver. En önskan från sjuksköterskorna och hemsjukvårdsläkarna var att tillhöra samma organisation. Flera lösningar för att tillhöra samma organisation har föreslagits i tidigare forskning, vilka skulle vara kunna undersökas i framtiden.

Hälso- och sjukvårdspersonal beskrev en ökad kontinuitet efter implementering av vårdmodellen, vilket även patienter och närstående gav uttryck för. Hemsjukvårdsläkarna och sjuksköterskorna uttryckte en bristande möjlighet att besöka patienterna under COVID-19 pandemin, vilket påverkade relationsbyggande med patienterna. MICM erfor var det bästa sättet att arbeta på i hemsjukvården. Patienterna och deras närstående beskrev en lättnad i ansvaret kring hälso- och sjukvården, och att deras liv hade förenklats sedan de började få vård i hemmet av hälso- och sjukvårdspersonalen i MICM. De åtgärder som är föreslagna i avhandlingen kan därför förbättra den redan uppskattade vårdmodellen MICM, samt andra integrerade vårdmodeller, och rusta dem för framtida kriser.
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1. Introduction

The healthcare system faces the challenge of meeting the complex care needs of the growing population of older persons, according to the World Health Organization (WHO, 2015b, 2022). These older persons often require health care from several healthcare providers. Doing so, however, may lead to uncertainty about the responsibility for their healthcare needs (Swedish Government Official Reports, 2017:21; WHO, 2015b, 2022). Thus, providing quality health care to older patients in the form of integrated care has been argued to be useful (WHO, 2017). Integrated care models have been described as being capable of overcoming fragmentation in the healthcare system by encouraging enhanced coordination between healthcare professionals and organizations (Kjelsnes & Feiring, 2022).

To meet the need for increased quality of care and cross-organizational collaboration, several types of integrated care models have been proposed and researched, each with its own distinct characteristics (Mateo-Abad et al., 2020; Park et al., 2014; Trankle et al., 2020). However, integrated care models have been expressed to often be developed with a single diagnostic focus, overlooking the complex care needs of many older patients (Struckmann et al., 2018). Accordingly, there has been a call to deepen and expand knowledge about the outcomes of integrated care for older patients and their next of kin, as well as for healthcare professionals (Smith et al., 2016; Törnfelt et al., 2021). Likewise, more research should be conducted on integrated care models in the home healthcare setting, which foremost applies to older persons (National Board of Health and Welfare, 2019b). Hence, this thesis study expectations, perceptions and experiences of integrated home health care from the perspectives of registered nurses, physicians, patients and their next of kin with a theoretical framework based on person-centered care.

The conditions under which the research project described in this thesis was carried out were partly influenced by the COVID-19 pandemic. Capturing the experiences of registered nurses and physicians made it possible to better understand how their work with the integrated care model was affected by the COVID-19 pandemic.
2. Background

In this chapter, the context of the phenomena will be described – namely, the expectations, perceptions and experiences of integrated home health care from the perspectives of registered nurses, physicians, patients and their next of kin. This thesis and the research on which it is based are anchored in the field of health and care sciences: the scientific study of individuals’ experiences, observations and resources, which, throughout life, can promote, preserve or restore health, as well as the organizations and systems responsible for the provision of health and social care (Jönköping University, 2020). To provide the reader with a better understanding of the research context, a description of the Swedish healthcare system and home health care is provided. Additionally, as the research project was partly conducted during the COVID-19 pandemic, its effects on home health care are also described. Lastly, previous research on and definitions and descriptions of integrated care, integrated teamwork and integrated care models are provided.

2.1. The Swedish healthcare system

The Swedish healthcare system refers to the entire constellation of organizations responsible for providing health care to patients, including regional, municipal and private health care on all levels. The provision of health care in the Swedish healthcare system is defined in the healthcare law (Swedish Code of Statutes, 2017:30), which specifies the obligations and regulations for health and medical care. The Swedish healthcare system is organized into two different healthcare authorities: regions and municipalities. Regional authorities are responsible for hospitals and primary health care, while municipal authorities are primarily responsible for social care (Swedish Code of Statutes, 2001:453) but also partly for health care (Swedish Code of Statutes, 2017:30). Social care includes basic care and support in daily life (Swedish Code of Statutes, 2001:453), whereas health care includes specific health and medical care (Swedish Code of Statutes, 2017:30).

Swedish health care has been reported to be of good quality (Janlöv et al., 2023; National Board of Health and Welfare, 2020), with patients generally
being satisfied with the overall quality of their care (Janlöv et al., 2023). However, overall, patients are less trusting of related healthcare services due to accessibility issues (National Board of Health and Welfare, 2020) and problems tied to the availability and continuity of healthcare professionals (Janlöv et al., 2023; National Board of Health and Welfare, 2023a). Other problems that have been reported in Swedish health care are related to additional healthcare needs among the population, poor working environments for healthcare professionals, and difficulties in the coordination and collaboration of healthcare organizations (Janlöv et al., 2023).

The Swedish healthcare system is currently undergoing a reform described as a transition to person-centered and integrated care, created by Swedish Association of Local Authorities and Regions (SALAR, 2023; Swedish Government Official Reports, 2020:19). The reform is aimed at making health care close, coherent, person-centered and integrated in an effort to improve the health of the population, allow for patient participation, and make healthcare resources more efficient. Focus is being placed on patients’ self-care, and on their relationships with healthcare professionals, with the overall goal of proactively promoting health and equal access to health care for the entire population. The value base of the reform is person-centered care, which is defined in the reform as the right of patients to participate in their own health care (SALAR, 2023). The shift to person-centered and integrated care has tasked primary health care with coordinating the contributions received by patients from different healthcare authorities (Government Offices of Sweden, 2022; Swedish Government Official Reports, 2020:19).

2.1.1. Home health care

Swedish home health care involves collaboration between primary health care centers and municipal home health care, with the majority of those receiving such care being 65 years of age or older (National Board of Health and Welfare, 2021b). The physical changes that accompany older age increase the risk of health problems (Maciejewski & Hammill, 2019; Meher et al., 2022; National Board of Health and Welfare, 2023b; Vetrano et al., 2019; WHO, 2015b, 2021a). These health problems can have adverse impacts on the physical and psychological capabilities of older persons (Kingston et al., 2018; Marengoni et al., 2011; WHO, 2015b), thereby increasing their reliance
on support in their daily life (Palmér et al., 2019; Shaw & Langman, 2017; Åberg et al., 2020). Despite their increased dependency, many older persons prefer to manage their health problems in their current home for as long as possible (Gillsjö et al., 2011; Åberg et al., 2020). One scoping review, however, suggested that older persons prefer residential care over remaining in their current home (Lehnert et al., 2019). The findings of this review have been partially supported by research that found that a third of older patients choose residential care over home health care (Kasper et al., 2019). When older patients are no longer able to travel to primary healthcare centers, their admission to municipal home health care becomes possible. The decision to admit these patients to home health care is made by physicians at primary healthcare centers (Swedish Code of Statues, 2017:30). Municipalities are responsible for providing health care to older persons within their homes (National Board of Health and Welfare, 2019b) through registered nurses, physiotherapists, occupational therapists and dieticians (National Board of Health and Welfare, 2019b). When older patients are admitted to municipal home health care, the responsibility for their medical care from physicians remains with the primary healthcare center (Swedish Code of Statues, 2017:30). This is because physicians are currently unable to provide clinical services when employed by municipal home health care (Government Offices of Sweden, 2020:142; Ädelreformen, 1998/99:So436). The amount of time general physicians work for the municipality varies nationally depending on how primary healthcare organizations view municipal physician support (SALAR, 2020b).

Registered nurses and physicians collaborate as required to provide quality home health care (Lillsjö et al., 2023; Modin et al., 2009, 2010; Vatnøy et al., 2019). Although such collaboration is considered to be effective, it is also complex since municipal home health care and primary health care belong to different healthcare authorities (Swedish Agency for Health and Care Services Analysis, 2023:3). Some challenges associated with collaboration between registered nurses and physicians include limited availability and time (Lillsjö et al., 2023) and communication barriers (Leff et al., 2022). These challenges can make it difficult to properly assess patient needs (Lillsjö et al., 2023). Some general physicians have argued that collaboration can be improved by having a designated general physician working towards the municipality organization (Christensen et al., 2023). Registered nurses would appear to
agree, as they have noted that frequent changes in the general physician appointed to home health care can negatively affect cross-organizational collaborations (Lillsjö et al., 2023). It has also been argued that challenges associated with cross-organizational collaborations have increased pressure on next of kin to take responsibility for their older relatives (National Board of Health and Welfare, 2021a; Rostgaard et al., 2022). To address these challenges, there is a wish for an appointment of general physicians to municipal home health care (Lillsjö et al., 2023), which is currently being investigated (Government Offices of Sweden, 2023:98).

2.2. The COVID-19 pandemic

The research upon which this thesis is based began on 1st of February 2020. The original focus was on studying older patients receiving home health care and their next of kin within the context of an integrated care model. On 11th of March, 2020, however, coronavirus disease 2019 (COVID-19) was declared a global pandemic by the WHO (2020). Persons over 60 years of age were viewed as being especially vulnerable to COVID-19 (Cawthon et al., 2020; Cudjoe & Kotwal, 2020; Powell et al., 2020) as they had a higher risk of developing serious symptoms and were thus also at heightened risk of hospitalization, severe complications and death (WHO, 2021b). Restrictions aimed at preventing the spread of the virus were implemented globally (Herby et al., 2023; Ludvigsson, 2023), with stricter restrictions recommended for those over the age of 70. Older persons were urged to limit the number of persons with whom they interacted in person and to communicate instead through telephone or digital devices to avoid being infected (Skoog, 2020). The focus of the thesis therefore expanded to include registered nurses and physicians working in the integrated care model as well. Ultimately, the outbreak of the COVID-19 pandemic provided a unique opportunity to examine an integrated home care model during a major health crisis.

2.2.1. Home healthcare professionals in the pandemic

Other research conducted in the context of home health care at the beginning of the COVID-19 pandemic reported that limited knowledge, equipment and guidelines (Ghezeljeh et al., 2022; Moi et al., 2022; Tarvis et al., 2022) caused
more stress among healthcare professionals than the pandemic itself (Tarvis et al., 2022). These limitations led to frequent changes in the way many home healthcare professionals worked (Ghezeljeh et al., 2022; Moi et al., 2022; Tarvis et al., 2022) and increased their workload (Ghezeljeh et al., 2022; Rydenfält et al., 2023; Tarvis et al., 2022). Other healthcare professionals, however, did not experience an increased workload as home visits to patients during the pandemic were reduced (Moi et al., 2022). Healthcare professionals working in home health care during the pandemic considered it to be mentally demanding (Ghezeljeh et al., 2022; Moi et al., 2022; Ruíz-Fernández et al., 2022). Registered nurses working in home health care during the pandemic experienced despair, increased anxiety, pessimism, and uncertainty about the future (Ruíz-Fernández et al., 2022) where health care professionals feared being infected and infecting their family or patients (Moi et al., 2022; Ruíz-Fernández et al., 2022; Rydenfält et al., 2023; Tarvis et al., 2022). There were also registered nurses who left the profession due to fear of contracting COVID-19 (Ghezeljeh et al., 2022). This fear was described by some as being stronger at the beginning of the pandemic due to the lack of sufficient protective gear (Moi et al., 2022; Ruíz-Fernández et al., 2022; Rydenfält et al., 2023; Tarvis et al., 2022). Some home healthcare professionals also expressed being undervalued compared to hospital healthcare professionals as priority was apparently given to the and were the first to be provided with vaccines (Ghezeljeh et al., 2022).

2.2.2. Next of kin in the pandemic

During the COVID-19 pandemic, the next of kin of older persons reported increased anxiety, worry and stress, primarily due to their responsibility for their vulnerable relatives, who had a greater risk of developing more severe symptoms of the virus if infected (Mauldin & Defelice, 2023; Rezende et al., 2022). These uncomfortable emotions motivated many next of kin to adopt more stringent preventive measures and to change their routines in daily life to follow recommended restrictions (Rezende et al., 2022). The perception among next of kin was that home health care during the pandemic struggled to provide the same level of care as before, consequently increasing the need for informal care (Russell et al., 2023; Tur-Sinai et al., 2021). Next of kin
living with home healthcare patients also feared that home healthcare personnel would bring COVID-19 into the home (Mauldin & Defelice, 2023).

2.2.3. **Home healthcare patients in the pandemic**

Many home healthcare patients committed to social distancing restrictions during the pandemic by isolating themselves from both the public and their family and friends (Dunford & Brooke, 2022; Kivi et al., 2021). Older home healthcare patients were reluctant to receive visitors due to fear of contracting COVID-19 (Sørbye et al., 2022), opting instead for telecommunication with healthcare professionals (Moi et al., 2022). Despite their commitment to social distancing restrictions (Dunford & Brooke, 2022; Kivi et al., 2021), many older patients found them difficult (Sørbye et al., 2022) as it increased their sense of loneliness (Johansson-Pajala et al., 2022; Van Tilburg et al., 2021). However, the results of research on experiences of loneliness and other effects of the pandemic on the mental health of older persons are not consistent. On the one hand, some studies noted increased loneliness (Parlapani et al., 2021) and worsening of mental health (Dunford & Brooke, 2022; Johansson-Pajala et al., 2022; Parlapani et al., 2021; Zaninotto et al., 2022) during the pandemic, while others reported opposite trends (Heidinger & Richter, 2020; Kivi et al., 2021; Röhr et al., 2020).

2.2.4. **Interactions in home health care during the pandemic**

Throughout the pandemic, home healthcare interactions were affected (Moi et al., 2022; Tarvis et al., 2022) by restrictions. Team meetings about health care were cancelled (Rydenfält et al., 2023; Tarvis et al., 2022) and communication between healthcare professionals, and between healthcare professionals and patients, were mainly conducted by telephone or video calls. Interactions between patients and healthcare professionals were also impacted by protective gear, such as masks and visors (Moi et al., 2022; Tarvis et al., 2022). Some described these changes as negative (Moi et al., 2022), while others viewed the development of digital capabilities in home health care more positively (Rydenfält et al., 2023). Registered nurses in home health care reported that interactions with general physicians working at primary healthcare centers became less frequent and more challenging (Moi et al., 2022; Tarvis et al., 2022). Registered nurses also described how the need for
physician support increased during the pandemic, but that it was difficult to accomplish. Home healthcare professionals reported that patients did not receive individual assessments from physicians in person during the pandemic; instead, assessments and rounds were conducted via telephone calls between registered nurses and the physicians. On the other hand, general physicians described the pandemic as having increased awareness about the need to priorities collaboration between home health care and primary health care (Tarvis et al., 2022).

2.3. Integrated care

Integrated care has been argued to differ from singular and sporadic health care (WHO, 2017, 2022) and to contribute to collaboration between healthcare organizations and authorities. Delivering person-centered integrated care has also been described as a priority in the provision of health care to older persons (Keating, 2022). However, existing research disagrees about the effects of integrated care on patients with complex care needs. Some have recognized its benefits (Mateo-Abad et al., 2020; Park et al., 2014; Trankle et al., 2020), while others have emphasized its shortcomings (Hughes et al., 2022; Kumpunen et al., 2019; Smith et al., 2016).

2.3.1. Definitions

Integrated care has several different definitions (Goodwin, 2016; Hughes et al., 2020; Struckmann et al., 2018; Thistlethwaite, 2023; Zonneveld et al., 2018), which have been argued to make it difficult to conclude integrated care research. The difficulties have been stated to be because of the complexity of the subject and a lack of stringency in research terms (Lewis et al., 2018). Integrated care has been described by the WHO as a system through which care contributions, delivery, management and organization in relation to diseases, treatment, care, rehabilitation and health promotion are combined (WHO, 2001). In one scoping review, integrated care has been expressed to be to provide coordinated, pro-active, person-centered and multidisciplinary care by two or more collaborating care professionals who may work at the same or different organizations (Struckmann et al., 2018). Others have expressed different definitions for different parts of the care system (Goodwin,
stating how for the health care system, integrated care is health services which are coordinated across the different levels of care. The health services patients receive throughout the life is to be according to their needs on a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services. A patients’ definition is also expressed, which describe how patients are to be able to plan their care with persons who work together, which understand patient’s context and goals, as well as allows the patient to have control (Lewis et al., 2010). There are overlaps in the definitions, which includes themes such as collaboration, co-ordination, co-produced and shared responsibility and accountability (Zonneveld et al., 2018).

2.3.2. Teamwork in integrated care

Integrated care has been categorized as consisting of three different types of teamwork (Singh et al., 2018). The first type is the multidisciplinary team, which utilizes the skills of individual professionals from different professions in the provision of health care, with each professional approaching the patient from their own professional perspective. In such teams, each professional communicates with one of the other professionals on the team, such as a registered nurse or physician, instead of communicating as a group (Mandy, 1996). The second type of team is the interdisciplinary team, which integrates the skills of each professional and pursues a high level of collaboration and communication in the team both within and across organizational borders (Körner, 2010; Sheehan et al., 2007). The interdisciplinary team makes joint decisions on assessments, treatments and goals for each patient (Sheehan et al., 2007). The third type of team is the transdisciplinary team, in which the lines separating the roles of each professional are blurred, making it possible for each professional to take on the responsibilities of any role, thereby creating team flexibility. This type of arrangement requires team members to be trained in a number of professions (Norrefalk, 2003).

Team meetings in integrated care need a clear goal in order to promote quality care and enhanced teamwork (Asakawa et al., 2017; Montano, 2020). However, healthcare professionals working in integrated care have reported different experiences (Grol et al., 2021; Montano, 2020). Physicians have experienced stress related to the demands of team meetings, while other
healthcare professionals have expressed the desire for increased team time (Montano, 2020). Team meetings have also been reported to be easier and more productive when team members were in close physical proximity (Eika & Hvalvik, 2022; Grol et al., 2021). It has been argued that holding team members accountable for their actions in the provision of health care is difficult when they are part of large teams with a high rate of turnover. Larger teams also make it difficult to determine who is primarily responsible for each patient, which in turn makes it harder to determine who is accountable for the patient (Carrigan et al., 2023).

One significant aspect of successful teamwork in integrated care is a shared understanding of care concepts (Aerts et al., 2020; Asakawa et al., 2017). More specifically, agreement by all members of the team about the vision and mission of integrated care is considered essential to overcoming associated challenges and strengthening collaboration. Lack of consensus and transparency, on the other hand, can hinder teamwork (Aerts et al., 2020). Protectionist attitudes about one’s own profession have been noted to emerge in such teams, making integration and collaboration more difficult (Montano, 2020). Even in cases of increased collaboration, a lack of knowledge about the duties of each professional on the team can interfere with the provision of integrated care. This may be attributable to a reluctance on the part of each professional to share knowledge and experiences (Mateo-Abad et al., 2020). Other studies, however, have described the opposite situation, with healthcare professionals experiencing teamwork as increasing their understanding of each other’s work (Asakawa et al., 2017; Trankle et al., 2020).

Building relationships has also been described as increasing mutual understanding of each profession represented in integrated care teams (Asakawa et al., 2017). General physicians noted that long-term relationships with team members improved collaborations, ultimately making the team stronger and more resilient to change (Grol et al., 2021). Furthermore, the development of teamwork in integrated care is heavily dependent on clear roles being outlined for each team member (Asakawa et al., 2017; Carrigan et al., 2023; Jolanki et al., 2017; Montano, 2020) – doing so, however, may initially be challenging (Trankle et al., 2020). Clear communication within the
team has been found to help team members better understand each other’s role – and their own – within the team (Asakawa et al., 2017; Montano, 2020).

Healthcare professionals engaged in team building in integrated care have emphasized the need for a leader who is capable of coordinating the team members and promoting communication between them (Asakawa et al., 2017; Carrigan et al., 2023; Kirst et al., 2017; Montano, 2020). Several studies have reported that the general physician on the team is preferred to assume the role of the leader. This is because general physicians are viewed as natural leaders by other healthcare professionals due to the established hierarchy of the healthcare system (Asakawa et al., 2017; Carrigan et al., 2023), a view supported by extant research on the perspectives of general physicians (Grol et al., 2021).

### 2.3.3. Integrated care models

Several different types of integrated care models have been researched and implemented, producing a wide variety of characteristics. These integrated care models have different foci, including specific diagnostic groups, such as diabetes and heart and lung disease (Trankle et al., 2020), the entire Native American population (Gottlieb, 2013), and different age groups, such as children (Burkhart et al., 2020; Wolfe et al., 2020), adolescents (Courtney et al., 2020) or older patients with multiple health problems and complex care needs (Mateo-Abad et al., 2020; Park et al., 2014). A foundation in relationship-centered care (Gottlieb, 2013), patient-centered care (Park et al., 2014) or person-centered care (Bradbury & Lifvergren, 2016) has been described in some studies, while others have not elucidated a clear foundation. Similar goals have, however, been reported for the different integrated care models, such as patient empowerment (Mateo-Abad et al., 2020; Park et al., 2014), cost reduction (Trankle et al., 2020), and the provision and coordination of care within the home (Mateo-Abad et al., 2020; Park et al., 2014). Many integrated care models have been evaluated as producing mainly positive results. However, some research has found that integrated care models at times fall short of their expected results (Baxter et al., 2018; Exworthy et al., 2017; Hughes et al., 2022; Kumpunen et al., 2019) since they were not designed to account for the complexities of real-world settings (Kumpunen et al., 2019) or were derived from previous knowledge on
integrated care models originally focused on a single disease (González-Ortiz et al., 2018; Struckmann et al., 2018). Furthermore, for patients with complex care needs, person-centered care in the development of integrated care models has been recommended (Struckmann et al., 2018). Understanding the needs of the group of older patients with complex care needs have therefore been argued for, when implementing integrated care models for the patient group (Threapleton et al., 2017).

There are several different types of integrated care models for older persons with complex care needs. One type was implemented in eight different European regions, The CareWell project, which outlines a specific pathway for patients with multimorbidity within the healthcare system as a complement to the usual provision of care (Mateo-Abad et al., 2020). Another type of integrated care model, created for older patients with complex care needs in Canada, involved registered nurses based in primary health care, the performance of in-home assessments, care planning, the monthly monitoring of conditions and coordinated efforts by healthcare professionals (Park et al., 2014). Several integrated care models have been implemented in Sweden as well, some of which are hospital-based (Fristedt et al., 2019; SALAR, 2018a, 2021c), such as an integrated care model consisting of a team of registered nurses and specialist physicians from a hospital medicine department making home visits to older patients. The team has been described as a bridge between the hospital and municipal health care during the acute phase of older patients’ deteriorating health (SALAR, 2021c). Another integrated care model, Collaborative health care model, involves collaboration between the national advisory telephone service (in Sweden known as 1177, the number a person dials for health and medical advice) and municipal registered nurses as well as ambulance nurses (SALAR, 2020a). Usually, these care organizations work independently due to separation between authorities and organizations (Hallgren et al., 2021). Other integrated care models involve collaboration between hospitals, primary health care centers and municipal home health care. These integrated care models comprise three parts, two of which operate from the hospital, and one from a primary healthcare center – all, however, collaborate with municipal health care (Bradbury & Lifvergren, 2016; SALAR, 2021c). One of these parts is the mobile integrated care model with a home health care physician, which is described in this thesis. Similar
integrated care models have also been described as currently delivering health care in Sweden (Larsson et al., 2023; SALAR, 2021b, 2021c, 2022a).

2.3.4.  **Experiences and effects of integrated care models**

From a structural perspective, integrated care models can overcome fragmentation in the healthcare system through enhanced coordination between healthcare organizations and professionals (Kjelsnes & Feiring, 2022). Such coordination can reduce hospitalizations (Di Pollina et al., 2017; Louras et al., 2023; Mateo-Abad et al., 2020; Park et al., 2014; Trankle et al., 2020). However, reduced hospitalizations have also been attributed to increased use of primary care services, with both general physicians and registered nurses. This increase has been argued to lead to the need to prioritize primary health care over hospital care (Mateo-Abad et al., 2020). Other research has found that the implementation of an integrated care model focused on older patients receiving home health care from an integrated team does not influence patients’ need for long-term health care or their mortality rate (Di Pollina et al., 2017).

Many healthcare professionals consider the implementation of integrated care models to be difficult, time-consuming and challenging, often due to bureaucracy within the healthcare system. However, over time, these professionals better understood the policies and processes of other organizations, and the provision of care by healthcare staff consequently improved (Trankle et al., 2020). Registered nurses have been argued to bear the brunt of the workload associated with integrated care models (Mateo-Abad et al., 2020). However, registered nurses and physicians in integrated care have also reported increased work satisfaction after implementation of integrated care (Park et al., 2014).

Barriers to the implementation of integrated care models, such as increased workload (Mateo-Abad et al., 2020; Montano, 2020) and altered work methods (Mateo-Abad et al., 2020), have been described. Differences in work culture within different healthcare organizations have also been noted as a challenge, especially between hospitals and primary healthcare centers (Trankle et al., 2020). Healthcare professionals have highlighted the importance of combining documentation produced by healthcare authorities.
to improve the integration of health care (Aerts et al., 2020; Carrigan et al., 2023; Grol et al., 2021; Trankle et al., 2020). Access to all such documentation is also crucially important for both healthcare professionals and patients. When different documentation systems are used, healthcare professionals can become concerned about privacy breaches in the transmission of patient data to other healthcare authorities (Carrigan et al., 2023).

Research on the experiences of next of kin with integrated care models is apparently scarce. In the research found, next of kin have expressed how they did not have many expectations of integrated care models prior to their involvement. After the admission of their relatives to integrated care next of kin were relieved to learn from healthcare professionals that they were doing the right thing (Mateo-Abad et al., 2020). Additionally, some next of kin have expressed appreciation for integrated care (Larsson et al., 2023) – for example, some noted that their sense of security was improved because they were fully informed of who to contact and when, especially after office hours. Many next of kin who co-habited with patients viewed integrated care as having a greater positive impact on their daily life than those who did not co-habitate because of the increased accessibility to healthcare professionals (Törnfelt et al., 2021). Furthermore, they were relieved to share responsibility when their relative was admitted to integrated care (Larsson et al., 2023). Receiving health care via an integrated care model helped next of kin as they did not have to spend time driving their relative to healthcare organizations (Törnfelt et al., 2021).

Patients expressed a lack of expectations and information about integrated care models before being admitted to them (Mateo-Abad et al., 2020). Once becoming admitted, however, many experienced their quality of health care being improved (Kodner, 2006), as had their functional abilities, mental well-being (Melis et al., 2008), sense of security and autonomy, degree of participation (Mateo-Abad et al., 2020; Sadler et al., 2019; Trankle et al., 2020), continuity of healthcare professionals (Sadler et al., 2019) and travel times to receive health care (Hallgren et al., 2021). In contrast, some patients worried about the competence of the healthcare professionals if they had an unusual condition since they had been accustomed to specialist health care (Carrigan et al., 2023). Furthermore, they feared being disempowered by increased healthcare services, particularly losing control over their own health
Some patients felt that the work carried out via integrated care models was conducted based on routines, not on their individual healthcare needs (Aerts et al., 2020). Other patients felt that involvement in integrated care was stressful as it required meeting with several healthcare professionals, making additional telephone calls and attending numerous appointments (Trankle et al., 2020). Such increased effort caused some patients to prefer managing their health with the support of their next of kin instead of becoming involved in an integrated care model (Sadler et al., 2019).

Previous research has argued that insufficient knowledge exists on the outcomes of integrated care for patients with complex care needs (Asakawa et al., 2017; Baxter et al., 2018; Törnfelt et al., 2021), their next of kin (Asakawa et al., 2017; Looman et al., 2019; Törnfelt et al., 2021) and healthcare professionals (Looman et al., 2019; Törnfelt et al., 2021). To deepen and expand knowledge on the outcomes of integrated care models, research should focus on evaluating experiences of these models by patients, their next of kin, and anyone else involved (Carrigan et al., 2023; Liljas et al., 2019; Smith et al., 2016). Accordingly, the project described in this thesis study the expectations, perceptions and experiences of registered nurses, physicians, patients and their next of kin within a integrated care model for older patients with complex health problems and care needs. The setting of the study was the mobile integrated care model with a home healthcare physicians (MICM). This model is further described in the methods section of this thesis.
3. Theoretical framework

In this chapter, the theoretical framework of the thesis is described. Person-centered care is often included in definitions of integrated care (McKillop et al., 2017; Struckmann et al., 2018) and has been described as the value base of the current national reform in Sweden – i.e. person-centered and integrated care – (SALAR, 2018b). Furthermore, person-centered care is the value base of MICM (Bradbury & Lifvergren, 2016).

3.1. Person-centered care

There are several definitions of person-centered care. One defines person-centered care as a conceptual framework derived from nursing for older persons (McCormack & McCance, 2006; Santana et al., 2018); others describe it as a care model (Parley, 2001), an ethic (Ekman, 2022) or a systematic approach at all organizational levels (Rosengren et al., 2021). Several definitions of person-centered care in relation to professions exist as well, such as nursing-specific (McCormack & McCance, 2006), general physician-focused (World family doctors Caring for people, 2011) and professionally unbound (Ekman et al., 2011) person-centered care. In this thesis, however, the definition established by the Gothenburg Center of Person-Centered Care is used. This definition of person-centered care is based on Ricœur’s little ethics and is instrumental to the reform shift to person-centered and integrated care (SALAR, 2023) as well as to the European standard for person-centered care (European Committee for Standardization, 2020). Furthermore, the definition is professionally unbound (Ekman et al., 2011), and was deemed more suitable for this research as it focused on more than one healthcare profession.

3.1.1. The patient as an active person

A defining element of person-centered care is the strive to diminish the act of making the patient passive in health care such that both healthcare professionals and patients are viewed as active parties (Kristensson Uggla, 2020; Schuster, 2006). This is because asymmetrical relationships can often
form in health care, with healthcare professionals exercising power over passive patients by limiting their participation. Ricoeur viewed all persons as both acting and suffering in their lives and argued that all humans have the ability to act, but only to a certain extent. Beyond that, humans suffer and become passive, and are as such in need of others to relive their suffering (Ricoeur, 2011). In person-centered care, acting and suffering have been used to refer to how health care may risk making patients passive since they are unable to act in the same ability as healthcare professionals to relieve their suffering. Healthcare professionals are thus traditionally viewed as acting on behalf of passive patients (Britten et al., 2020; Ekman et al., 2011; Gyllensten et al., 2020; Schuster, 2006).

A person is defined as a who constructed by an endless series of what, defined as different roles. The roles of each person have different degrees of significance in different contexts, such as the role of patient when seeking health care (Ekman, 2022; Kristensson Uggla, 2020). In accordance with person-centered care, being a patient has been defined as a role assumed by a person (Ekman, 2022; Kristensson Uggla, 2020). This role has benefits in the healthcare context as dictated by laws and regulations (Ekman, 2022; Kristensson Uggla, 2020). The delineation of the patient role by laws and regulations is therefore needed in the healthcare system (Kristensson Uggla, 2020).

3.1.2. Person-centered care ethics

The definition of person-centered care stems from Ricœur’s little ethics (Ekman, 2022; Kristensson Uggla, 2020): ‘aiming for a good life with and for others in just institutions’ (Ricoeur, 1992, p. 172). These ethics are divided into three parts: aiming for a good life, with and for others, in just institutions. Ricœur’s little ethics have been applied to the healthcare context to build person-centered ethics.

Aiming for a good life is individual to each person (Ricoeur, 2011), who must determine what aiming for a good life entails for themselves. When patients inform their healthcare professionals what a good life entails for them, they can strive together towards that life (Ekman, 2022; Kristensson Uggla, 2020). The practical and individual motivations underlying the pursuit of a good life
for each person are evident in their actions (Kristensson Uggla, 2020). Aiming for a good life was described by Ricœur as being created *with and for others*. In the healthcare context, *with and for others* is required by patients in order to receive care by others, such as healthcare professionals and next of kin. Health care is therefore created with and for the patient by healthcare professionals. When receiving care, patients also receive help in their aim to attain a good life (Ekman, 2022; Kristensson Uggla, 2020). According to the principles of person-centered care, health care needs to be provided through *just institutions*. These institutions include the healthcare system and its ability to ensure the provision of fair and appropriate health care. For an institution to be considered just, it must allow patients to express their needs and capabilities. Furthermore, just institutions should be fundamentally democratic in nature (Ekman, 2022), bonded by common practices and the just distribution of health care (Ekman, 2022; Kristensson Uggla, 2020). A good life can be argued to extend beyond personal relations to institutions as a whole. Healthcare professionals should therefore be mindful of all who need health care within the system, not merely their own patients (Ekman, 2022).

### 3.1.3. The three routines of partnership in person-centered care

The strive for person-centered care entails three routines: *initiating the partnership*, *working the partnership* and *safeguarding the partnership*. The first routine, *initiating the partnership*, is based on the narrative told by patients about their health problems, social situations, contexts and capabilities. For their part, healthcare professionals should seek to understand who their patients are beyond their need for health care. It is through the narratives of patients that healthcare professionals are able to identify patient histories, current situations, resources and needs (Britten et al., 2020; Ekman et al., 2011; Ekman et al., 2015; Gyllensten et al., 2020). The patients’ views about their situation and condition are central to the initiation of the partnership. Capturing the narratives of patients entails understanding their suffering in everyday contexts. These narratives should be viewed as complementary and equal to medical tests in person-centered care. Encouraging patients to share their narrative can be therapeutic for them but also serve as a pathway to
proactively engaging them in developing a viable healthcare plan (Ekman et al., 2011).

The second routine of person-centered care involves working the partnership (Ekman et al., 2011). When working the partnership, healthcare professionals and patients co-create a healthcare plan. This plan includes medical and health measures but also identifies patients’ resources and challenges in order to arrive at a common understanding of how they experience their illness. From this shared understanding, shared deliberation and decision making can occur. Through shared decision making, goals can be set and achieved in the co-created healthcare plan. At diagnosis, the healthcare team, including the patient, evaluates all aspects involved in managing the patient’s health condition(s), including not just available treatment options but also lifestyle, preferences and values (Britten et al., 2020; Ekman et al., 2011; Ekman et al., 2015; Gyllensten et al., 2020).

The third routine of person-centered care is safeguarding the partnership (Ekman et al., 2011) through comprehensive and transparent documentation. This documentation includes the patient’s preferences, values and beliefs. Furthermore, the patient’s healthcare plan should be safeguarded by monitoring and adaptation, as well as aligning the patient’s goals and context with the healthcare plan. The narratives of patients should be regarded as equally important as the registration of medical information, such as clinical and lab findings (Britten et al., 2020; Ekman et al., 2011; Ekman et al., 2015; Gyllensten et al., 2020). Together, the three routines of person-centered care are mutually supportive and should not be viewed as a linear process but rather as an iterative process. For example, after the partnership has been documented, should the patient’s situation change, the healthcare plan and associated needs should be adjusted accordingly (Ekman et al., 2011).

The connection between person-centered care, the integrated care model researched and the current national person-centered and integrated reform, justify its local and national relevance. Globally, person-centered care has been promoted by the WHO to address challenges faced by healthcare systems worldwide as the life expectancy of the global population continues to increase (WHO, 2015a). Person-centered care has been described as being especially advantageous when aiming to meet the healthcare needs of older patients (WHO, 2015b).
4. Rationale

This thesis must be viewed in light of existing research and knowledge regarding the provision of health care to older persons through integrated care and integrated care models. Existing reports and research have already described various aspects of integrated care and integrated care models. However, since integrated care models have often been developed with a single diagnostic focus, complex care needs and their complications might not have been incorporated, thereby warranting the generation of additional knowledge about integrated care models for older patients with complex care needs. Furthermore, a person-centered care perspective should also be considered when developing integrated care models for patients with complex care needs. Previous research has called for the generation of more in-depth knowledge about the outcomes of integrated care among healthcare professionals, patients and their next of kin. There is also a need to better understand how the COVID-19 pandemic affected integrated home healthcare models so that more knowledge about how integrated care models operate in crisis situations can be known. By using person-centered care as a theoretical framework, the findings of the research described in this thesis can be discussed and elevated theoretically, scientifically and clinically.
5. Aim

The overall aim is to study expectations, perceptions and experiences of an integrated home health care model from the perspective of registered nurses, physicians, patients and their next of kin.

Specific aims

I. To describe nurses’ experiences of working and providing health care in the Mobile Integrated Care Model in the home with home health care physician.

II. To describe home health care physicians’ perceptions of working and providing health care in the Mobile Integrated Care Model, as well as perceptions of participating in and forming health care.

III. To describe the experiences of RNs and MICM-physicians working in home health care in an integrated care model during the COVID-19 pandemic.

IV. To illustrate patients’ and next of kin’s expectations and experiences of the mobile integrated care model with a home health care physician at baseline and at six months of follow-up.
6. Methods

6.1. Design

In this thesis different qualitative methods were used in the four studies (Table 1). Qualitative studies can consist of multiple theoretical paradigms, methods and strategies (Denzin & Lincoln, 2011). In these studies, narrative data are organized and interpreted with the purpose of finding obvious and underlying themes, categories and patterns of relationships in the studied phenomenon. Qualitative studies also provide researchers with the opportunity to examine individuals’ subjective experiences (Polit & Tatano Beck, 2020). As a goal of the studies described in this thesis was to capture individual expectations, perceptions and experiences, qualitative methods were considered both suitable and promising. The four studies employed an inductive qualitative design that was inherently data-driven and aimed at identifying patterns (Braun & Clarke, 2006; Graneheim et al., 2017) and variations (Marton, 1981) in the data. An inductive approach is recommended in cases where there is insufficient or fragmented knowledge about a phenomenon (Elo & Kyngäs, 2008).
Table 1. Overview of the four studies included in the thesis

<table>
<thead>
<tr>
<th>Paper</th>
<th>Participants</th>
<th>Data collection method</th>
<th>Data collection timeline</th>
<th>Data analysis</th>
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<td>I</td>
<td>18 registered nurses</td>
<td>Individual semi-structured interviews</td>
<td>5 interviews conducted in Winter of 2018. 5 interviews conducted in Spring 2019. 8 interviews conducted in Autumn 2020.</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>II</td>
<td>16 physicians</td>
<td>Individual semi-structured interviews</td>
<td>6 interviews conducted in late 2018. 4 interviews conducted in Spring 2019. 6 interviews conducted Autumn 2020 through Spring 2021.</td>
<td>Phenomenography</td>
</tr>
<tr>
<td>IV</td>
<td>17 patients 17 next of kin</td>
<td>Semi-structured interviews conducted on two occasions six months apart</td>
<td>Interviews conducted in Autumn 2021–Autumn 2022.</td>
<td>Thematic analysis</td>
</tr>
</tbody>
</table>
6.2. Setting

Healthcare authorities in Skaraborg county, Sweden, expressed the desire for the organized development of a collaboration between the health care authorities; hospital, primary health care and municipalities that resulted in the creation of the mobile integrated care model. The model has its value base in person-centered care (Bradbury & Lifvergren, 2016). Healthcare professionals from different healthcare organizations worked in teams to provide health care across health care authorities and organizational borders. The model was implemented in one municipality in 2008, after which it was expanded to five municipalities in 2011 and 15 municipalities in 2013. By 2019, the model had expanded to the region of Västra Götaland, consisting of 49 municipalities (Norén & Segerberg, 2019). The goal of the model was to improve health care foremost for older persons with multiple health problems and complex care needs, often accompanied by repeated hospitalizations. Furthermore, the goal of the model was to improve the overall quality of home health care and making it more individually tailored, cost-effective, continuous and coherent for patients (Bradbury & Lifvergren, 2016; Norén & Segerberg, 2019).

The mobile integrated care model consists of three forms of health care (Figure 1). The first form is the mobile hospital healthcare team, which is hospital-based and encompasses the provision of advanced health care to all municipalities in Skaraborg county that require home visits to avoid repeated hospitalizations. The second form is the mobile hospital palliative team, which is also hospital-based but is orientated towards providing health care to palliative patients who want to continue living at home. The third form in the model, and the research setting of this thesis – is the mobile integrated care model with a home health care physician (MICM) (Norén & Segerberg, 2019).
6.2.1. **MICM**

The major partners collaborating in the MICM are registered nurses employed by the municipalities and a home healthcare physician from one or more primary healthcare centers. The two professional groups work across healthcare authorities and organizational borders.

The MICM is based on the following:

- Each patient has an appointed physician responsible for their medical care.
- The municipal registered nurse and the home healthcare physician make visits to each patient’s home.
- The integrated team co-creates a medical healthcare plan with each patient and their next of kin at least once a year.

Other municipal healthcare personnel, including physical therapists, occupational therapists and assistant nurses, can be involved in the MICM to varying extents. The term ‘healthcare personnel’ will hereafter be used when referring to all groups of personnel involved in the MICM. When referring to personnel with a healthcare certificate, the term ‘healthcare professionals’ will be used. The integrated teams coordinating the health care of patients are their core contact in the overall healthcare system (Bradbury & Lifvergren, 2016; Norén & Segerberg, 2019).
6.3. Recruitment

The head of the Department of Health and Social Care in the 15 municipalities where the MICM was first implemented was contacted by the project manager. Each head consented to the participation of their organization in the study, thereby allowing unit managers to recruit registered nurses, patients and their next of kin in their units. Of the 15 municipalities, 12 fulfilled the inclusion criterion of having employed a home healthcare physician for at least six months prior to the start of data collection and agreed to participate. The primary healthcare managers of two primary healthcare territories and the unit managers at two private primary healthcare centers consented to allowing home healthcare physicians in their organization to be interviewed. Unit managers at primary healthcare centers employing a home healthcare physician in 12 out of the 15 municipalities consented to having data collected for the study. Three declined, since they did not have the preconditions to work according to the MICM and one did not respond. Physicians in the remaining 11 municipalities who had worked as home healthcare physicians for at least six months were asked by their unit managers if they wanted to participate.

6.3.1. Recruitment of healthcare professionals

Registered nurses were recruited by their unit manager via purposive sampling since their work in the MICM was considered to benefit the study. This sampling method has been described as helping to recruit those participants who will most benefit the study (Polit & Tatano Beck, 2020). Registered nurses who agreed to participate in the study had their contact information sent by the unit manager to the project manager. The research group was informed about which registered nurses agreed to participate, but not those who declined to participate. Participating nurses were given further information about the study by the project manager via email or telephone communication. The information included the study background, aims, methods, the manner in which the study was to be conducted, the way in which data would be collected and treated, and the contact information of the researchers and affiliated institution. All potential participants were given an information letter as well. Those who ultimately participated provided both written and oral informed consent to be interviewed. All of the participating
registered nurses had a bachelor’s degree in nursing, and some also had a master’s in primary health care and/or the geriatric field. For Paper I, 18 registered nurses participated, one to three from each of the 12 participating municipalities (Table 2). For Paper III, eight registered nurses from eight different municipalities participated.

**Physicians:** were approached by their unit manager at the primary healthcare center or were contacted directly by the project manager after the unit managers gave permission to do so. To participate, they were to fulfill the inclusion criterion of having worked for at least six months as a home healthcare physician. For paper II, 18 physicians were asked to participate, and 16 physicians agreed (Table 2). One to three physicians from each of the 11 municipalities participated. Most had a specialization as a district physician, while others specialized in internal medicine or geriatrics. For Paper III, eight physicians were asked to participate, of whom six from six different primary healthcare centers in six different municipalities participated.

Table 2. Characteristics of the registered nurses and home healthcare physicians: age at interview, gender and work experience in their profession.

<table>
<thead>
<tr>
<th></th>
<th>Age range (mean)</th>
<th>Female (n)</th>
<th>Male (n)</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses, Paper I.</td>
<td>25–60 (46)</td>
<td>17</td>
<td>1</td>
<td>7 months–39 years</td>
</tr>
<tr>
<td>Physicians, Paper II.</td>
<td>37–68 (53)</td>
<td>6</td>
<td>10</td>
<td>12–45 years</td>
</tr>
<tr>
<td>Registered nurses, Paper III.</td>
<td>30–60 (47)</td>
<td>7</td>
<td>1</td>
<td>6–38 years</td>
</tr>
<tr>
<td>Physicians, Paper III.</td>
<td>37–68 (53)</td>
<td>3</td>
<td>4</td>
<td>12–45 years</td>
</tr>
</tbody>
</table>
6.3.2. Recruitment of patients and their next of kin

Purposive sampling (Polit & Tatano Beck, 2020) was used to recruit patients and their next of kin, as both groups were considered to be beneficial to the study. The unit managers supplemented information about healthcare professionals within their organization, and a contact person in the research project for each municipality was chosen and reported to the project manager. The contact person worked as a bridge between the municipality and the research team, participating in monthly meetings at which the recruitment of participants was discussed between the contact persons and the research team. The contact persons found potential participants who met the following inclusion criteria for the study: (1) 65 years of age or older, (2) received services from municipality-based home care on a daily basis, (3) were admitted to the MICM but had not yet met the home healthcare physician. In addition, each patient was asked to nominate a next of kin who was then invited to participate in the study. All patients and their next of kin were recruited in pairs. Both the patients and their next of kin had to be willing to participate and able to understand and answer questions, as well as hold conversations, in Swedish in order to be asked to participate in the study.

The contact person contacted and informed the potential participants about the study both orally and in writing. This information included the study background, aims, methods, the manner in which the study was to be conducted, the way in which the data would be handled, and the contact information of the researchers and responsible institution. After the potential participants were given this information, the contact person asked them if they would be willing to participate in the data collection (Figure 2). All participants were assured that their participation in the study was completely voluntary and that they could end their participation at any time without giving an explanation, with no effects on their own or their relative’s health care. Those who were interested in participating in the study were asked if their contact information could be relayed from the contact person to the author of this thesis. If they accepted, their information was communicated between the contact person and the author of this thesis over the telephone to preserve their identity. Further contact with the participants was undertaken by the author of this thesis over the telephone. During these telephone calls, the author of this thesis provided additional information and was able to answer any questions.
the participants had. The author of this thesis also contacted the next of kin to inform them about the study. If both the patient and their next of kin were interested in participating, one joint (patient and next of kin) or two separate (with patient and next of kin separately) meetings were set for the purpose of data collection. Whether one or two sessions were booked depended on whether the participants chose to be interviewed together or separately.

Figure 2. Flow chart of data collection with patient and their next of kin.

The study was designed as a follow-up study with two data collection points separated by six months. In total, 17 patients and 17 next of kin participated in the initial data collection, and 15 patients and 15 next of kin from the original group participated in the follow-up data collection (Table 3). The second data collection point was booked through telephone calls by the author of this thesis, who asked whether the participants would like to participate in the follow-up data collection. The same next of kin participated in both the initial and follow-up data collection. Five potential participant pairs declined to participate after receiving oral information by the author of this thesis. Information about possible participants who declined participation when the contact person informed them was not relayed to the researchers.
Table 3. Characteristics of patient and next of kin participants

<table>
<thead>
<tr>
<th></th>
<th>Patient initially (n=17)</th>
<th>Patient follow-up (n=15)</th>
<th>Next of kin initially (n=17)</th>
<th>Next of kin follow-up (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age range (mean)</strong></td>
<td>72–101 (85)</td>
<td>72–95 (84)</td>
<td>33–79 (62)</td>
<td>33–79 (61)</td>
</tr>
<tr>
<td><strong>Female (n)</strong></td>
<td>9</td>
<td>8</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td><strong>Male (n)</strong></td>
<td>8</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Next of kin being:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohabitig partner (n)</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Next of kin being:</strong></td>
<td></td>
<td></td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Adult child (n)</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.4. Data collection

Data were collected through semi-structured interviews with registered nurses, home healthcare physicians, patients and their next of kin. Patients and their next of kin participated in interviews once at baseline and again after six months, while registered nurses and physicians were interviewed once.

6.4.1. Registered nurses and physicians

Data collection for Paper I and Paper II focused on registered nurses’ experiences and home healthcare physicians’ perceptions of the MICM and was conducted in three phases. The first phase occurred in Winter of 2018 and was carried out by nursing students pursuing a master’s degree. In total, 11 interviews were conducted by the students, five with registered nurses and six with physicians. Nine additional interviews were conducted in the second phase, four with physicians and five with registered nurses, during Spring
2019 by senior researchers involved in the research project. During the initial analysis, differences in perceptions between the professions became clearer, and the decision was made to focus on each profession in a separate study. In the third phase, which occurred during Autumn 2020 through Spring 2021, additional interviews were conducted by the author of this thesis with eight registered nurses and six physicians and were included in Papers I and II. These interviews provided the opportunity to include additional municipalities and primary healthcare centers for Papers I and II. The interviews also comprised the data collection conducted for Paper III, along with field notes written after each interview.

Before the individual interviews with the registered nurses and physicians started, the researcher introduced the project, obtained informed consent and collected demographic data about age, gender, work life experience, years working in the profession and education. Data were collected for Papers I–III through individual semi-structured interviews. The interviews followed an interview guide with open-ended questions used to provide the participants with the opportunity to share their own experiences (Appendix 1). The questions in the interview guide for Papers I and II focused on the registered nurses’ experiences and physicians’ perceptions of the MICM within municipality-based care and collaboration with other professions. Furthermore, the interview guide raised questions about the participation of healthcare professionals in forming and developing health care. During the third phase of data collection, a question was added about the effect of the COVID-19 pandemic on the work conducted in the MICM since the pandemic had started. Follow-up questions included the following: *What would be an example of that experience or perception? How did that make you feel? What prompted you to feel that way? Can you elaborate?* These questions were asked to encourage the participants to reflect more deeply on each subject and further enrich their descriptions. During the third phase of the data collection, field notes were written which became a part of the analysis. Field notes were written directly after each interview was conducted and were aimed at summarizing the researcher’s experience of the interview as well as initial thoughts regarding the interview in relation to the aims of the study. The registered nurses and physicians chose the location and setting for their interviews (Table 4).
<table>
<thead>
<tr>
<th></th>
<th>Paper I</th>
<th>Paper II</th>
<th>Paper III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length of interviews (min)</strong></td>
<td>36–106</td>
<td>20–72</td>
<td>20–72</td>
</tr>
<tr>
<td><strong>Participants (n)</strong></td>
<td>18</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td><strong>In-person interviews (n)</strong></td>
<td>17</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td><strong>Video interviews (n)</strong></td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Participants’ workplace setting (n)</strong></td>
<td>18</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td><strong>Participants’ home setting (n)</strong></td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

**6.4.2. Patients and their next of kin**

Data collection focused on the patients’ and their next of kin’s expectations and experiences of the MICM began in Autumn 2021 and ended in Autumn 2022. The data were collected by the author of this thesis through semi-structured interviews and field notes. The initial data collection period allowed for the capture of the participants’ expectations, with the follow-up used to evaluate whether their expectations had been met as well as any additional experiences they had. A six-month window was chosen for the follow-up to allow the participants to accumulate experiences over a suitable period of time but also to permit comparisons of their experiences with their expectations. Four separate interview guides were used: one for patients recently admitted (Appendix 2), one for these patients’ next of kin (Appendix 3), one for patients six months after admission (Appendix 4), and one for these patients’ next of kin (Appendix 5). The interviews were conducted either separately or jointly depending on the participants’ preference (Table 5). Field notes were written directly after each interview was conducted and were aimed at summarizing
the researcher’s experience of the interview as well as initial thoughts regarding the interview in relation to the aims of the study.

During the first data collection period, demographic data about age, gender, social situation, work life experience, and social and health care need were collected prior to the start of each interview. This information was collected to better describe each participant group as well as to detect potential patterns in their demographic data. During the first interviews, questions about expectations of the MICM were asked, as were questions about the sense of support the participants experienced in daily life in relation to the provision of health care, their level of participation, their sense of security, their home, their well-being, their degree of loneliness, and their experiences of the COVID-19 pandemic in relation to health care. The first question asked during interviews with patients was as follows: *What are your expectations of receiving home health care with a home healthcare physician?* The first question asked of next of kin was the following: *What are your expectations of your relative receiving home health care with a home healthcare physician?* Supplementary follow-up questions were asked, such as the following: *What would be an example of that expectation? How did that make you feel? Can you elaborate?* These questions were asked in order to encourage the participants to more deeply reflect on each subject and further enrich their descriptions. The initial interviews lasted between 19–78 minutes and were transcribed verbatim.

During the follow-up interviews six months later, focus was placed on experiences of the MICM and any influence it might have had on the participants’ sense of home, well-being, security, meaningfulness, loneliness and autonomy. The initial question asked of patients was as follows: *What are your experiences of receiving home health care with a home healthcare physician?* The first question asked of next of kin was the following: *What are your experiences as a next of kin having a relative receive home health care with a home healthcare physician?* The participants were asked questions about the quality of care they had received as part of the MICM as well as about their experiences participating in the development of their health care. The follow-up questions were similar to those described above. These interviews lasted between 10–64 minutes and were held in person, through telephone or video call (Table 5). The participants themselves decided which
form of interview they preferred. Field notes were written directly after each follow-up interview to help the author reflect on the context and content of the interview in relation to the study aims.

Table 5 – Data collection at baseline and at follow-up

<table>
<thead>
<tr>
<th></th>
<th>Patients initially n=17</th>
<th>Patients follow-up n=15</th>
<th>Next of kin initially n=17</th>
<th>Next of kin follow-up n=15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewed together (n)</td>
<td>13</td>
<td>10</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Met separately (n)</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Phone meeting (n)</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>In-person meeting (n)</td>
<td>16</td>
<td>14</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Video meeting (n)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

6.5. Data analysis

The four studies described in the papers employed an inductive qualitative design with three different analytical methods. The data for Paper I were analyzed via qualitative content analysis, the data for Paper II were analyzed through a phenomenographic approach, and the data for Papers III and IV were analyzed through thematic analysis.

6.5.1. Qualitative content analysis

The aim of the study described in Paper I was to describe nurses’ experiences of working and providing health care in Mobile Integrated Care Model in the home with home health care physician. An inductive qualitative content
analysis as outlined by Graneheim and Lundman (2004) was employed to answer the following research question: *What are nurses’ experiences of working via the MICM with a home healthcare physician?* Qualitative content analysis was chosen by the authors of Paper I for several reasons. First, this analytical method was suitable for accessing and describing the registered nurses’ experiences. Second, the method can yield knowledge and insights as well as both a condensed and broad description of the phenomenon studied (Krippendorff, 2018). Lastly, the text close way of the analysis method was deemed suitable for achieving the aim of describing the registered nurses’ experiences while grounding the results as much as possible in the actual data to derive their manifest (obvious) and latent (underlying) meanings (Graneheim & Lundman, 2004). The study was inductive and data-driven by design, which provided the opportunity to search for patterns within the data (Graneheim et al., 2017). The analysis was conducted by first transcribing the interviews verbatim and then reading through the text several times to gain a deeper understanding of the data. Meaning units that served to achieve the aim of the study were derived from the transcribed text. Similarities and differences in the data were also identified. The meaning units were then condensed and coded to identify the core of the data. The codes were gathered into clusters based on the similarities and differences in the interview content. Codes containing similar content were subsequently compiled to create subcategories and main categories. Three main categories with two subcategories each emerged during the analysis. When reading over the categories, an overarching theme was identified; *Mutual trust is a prerequisite for nurses’ sense of safety and work satisfaction.* The latent meaning of the phenomenon is evident in the discussion of the overarching theme in Paper I, while the manifest content can be derived from the categories.

6.5.2. *Phenomenography*

A phenomenographic approach was used to analyze the data collected and presented in Paper II in order to answer the following research questions: *What are home healthcare physicians’ perceptions of working via the MICM? What are home healthcare physicians’ perceptions of providing health care through the MICM? What are home healthcare physicians’ perceptions of participating in health care? What are home healthcare physicians’*
perceptions of forming health care? When reading through the interview transcripts, the authors of Paper II noted a wide variety of experiences of being a home healthcare physician. Such variety was determined to be greater than that observed in the data collected from the other participant groups. As phenomenography is well-suited for handling varied data as well as describing perceptions, it was chosen as the analytical method for the interviews. Phenomenographic research is both empirical and qualitative and is aimed at describing the various ways in which different phenomena are experienced, conceptualized, understood and created (Marton, 1981). The phenomenographic approach generates knowledge by developing qualitatively different descriptive categories, consequently creating an outcome space and making it possible to understand the character of the phenomenon in question – the primary interest of qualitative research (Sjöström & Dahlgren, 2002). In phenomenography, a distinction is made between first-order research perspective, which seek to identify what something really is, and second-order research perspective, which is aimed at understanding how a phenomenon is conceived by persons. Phenomenography primarily focuses on the second-order perspective (Marton, 1981). It was originally used in the educational field (Marton, 1981) before being expanded to the broader context of qualitative research (Dahlgren & Fallsberg, 1991; Stenström et al., 1993) and further developed and employed in nursing research (Sjöström & Dahlgren, 2002).

According to Sjöström and Dahlgren (2002), the phenomenographic approach consists of seven steps. The analytical process is not linear, but iterative, with different analytical steps repeated as necessary. In the context of this study, the first step, familiarization, was applied to each recorded and transcribed interview, which were listened to and read through several times to become familiar with their content. This step provided the researchers with an initial understanding of the transcribed text. The second step, compilation, involved selecting significant elements that best addressed the study aim, resulting in 759 significant elements. Next, in the third step, condensation, longer significant elements were condensed to highlight their main content. In the fourth step, grouping, any condensed data that demonstrated similarities were preliminarily classified. At this stage, 19 groups corresponding to the study’s aim were preliminarily classified. This compilation of significant elements
was then used to identify similarities and differences in the data in order to establish boundaries between preliminary categories in the fifth analytical step, comparison. Six descriptive categories were found, each of which revealed qualitative differences in how the phenomenon was perceived. In step six, naming, the categories were given labels to represent their core meaning. In the final step, constative comparison, each category was described and organized in the outcome space to demonstrate its unique character. The outcome space consisted of the descriptive categories from the findings that qualitatively outlined the different ways in which the phenomenon was perceived and how these categories related to each other. The data analysis was accompanied by continuous discussions by the research group until a negotiated consensus (Wahlström et al., 1997) was reached between the researchers.

6.5.3. **Thematic analysis**

Thematic analysis by Braun and Clarke (2006) was used for the study described in Paper III, whereas reflexive thematic analysis, also outlined by Braun and Clarke (2019), was employed in the study outlined in Paper IV. Thematic analysis is generally used to identify, analyze and interpret patterns of meaning within qualitative data, unbound by theoretical commitments, and is therefore viewed as a tool or technique rather than a methodology (Clarke & Braun, 2017). According to Braun and Clark, qualitative research is always context-bound, positioned and situated. The knowledge provided from thematic analysis must thus be examined in the context from which it emerged (Braun & Clarke, 2019). The choice of thematic analysis for the studies presented in Papers III and IV was aimed at generating knowledge about the phenomenon in the context in which it emerged. In thematic analysis, knowledge is about meaning and meaning-making from the experiences of the participants rather than discovering an absolute truth in the data (Braun & Clarke, 2006, 2019).

**Paper III**

The aim of the study presented in Paper III was to describe the experiences of registered nurses and physicians working in home health care in an integrated care model during the COVID-19 pandemic. The following research question
was addressed in the study: *What are the experiences of registered nurses and physicians working in home health care via an integrated care model during the COVID-19 pandemic?* The thematic analytical process involved six phases (Braun & Clarke, 2006), each of which could be repeated if needed. These phases began with familiarization, in which the transcribed interviews and field notes were read over several times. Throughout these readings, initial reflections were written down. The second phase involved generating initial codes from the transcribed interviews and field notes, with both explicit and latent data being coded across the data set. Initially, 13 codes were identified, all of which were discussed within the research team. The initial codes were preliminarily labelled as follows: *home visits, paused ways of working because of the pandemic, supporting the patient, worry among the personnel, removal of social places, patients’ mental health, protective gear/restrictions, testing, digital and phone solutions, shifting directives, vaccination, the future and next of kin*. After the discussion of the initial codes, the third phase commenced, which involved generating preliminary themes through sorting and reviewing the codes. These codes were then placed on a thematic map, similar to a mind map, which served as the basis for further discussions by the research team. These discussions, the fourth phase, involved more detailed codes as well as possible hierarchies between them. During the discussions, the codes along with their associated data were sorted and then reduced from 13 to eight potential themes. The themes were then reviewed and refined in relation to the codes and extracted data, after which the themes were cross-checked against the transcribed interviews and field notes. Overlapping themes were found during the cross-check, which were subsequently merged into three main themes and seven sub-themes. When all of the themes had been cross-checked, they were defined and named in light of the codes from the extracted data – the fifth phase. The extracted data in the codes were then written into text in the final phase accompanied by the core context of each theme from the analysis and were illustrated through quotes.

**Paper IV**

The aim of the study described in Paper IV was to illustrate patients’ and their next of kin’s expectations and experiences of the mobile integrated care model with a home health care physician at baseline and at six months of follow-up. Reflexive thematic analysis, a further development of thematic analysis
(Braun & Clarke, 2006; Clarke & Braun, 2017), was employed to deeply analyze and interpret the data to tell a story about the phenomenon (Clarke & Braun, 2018) and answering the following research questions: What are patients’ and next of kin’s expectations of the MICM with a home healthcare physician? What are patients’ and next of kin’s experiences of the MICM with a home healthcare physician? The reflexive thematic analysis also allowed the researchers to reflect on their own preunderstandings to a greater extent than otherwise possible. To do so, field notes received particular emphasis, which further justified the use of this analytical method.

The findings from the two data collection periods (baseline and after six months) were analyzed separately. The baseline data collection period involved semi-structured interviews and field notes from the data collection that occurred prior to the patients and their next of kin meeting the physician. The second data collection period involved interviews and field notes from the six-month follow-up. The transcribed interviews along with the field notes from the interviews were read several times to become familiarized with the data as well as to detect patterns of meaning. The data used to address the study aim were extracted from the transcribed interviews and field notes, generating codes. For the baseline data collection period, nine initial codes were detected: MICM being great, travelling, home, collaboration, someone to turn to, no information, responsibility, losing control and contacting health care. For the data collection conducted six months later, 11 initial codes were detected: no need to travel, hierarchy, the physician’s role, easy access, participation, safety, structure, joined visits, medical records, someone to turn to and information. When the initial codes had been detected, reflections from the research group were written down. Analytical coding of the transcribed interviews and field notes followed, with both explicit and latent data being coded across the data set. The codes were placed on a thematic map, similar to a mind map, which served as the basis for further discussion among the research team. From the discussion, seven potential themes were generated from the first data collection period focusing on expectations and eight were generated for the second data collection period focusing on experiences. The discussions also involved possible hierarchies between potential themes. After a discussion among the research group, the potential themes that bore similarities were merged. The themes were cross-checked against the two data sets, which generated three main themes and eight sub-themes over the entire
data set. One main theme with two sub-themes illustrated the findings from the initial data collection period, containing the expectations of the patients and their next of kin. Two main themes with three sub-themes each illustrated the experiences of the patients and their next of kin as generated during the follow-up data collection period. The data in the codes were then transcribed and were accompanied by the core context of each theme as illustrated by selected quotes.

6.6. Preunderstanding

Researchers can productively draw on their preunderstanding while conducting research (Alvesson & Sandberg, 2022) since, in qualitative research, mutual understanding and cooperation between the researcher and the participants are needed. The creation of an interview is mutual, contextual and value-bound (Lincoln & Guba, 1985). Because of this co-creation, the preunderstanding of the researcher must be considered. The author of this thesis has a bachelor’s degree in nursing, a master’s degree in geriatric nursing and clinical experience of geriatrics within municipal health care, primarily at long-term care facilities. As registered nurses working in home health care and long-term care facilities within municipalities often have the same employer in Sweden, the author had a preunderstanding of the care model prior to starting the research project because of previous work experience in the organization of implementation. However, the author had no previous experience working directly in MICM. An awareness of one’s history, such as previous work experience, can reduce the risk of asking questions based upon a narrow perspective (Nyström & Dahlberg, 2001) and therefore also decrease the risk of preunderstanding restricting research questions based on preconceptions of potential answers. The preunderstanding of the author of this thesis were written down prior to beginning involvement in the project and were continuously discussed by members of the research group. In the analysis, subjective interpretations of the data were based on cooperation between the participants and the researcher and as such could not be fully separated from the analysis (Graneheim & Lundman, 2004). The findings of each of the studies outlined in the four papers can therefore also not be fully separated from the author of the thesis, nor the author’s supervisors. In qualitative analysis, subjectivity can be viewed as a resource because of its
relation to context and the ability for meaning-making (Braun & Clarke, 2019). Without recognizing and reflecting upon the author’s preunderstanding, important findings related to context and meaning in relation to the phenomenon may have been missed.

6.7. Ethical considerations

In this project, data were collected through interviews with registered nurses, home healthcare physicians, patients and their next of kin. Prior to recruiting participants and collecting data, the project received ethical approval from the Swedish Ethical Review Authority. Ethical approval was obtained for data collection from registered nurses and general physicians (Dnr 2019-02563) with additional ethical approval granted for subsequent interviews (Dnr1020-17). Similarly, ethical approval was obtained for the data collection from patients and their next of kin (Dnr 2020-07149). Potential ethical issues were considered prior to applying for ethical approval as well as throughout the research project according to the Declaration of Helsinki (World Medical Association, 2013) and the principles of autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2001).

The principle of autonomy states that researchers should always respect the dignity, integrity and vulnerability of participants (Beauchamp & Childress, 2001). In this project, the principles of autonomy and integrity were honored by respecting the participants’ freedom of will and protection of privacy. Given that healthcare professionals were asked by their unit manager to participate in the study, their sense of autonomy could have been adversely impacted. It was therefore important to follow the principle of autonomy by informing all participants of the voluntary nature of their participation. Patients and their next of kin were similarly informed, although they were asked to participate by contact persons working in municipal health care – this could be viewed as an ethical problem. It was therefore critically important to fully inform all participating patients and their next of kin of the voluntary nature of their participation and to assure them that their health care would not be affected. Furthermore, information about whether the patients and their next of kin ultimately chose to participate in the study was not communicated to the contact persons. All participants received detailed written and oral information about the studies, including aims, data collection protocols and
contact information for the responsible project manager. The participants were further informed about their right to withdraw their participation at any point in the research process without explanation or repercussions. The participants were also assured that all data would be handled confidentially in order to guarantee that no one outside of the research group would be able to identify them. Informed consent was obtained both orally and in writing from all participants. As many of the participants were vulnerable patients with health problems, sensitive decisions had to sometimes be made by the author of this thesis about which information to provide to them regarding the MICM. During the data collection period, some patients expressed concerns over municipal health care, which had caused them suffering. Because of the author of this thesis’ background, knowledge about the type of support and care to which patients were entitled within municipal home health care were known. When such situations emerged, the author of this thesis chose not to disclose information regarding municipal home health care during the interview since the aim was to capture the participants’ expectations and experiences of the MICM at that moment. However, after the interview was finished, the author of this thesis provided the patient with information about whom to contact for assistance with their concerns.

The principle of non-maleficence states that no research is allowed to cause discomfort or harm to participants (Beauchamp & Childress, 2001). As some of the participants in this study were patients over 65 years of age with complex care needs, being visited by strangers and being asked to participate in interviews about potentially sensitive topics could have been perceived as tiring and burdensome. These considerations were discussed when contacting the participants and when planning the time and setting for the data collection. A good amount of time was allotted for each meeting, and the participants were informed that data collection could be performed on several occasions if necessary. No participant was perceived to have been harmed or to have experienced discomfort during the data collection. Another potential issue was the COVID-19 pandemic, which could have made meeting with researchers uncomfortable and even frightening. To address this issue, participants were given the option of being interviewed by telephone or video call, which some preferred. The participants also had the option of wearing protective gear, as did the author of this thesis, to ensure that everyone felt comfortable during the data collection. Although at the time of data collection, no protective gear
was mandated, a few of the patients preferred to wear masks, and the author of this thesis complied accordingly.

The principle of beneficence refers to how research can potentially be used to benefit those who participated in the study (Beauchamp & Childress, 2001). Home health care requires more development since many older persons prefer to remain at home (Gillsjö et al., 2011). Furthermore, older patients receiving health care in the home is the political direction that is currently conducted (Swedish Government Official Reports, 2017:21). The MICM had not been evaluated qualitatively prior to this project. The few studies that had been conducted on the MICM had focused on the whole care model, not its constituent parts. It is therefore vital to continue to evaluate and develop the MICM since it is currently being promoted at the national level (Swedish Government Official Reports, 2020:19).

The principle of justice maintains that it is the researcher’s duty to protect the limited autonomy of research participants and to generate knowledge that can be employed to both relieve and prevent suffering (Beauchamp & Childress, 2001). In this study, there was a risk that the participants would experience uneasiness during the data collection due to the reasons described above. The possibility of participants experiencing uneasiness was however considered to be low in comparison to the benefits of evaluating the MICM. There was also a risk that some patients or next of kin could feel pressured to participate because the patient of their next of kin wanted them to, especially since the participants were recruited in pairs. This risk was ameliorated by assuring the participants that their participation was entirely voluntary and that they could withdraw from the study at any time with no explanation or consequence. Additionally, data security was high – for instance, demographic data from the participants were coded, and the codes were stored separately from the data. Moreover, the code key was stored in a password protected server. Therefore, there was little risk of information from participants being exposed.
7. Findings

The findings from each study are described in this section. More detailed descriptions can be found in the papers associated with each study.

7.1. Paper I

Paper I describes registered nurses’ experiences of working and providing health care in the MICM. The analysis resulted in one theme and three main categories, divided into six sub-categories.

7.1.1. Theme: Mutual trust is a prerequisite for nurses’ sense of safety and work satisfaction

The overarching theme of Paper I permeated the findings as a whole. Mutual trust was found to be a pervasive component of the registered nurses’ sense of work satisfaction. Having time to build mutual trust, along with having continuity with and accessibility to the physician in the MICM, was found to be a significant factor in feeling safe in providing health care. This sense of safety made the registered nurses’ work easier. One goal among the registered nurses was to cultivate a sense of safety among their patients – through the creation of trust.

Category: Being the center of the MICM, with limited power to influence it

The first main category; *Being the center of the MICM, with limited power to influence it*, describe the experiences of the registered nurses with regard to the structure of the MICM. This main category had two sub-categories; *The working conditions of the nurses are influenced by the MICM physician’s ability to work for the patient as a whole* and *A sense of powerlessness towards organizational prioritization.*

The working conditions of the nurses are influenced by the MICM physician’s ability to work for the patient as a whole. The registered nurses witnessed how physicians influenced the organization of the MICM in each
municipality. Differences were observed in how physicians conducted home visits. The registered nurses described that some of the physicians took time for home visits and came well-prepared. In other cases, they seemed to not take a holistic approach or have sufficient time to fully evaluate patients. Differences among the individual physicians’ ability were also noted in terms of their creation of medical healthcare plans, ultimately making these plans more or less useful. The registered nurses also expressed that they worked more closely with both patients and physicians than any other healthcare professional, which made them feel like they were the center of the MICM. The nurses also described having difficulties remembering how they had worked prior to the implementation of the MICM. They could not imagine working any other way.

**A sense of powerlessness toward organizational prioritization,** was experienced by the registered nurses. This manifested as an obstacle to effective care when primary healthcare organizations did not prioritize the MICM. The registered nurses described how the structure of the MICM led to greater continuity with the physician, which in turn facilitated the development of a trusting relationship. Continuity was possible when the organization prioritized the MICM, which also made the registered nurses feel less powerless. When a lack of continuity with the physician was experienced, the registered nurses felt as if their sense of being at the center of the care model increased. According to them, the primary healthcare center prioritized different aspects within the MICM due to available resources. Some primary healthcare centers prioritized the creation of medical healthcare plans by the physician, while others prioritized acute visits. The registered nurses often experienced a shortage of time among the physicians in their provision of health care for older patients. This shortage made it difficult to have sufficient time to complete both medical healthcare plans and acute visits. The registered nurses also described a lack of access to other organizations’ documentation and medical equipment within the MICM, which increased their sense of powerlessness in their work with patients.

**Category: The team is key to quality health care**

The second main category, *The team is key to quality health care,* describes the experiences of the registered nurses regarding teamwork. The main
category has two sub-categories; *The work around the patient cannot be done alone* and *The MICM physician as a part of the team and yet an outsider*.

**The work around the patient cannot be done alone**, according to the registered nurses. This work instead required teamwork, which was carried out in different ways and among different constellations of professionals in the municipalities. The registered nurses, occupational therapists, physiotherapists, care administrators and assistant nurses were all described as being part of the team. In some municipalities, there were routinely organized team meetings, while teamwork in other municipalities was built on individual personal relationships without organized meetings. The registered nurses felt they had a trusting relationship with the other professionals in their team.

**The MICM physician as part of the team and yet an outsider**, was described by the registered nurses. Collaboration between the registered nurses and the physician working in the MICM was considered to be generally good and satisfying for the registered nurses. Collaboration between physicians and other professionals, however, was often limited, according to the registered nurses, since they experienced that physicians only rarely participated in teamwork. The registered nurses expressed the desire for the physician to participate more in team collaborations, which, according to them, could contribute additional perspectives on the provision of health care.

**Category: Increased possibilities for involving the patient and their next of kin**

The third main category; *Increased possibilities for involving the patient and their next of kin*, describes the experiences of the registered nurses concerning participation by patients and their next of kin. The main category has two sub-categories; *Being a guest in the workplace environment* and *The key to patient and next of kin participation is the nurses’ approach*.

**Being a guest in the workplace environment**, as a registered nurse increased the probability of patients participating in their own care, especially as it was provided in their home. The patients seemed to have more power over the provision of their health care in their home as opposed to at traditional healthcare institutions. The registered nurses felt it was easier for the physician
The key to patient and next of kin participation is the nurses’ approach; to patients and their next of kin. Some registered nurses expressed that their work was grounded in the patient’s consent in the provision of health care. Others described having a flexible and compromising approach. In contrast, some registered nurses stated that patients were not invited to participate in their healthcare planning. Nurses believed that the next of kin felt a sense of safety when being invited to participate. Building trusting relationships with next of kin was described as a time-consuming and sometimes challenging effort.

7.2. Paper II

Paper II describe home health care physicians’ perceptions of working and providing health care in the MICM, as well as perceptions of participating in and forming health care. The analysis in this study resulted in an outcome space consisting of six descriptive categories, each describing the phenomenon.

7.2.1. Outcome space

The outcome space constituted qualitatively different descriptive categories in which internal relationships and hierarchies between categories are described. The first five descriptive categories represent the range of perceptions of physicians working with the MICM. All of the categories are main categories: A different way of working as a physician, A piece in the team puzzle, Being in the patient’s home adds a unique dimension, Respecting patient autonomy in medical decision making and A divided view on next of kin participation. In the second part of the aim of Paper II, the physicians’ perceptions of participating in and forming the healthcare are represented in the final descriptive category: Need for additional resources and structure.
when working in different organizations – that addresses the need for improving the MICM.

7.2.2. A different way of working as a physician

Working in the MICM was perceived by the physicians as a different way of working as opposed to working at the hospital or primary health care center. Working as a home healthcare physician was described as flexible, enjoyable and exciting. The physicians expressed the MICM was the best way of working and was the future of health care for older patients with complex care needs because of its structure, which provided continuity and accessibility to physicians. The role of physicians working in the MICM was perceived by them to include responsibility for the medical care of patients, including assuring them that would not be prescribed unnecessary medications to avoid troublesome side effects. They also perceived their role to include being pedagogical about their decisions concerning patients and healthcare personnel. There were different perceptions among the physicians about their role in providing a sense of meaningfulness to patients in their daily life. Some were of the opinion that they should concern themselves with who each person was behind the patient role, while others felt that providing a sense of meaningfulness and well-being to patients was outside of their role.

7.2.3. A piece in the team puzzle

Being a physician working in the MICM entailed being one piece of the team puzzle involving the patient. The physicians had different perceptions about their role in the team, mainly in two different ways. The first was like a spider in a web, being the center of the team around the patient. The second was as a consultant, with the municipality commissioning the physician’s time and competence. Team-based care was experienced as improving the quality of health care since different healthcare professionals had different perspectives. Some physicians regularly met with all of the healthcare professionals within their municipality. Others described collaborating mainly with registered nurses, a collaboration which they described as good. This collaboration was perceived as benefiting from building a trusting relationship with the registered nurses, which was aided by maintaining physical proximity, sharing educational experiences, such as conferences, and conducting teambuilding
activities together. The physicians viewed assistant nurses as a team resource. Their presence during home visits was perceived to be beneficial since they could contribute useful information about each patient’s specific situation.

7.2.4. Being in the patient’s home adds a unique dimension

There was an experience among the physicians of how providing health care in the homes of patients added a unique dimension to the provision of health care. The home dimension was not accessible to them when working at a primary healthcare center. Meeting patients in their home, where the physician was a guest, was considered a positive experience. Home visits benefited the physicians by allowing them to gather more information about their patients. The home dimension was also perceived by the physicians as being a person-centered way of providing health care. The physicians believed that patients complied more with health and medical advice when they were at home. In contrast, other physicians did not consider the home dimension within their role as a physician working in the MICM. There were also differences in their perceptions of their role in terms of socialization with the patients in their home. Regarding interaction, some physicians were of the perception of how their role included being social with the patients, while others believed it was not their primary focus.

7.2.5. Respecting patient autonomy in medical decision making

It was perceived by the physicians as essential for patients to have the autonomy needed to make their own decisions about treatment options. For patients to make educated decisions, the physicians would first listen to their expectations and then inform them about the available options. The physicians perceived themselves to be the medical authority within the MICM and as such ultimately had the final say concerning medical decisions. At other times, patients did not want to make decisions according to the physicians’ advice, which often led to the physicians making these decisions for the patients. The physicians stated that they needed to be well-versed in each patient’s medical history, needed to be open with their medical records, and needed to be able
to discuss difficult subjects when approaching patients in ways that allowed them greater autonomy in their decision making.

7.2.6. A divided view on next of kin participation

The physicians were divided concerning participation by next of kin. Some physicians did not think next of kin should participate at all, whereas others believed that next of kin should always be involved. The physicians noted that participation by next of kin needed to be approved by the patients before they felt comfortable including them in care plans and decisions. When approved by patients, involving next of kin made them feel safer. In cases where differences of opinion arose between patients and their next of kin, the physicians prioritized the patients. The physicians also noted that contact with next of kin was mainly the task of registered nurses.

7.2.7. Need for additional resources and structure when working in different organizations

The physicians perceived the need for additional resources within the MICM. The allocation of resources differed in different municipalities, which could be observed in the varying percentages of work available to the physicians in the MICM. Time was considered a resource by the physicians, with some having enough time and others wishing for more hours to work in the MICM. Furthermore, a desire for sharing on-call schedules between the physicians working in the MICM was regarded as valuable. Moreover, the physicians desired the opportunity to admit patients to institutional care, to have closer collaborations with other MICM teams, and to have improved access to medical equipment. Access to municipal healthcare documentation was also perceived to be an area that could be improved in MICM.

7.3. Paper III

Paper III describes the experiences of registered nurses and home health care physicians working in home health care in an integrated care model during the COVID-19 pandemic. The analysis resulted in three main themes and seven sub-themes.
7.3.1. **Forced into a changed way of working**

The first main theme; *Forced into a changed way of working*, depicts how the pandemic changed the work lives and experiences of the registered nurses and physicians. This main theme has three sub-themes; *Avoiding ‘unnecessary’ visits led to disrupted relationships with patients*, *Forced to pause usual work; development of health care on hold* and *Forced to use digital and phone communication, which influenced quality of care*.

**Avoiding ‘unnecessary’ visits led to disrupted relationships with patients**, according to the registered nurses and physicians in the MICM. As there was no definition of what constituted a necessary visit, the registered nurses and physicians had to decide for themselves which visits were necessary. Creating and maintaining relationships with the patients was difficult during the pandemic. The registered nurses and physicians could not use the same strategies to build relationships with patients as they had previously, such as frequent visits or physical contact, e.g. holding the patient’s hand. The physicians working in the MICM were described as becoming invisible according to the participants since there were limited opportunities to physically meet. Avoiding visits was described as leading to need-oriented health care rather than person-centered care based on trusting relationships.

**Forced to pause usual work; development of health care on hold**, was lamented by the registered nurses and physicians. Projects that had been planned years in advance could not be prioritized and had to be put on hold. Focusing on the pandemic entailed shifting the focus from routine care considerations, such as fall prevention, nutritional status and the structure of medical safety, to dealing primarily with the pandemic and preventing its spread. Having to pause healthcare developments was described as impacting the safety of everyday health care. The registered nurses and physicians working in the MICM hoped for a before and after of the COVID-19 pandemic. They hoped to be able to get back to working as they had before and to continue developing healthcare plans. Some, however, did not think the pandemic would ever end – and even if it did, the world would be changed forever.

**Forced to use digital and phone communication, which influenced the quality of care**, during the pandemic was emphasized by the participants.
Completing their rounds over the telephone or on video calls was described as not working very well in comparison to in-person rounds, leading to additional work due mainly to miscommunication. In contrast, some physicians felt that video calls worked quite well. Team meetings between the registered nurses and other municipal healthcare personnel were held through video meetings or were cancelled. Video meetings were often considered to be more efficient. The registered nurses met with the assistant nurses less often to avoid infection, which led to increased telephone calls and, at times, miscommunication regarding instructions or other information. Other registered nurses actually met with assistant nurses more often to ensure that they felt supported. The registered nurses described how they changed the way they communicated with patients, keeping in contact with them over the telephone rather than meeting with them in person. Maintaining contact over the telephone compelled the registered nurses to make evaluations without seeing their patients, which was described as a challenge.

7.3.2. **Worry about illness brought into the work setting**

The second main theme; *Worry about illness brought into the work setting*, represented the fear among the registered nurses and physicians about providing health care during the COVID-19 pandemic. This main theme has two sub-themes; *Worry about infecting patients, co-workers, and oneself* and *Worry about maintaining provision of care due to colleagues increased sick leave*.

**Worry about infecting patients, co-workers, and oneself**, were described by the registered nurses and physicians working in the MICM. Some physicians were at higher risk of becoming severely ill if infected due to their age or preexisting conditions and therefore avoided seeing patients. At the beginning of the pandemic, registered nurses and physicians were not allowed to wear protective gear since they were scarce and hospital staff were prioritized. When protective gear was available, it was a relief to the participants. To prevent disease transmission, the participants adhered to restrictions, even though they often changed. Fear over transmitting COVID-19 was reduced when the registered nurses and physicians followed established recommendations. Both the registered nurses and physicians believed that some patients did not fear the virus, while others declined help
precisely because they were afraid of becoming infected. Patients were liberally tested to ensure that the virus did not spread, as well as to ease worries among the patients, staff and healthcare professionals.

**Worry about maintaining provision of care due to colleagues increased sick leave,** was common among healthcare professionals during the pandemic. Assistant nurses were especially affected by increased sick leave and had to provide care to increased numbers of patients. The registered nurses were also affected by increased sick leave, as fewer registered nurses were available to care for patients, thereby increasing their workload. Consequently, daily plans had to be changed every morning to compensate for those registered nurses who were sick. Increased sick leave prevented staff from taking vacation days due to the lack of home healthcare personnel. This caused discontent among the registered nurses as they were exhausted from covering more shifts.

### 7.3.3. **Trying to bridge the gap of patients’ isolation**

The third main theme; *Trying to bridge the gap of patients’ isolation*, describes how the registered nurses and physicians feared for the health of their patients and the patients’ next of kin. This main theme has two sub-themes; *Powerless in the face of declined health for isolated patients* and *Meeting increased worry and guilt from the next of kin*.

**Powerless in the face of declined health for isolated patients**, depicts how pandemic-induced isolation influenced the well-being of patients more so than the fear of COVID-19. Patients who were especially social prior to the restrictions imposed due to the pandemic were described to be particularly affected by isolation. The registered nurses and physicians felt powerlessness to help patients who were in declining health, particularly since their next of kin could not visit them. Healthcare personnel became the only persons with whom these patients met, and COVID-19 was the predominant topic of conversations. Wearing protective gear made meetings feel less personal, leading to an overall absence of real contact with patients.

**Meeting increased worry and guilt from the next of kin,** was expressed by the registered nurses and physicians during the COVID-19 pandemic. Next of kin were worried about their older relative, which led to increased telephone
contact with healthcare professionals. Which professionals received more telephone calls varied in different municipalities. While many next of kin followed pandemic-related restrictions, some defied these restrictions and visited their relatives to end their isolation and alleviate their own sense of guilt. For older patients who could not receive visits from their next of kin, healthcare personnel became a bridge between them.

7.4. Paper IV

Paper IV illustrates the expectations and experiences of patients and their next of kin concerning the MICM at baseline and after six months. The analysis resulted in three main themes and eight sub-themes.

7.4.1. Expectations of safe and coherent health care

The first main theme; *Expectations of safe and coherent health care*, defined the expectations of patients and their next of kin at baseline. This main theme has two sub-themes; *A hope of relief and shared responsibility* and *A wish for personal contact and continuity*.

*A hope of relief and shared responsibility*, was expressed by both patients and their next of kin upon admission to the MICM. They expected a sense of relief from sharing responsibility with healthcare professionals, such as making decisions and easing the burden of being a care giver. The structure underlying the provision of health care in the MICM was also expected to alleviate healthcare concerns and worries. Patients and their next of kin were relieved to know how they could contact healthcare professionals when they needed help. Furthermore, they anticipated the reduced number of visits to healthcare centers.

*A wish for personal contact and continuity*, was anticipated by patients and their next of kin in the future provision of health care. The expectation of continuous contact was also an expectation of personal contact. Being provided with a designated registered nurse led to the expectation of not needing close contacts with home healthcare physicians. Other patients and their next of kin worried about the potential lack of physician contact in the MICM. They experienced a lack of information related to the MICM, which
made it difficult to even have expectations regarding the provision of health care. Those who had expectations desired for their medications to be reviewed and to obtain answers about why they had such extensive care needs that they warranted admission to the MICM.

7.4.2. An easier daily life

The second main theme; *An easier daily life*, was experienced by the patients and their next of kin six months after baseline. This main theme has three sub-themes; *Less time to travel, more time to live, Direct access enabled reduced responsibility* and *A personalized contact to provide safety.*

**Less time to travel, more time to live,** was experienced by the patients and their next of kin six months after baseline. Overall, they enjoyed an easier daily life and a sense of relief since being admitted to the MICM as health care was now provided at home. They also had a sense of relief concerning the reduced amount of time they had to spend travelling to healthcare centers. Daily life became easier as their medications were brought to their home and registered nurses visited to perform exams and treatments. Receiving health care at home was described as reducing the number of times next of kin had to drive their relative to healthcare organizations. However, some experienced home healthcare visits to be tiresome and restrictive.

**Direct access enabled reduced responsibility,** which the patients and their next of kin related to as a clear way to contact healthcare professionals who could help them carry out the responsibility of health care. They experienced a sense of relief at not being home alone during the provision of health care as well as having someone to call for help if needed. However, some also believed that the healthcare professionals did not keep track of everything, resulting in patients and their next of kin not being able to fully let go of their responsibilities.

**A personalized contact and continuity to provide safety,** was described by the patients and their next of kin as being fulfilled during the initial data collection period. Building personalized contacts with registered nurses and home healthcare physicians was described as being able to talk about other things than health care and to make jokes together. The participants
experienced that the personal characteristics of the healthcare personnel influenced their sense of safety. Some mentioned not having much in-person or telephone contact with the home health care physician since their admission. Thus, experiences varied among the patients and their next of kin, with some having frequent contacts with registered nurses and others not. Patients and their next of kin stated that their assistant nurses were the most important persons in their health care, as they were responsible for closer personalized contact and met with them more frequently, even on a daily basis.

7.4.3. A hierarchical structure with an impact on participation

The third main theme; A hierarchical structure with an impact on participation, also described the expectations of patients and their next of kin six months after baseline. This main theme has three sub-themes; A structural impact of having a singular physician, A care model with a hierarchic structure and Possible participation on the terms of the MICM structure.

A structural impact of having a singular physician, was described as being associated with not being allowed to seek a second opinion outside of the MICM. Some patients worried that their home healthcare physician would lack competence about their specific condition, for which they had previously received specialized health care. In contrast, other patients and their next of kin described feeling safe with their physician, who was considered to be considerate and competent. The patients and their next of kin who described having the opportunity to discuss their needs and concerns during meetings experienced a sense of safety with their physician.

A care model with a hierarchic structure, was described by those patients who felt that they were at the bottom of the MICM hierarchy. Some preferred this type of structure, while others were uncomfortable with it. Some patients and their next of kin believed that the registered nurses and the physician were closely collaborating, meeting weekly to discuss patient cases. Other patients described situations in which registered nurses and physicians teamed up against them, making them feel like they were at the bottom of the hierarchy.

Possible participation on the terms of the MICM structure. Some patients and their next of kin felt encouraged to participate in the provision of their
health care. In contrast, others did not feel included in their medical decisions. In these instances, medical records were described as being inaccessible and patients believed they were not allowed to be in charge of their own medications, which some experienced as solidifying the hierarchy. Stress among the healthcare professionals within the MICM structure was postulated to influence participation since meetings with physicians were often postponed, cancelled or rushed. In contrast, some felt that their meetings with their home health care physician were calm and thorough.
8. Discussion

8.1. Methodological considerations

In this chapter, the methodological considerations of this thesis will be discussed. The thesis was based on qualitative data and therefore applied four criteria for trustworthiness: credibility, transferability, dependability and confirmability (Polit & Tatano Beck, 2020). These criteria are used to discuss the research process and findings of this study.

8.1.1. Credibility

Credibility is a criterion for evaluating the integrity and quality of qualitative studies and refers to confidence in the data and the findings. The fulfilment of this criterion is decided based on the way in which the research is conducted and reported (Polit & Tatano Beck, 2020).

Participants and recruitment

Regarding participants, credibility was strengthened by clearly and transparently presenting the sampling procedures and thoroughly describing the participants (Graneheim et al., 2017). Patients who had recently been admitted to the MICM and their next of kin were considered appropriate for illuminating their expectations. Conducting the follow-up data collection with the same participants after six months provided the opportunity to capture the experiences of the MICM, which further strengthened the credibility of the findings. Because of the inclusion criteria, patients with cognitive impairments, palliative patients and patients with suspected short-term needs for home health care were excluded from participating. The contact persons stated that the most common patients admitted to the MICM were those with cognitive impairments. Previous research has described older patients as having complex and diverse care needs. Future research should thus include a broader description of the participants (Looman et al., 2019) since doing so would reduce the risk of excluding older persons whose experiences would be relevant to the study (Smith et al., 2016). As some relevant patients were excluded from this study, the exclusion criteria can be considered a limitation.
related to credibility since the findings may not represent all patients and their next of kin in the MICM. However, employing exclusion criteria was necessary since participants needed to have had relevant experiences and be able to describe the phenomenon for the purpose of strengthening the credibility of the study (Graneheim et al., 2017). As next of kin were recruited in pairs alongside patients, they did not represent relatives of patients who had been excluded. Had the next of kin and patients been recruited separately, it may have been possible to capture variations in their expectations and experiences, which could have enriched the findings presented in Paper IV. Originally, the project was designed to include four studies with patients and their next of kin. In the original plan, two papers were to be qualitative, and two quantitative. To reach validity in the statistical findings of the quantitative studies, the number of participating patients and next of kin needed to be enough to conduct statistical analysis. The original plan was changed since there were issues in recruiting enough participants, related to the COVID-19 pandemic.

As just described, all participants needed to have had relevant experiences of the phenomenon in order to strengthen the credibility of the study (Graneheim et al., 2017). Due to the organization of the MICM (Norén & Segerberg, 2019) the most relevant professional groups who were invited to participate in the study were registered nurses and home healthcare physicians. However, during the data collection, the significance of assistant nurses became apparent. Assistant nurses primarily work under the law regulating social care (Swedish Code of Statutes, 2001:453), while the MICM operates under the law of health care (Swedish Code of Statues, 2017:30). Therefore, registered nurses and physicians were chosen to participate in the study, not assistant nurses. However, assistant nurses do work in the MICM to some extent when conducting healthcare tasks delegated to them by the registered nurses. Their experiences could complement the knowledge gained about teamwork within the MICM from a new perspective. Furthermore, their experiences could also highlight possible differences in how work is performed in home health care. In comparison, other healthcare professionals, such as occupational therapists and physiotherapists, were mentioned in the interviews only briefly and can therefore be understood as less visible in the teamwork in the MICM.
The participants described in Paper III were registered nurses and physicians working in the MICM who had participated in the third phase of data collection for Papers I and II. These participants yielded valuable data about their experiences of working in home health care during the COVID-19 pandemic and therefore strengthened the credibility of the findings. As the interviews did not focus on COVID-19, it can be inferred that the participants did not have any particular bias concerning the pandemic.

The recruitment of participants was assisted by unit managers and contact persons, who could be considered gatekeepers. Gatekeepers have been described as playing a key role in ensuring that researchers gain access to participants (McFadyen & Rankin, 2016). Without the help of unit managers and contact persons, recruiting participants would have been difficult. However, such gatekeepers may also limit access to potential participants (McFadyen & Rankin, 2016), which may have occurred during the recruitment of participants in this study. It is possible that the participants felt pressured to participate due to the gatekeeper’s role in their life. The participating patients might have felt such pressure since they were being asked to by a registered nurse who worked in home healthcare. There was also a risk that the healthcare professionals felt pressured to participate as well since the majority of participants were asked by their unit manager if they were willing to participate. This may have detracted from the credibility of the study. As participant consent is crucial for strengthening credibility (Lincoln & Guba, 1985), all participants in this study received oral and written information that assured them that their participation was entirely voluntary and could be ended at any time without reason. Consequently, oral and written informed consent was obtained from all participants. One healthcare professionals and five patient and next of kin pairs declined to participate after receiving the above information from the researcher. Furthermore, two patient and next of kin pairs did not participate in the follow-up data collection, demonstrating that these participants knew they could withdraw from the study at any time. The reason why they declined to participate further was not determined since they did not have to provide a reason.
Data collection

To increase the credibility of a study, prolonged engagement is typically needed, which in turn requires an investment of sufficient time by the researcher for the purpose of learning the culture of the research phenomenon, testing misinformation and building trust within the research context (Lincoln & Guba, 1985). For Papers I and II, data were collected from registered nurses and physicians in three phases, the last of which occurred during the COVID-19 pandemic. Data collection from patients and their next of kin for Paper IV lasted for one year, with the same participants being interviewed twice over the course of six months, also during the pandemic. In the data collection from both healthcare professionals and patients and their next of kin, prolonged engagement allowed the researchers to learn more about the culture of the research context and to cultivate trust with the participants in the context of the MICM. Furthermore, collecting data from different groups of participants can be considered triangulation, as several types of sources were involved (Lincoln & Guba, 1985).

The preunderstandings of the researchers regarding their experiences of working in municipal health care could be viewed as a limitation that detracted from the credibility of the study since there was a risk of the researcher ‘going native’ and identifying with the research culture (Lincoln & Guba, 1985). However, having previous knowledge about the phenomenon being studied has been argued to be beneficial when performing semi-structured interviews (Kelly et al., 2010). The preunderstandings of the researchers were therefore valuable both when creating the interview guide and when performing the interviews and helped the researchers ask relevant follow-up questions that ultimately deepened their reflections and made the answers provided by the participants insightful. The data collected via semi-structured interviews are regarded as the most common type of data in qualitative research on health care (Kallio et al., 2016). Semi-structured interviews have the advantage of enabling reciprocity between the researcher and the participants (Galletta, 2013) as well as of allowing the researcher to improvise follow-up questions (Polit & Beck, 2020).

Some patients and their next of kin asked whether it was possible to be interviewed together. Conducting paired interviews was consequently discussed among members of the research group and a decision was made
about how to conduct these interviews. The majority of the interviews for Paper IV were paired interviews, which may have influenced the credibility of the findings since some participants may not have been comfortable speaking about certain topics in front of others. In the paired interviews, the participants can interact with each other to provide more in-depth answers to the interview questions (Morris, 2001). Furthermore, it has been argued that paired interviews allow participants to fill in information for each other (Wilson et al., 2016), which was observed in the present study, thereby strengthening the credibility of the data. However, it is important that the researcher view these interviews as two interviews and keep track of who said what (Morris, 2001) – the author of this thesis who conducted the interviews for this study did so. Furthermore, in paired interviews, there is a risk that one of the participants might dominate the interview (Arksey, 1996), which would in turn pose a risk to the credibility of the data. In this study, some participants appeared to dominate in their paired interviews. Therefore, the author of this thesis remained mindful of this and sought to include less dominate participants. Additionally, the author of this thesis employed two separate interview guides – one for patients and one for their next of kin – and ensured that both participants answered questions from their designated interview guide.

Field notes were used in addition to interviews for Papers III and IV, as doing so provided more thorough qualitative descriptions (Phillippi & Lauderdale, 2018). The field notes were analyzed together with the interview transcripts, achieving triangulation and therefore strengthening the credibility of the data (Lincoln & Guba, 1985). The field notes were written down by the author of this thesis after each interview as well as during the third phase of data collection with registered nurses and physicians. They were not used in Papers I and II, but they were used as a reflective tool to promote discussions with the research group. For Papers III and IV, however, field notes were employed alongside interviews. In Paper IV, field notes were considered to be a structured way of utilizing preunderstandings well-suited for reflexive thematic analysis (Braun & Clarke, 2019).

Data analysis

Credibility is also important with respect to different qualitative analysis methods. The criteria used to determine the credibility of the analytical
methods used in this thesis – qualitative content analysis (Graneheim et al., 2017), phenomenography (Sjöström & Dahlgren, 2002) and thematic analysis (Nowell et al., 2017) – will be discussed below.

In qualitative content analysis, which was used for Paper I, credibility is strengthened by using quotations from the findings to demonstrate different levels of abstraction in the categories and themes (Graneheim et al., 2017). The categories presented in the findings for Paper I were analyzed on the manifest level. The credibility of the manifest findings was strengthened by the textually close analysis (Graneheim & Lundman, 2004). The overarching theme represented the latent level, with a higher level of abstraction. Because of this higher level of abstraction, it can be challenging to demonstrate increased credibility. The researcher is the co-producer of the data in manifest and latent analysis, and because the researcher interprets the analytical findings, it becomes a subjective endeavor (Graneheim et al., 2017). However, it has also been argued that texts can have more than one meaning, but it is the researcher’s interpretation of the meaning that is presented (Graneheim et al., 2017). The thesis author’s preunderstandings as described earlier in the thesis may therefore be of value to the reader in gaining a better understanding of how subjective interpretations were made.

The credibility of phenomenographic studies such as Paper II is based on a precise description of each part of the research process, an explicit presentation of interview questions and procedures, and a careful description of the analyses (Sjöström & Dahlgren, 2002). The steps of the research process for this study are described in detail in the methods section in both Paper II and this thesis, strengthening the credibility of the findings (Sjöström & Dahlgren, 2002; Stenfors-Hayes et al., 2013). The quality of the findings was determined based on the extent to which the descriptive categories were qualitatively different and the ways in which they were identified (Stenfors-Hayes et al., 2013). Several discussions among members of the research team were conducted until a consensus was reached about the findings, thereby enhancing the credibility of the phenomenographic research (Stenfors-Hayes et al., 2013; Wahlström et al., 1997). Furthermore, credibility in phenomenographic research involves internal relationships between the data and the categories, for which excerpts from the interviews can be provided (Sjöström & Dahlgren, 2002) – as done in Paper II through quotes. The quality
of a phenomenographic study can further be determined by presenting the findings in as few descriptive categories as possible (Marton & Booth, 2013). In Paper II, six descriptive categories were identified, which can be viewed as a large number of descriptive categories. However, the aim of the study was multifaceted, as it was motivated by the need to generate a large number of categories. The qualitatively different ways in which the phenomenon was perceived were presented in a defensible, meaningful and useful way for readers – a significant part of phenomenography (Uljens, 1996; Åkerlind, 2005). Lowering the number of qualitatively different categories could have weakened the presentation of the findings to the intended audience. The outcome space, consisting of the descriptive categories, demonstrated the range of variation in perceptions of the role of home healthcare physicians and how it was understood. In the outcome space, the structure and hierarchy of the qualitatively different categories were described (Marton, 1981). The first category of the findings, A different way of working as a physician, described the home healthcare physicians’ perceptions of their role. This category was viewed as being higher in the hierarchy than the others since the physicians’ views of their role affected and permeated the ways in which they perceived the phenomenon and expressed themselves. The other categories were considered to be at the same hierarchical level.

In thematic analysis, credibility can be enhanced when the data are analyzed by more than one researcher (Lincoln & Guba, 1985; Nowell et al., 2017), as was done in both Paper III and Paper IV. The research described in Paper III involved three researchers, each of whom participated in the analysis of the findings. In the research described in Paper IV, four researchers were involved. Furthermore, the credibility of the findings generated in thematic analysis can be strengthened by having the themes and codes scrutinized by the entire research team (Nowell et al., 2017), as was done in Papers III and IV. Thematic analysis, as a qualitative technique, situates the researcher as a resource and as a generator of themes (Braun & Clarke, 2019). For Paper IV, reflexivity allowed the researchers’ preunderstandings to pervade their field notes (Braun & Clarke, 2019). Reflexive thematic analysis entails maintaining a reflective stance and requires researchers to use their own preunderstandings during the research process (Malterud, 2001). Such preunderstandings were used and questioned in discussions among members of the research group during the analytical process for Paper IV and could therefore be considered
to have strengthened the credibility of the findings. Some team members had experience working in home health care, but not in the MICM, which was used as a preunderstanding in the analysis described in Paper IV. The use of the researchers’ preunderstandings allowed for additional data to be collected through field notes since patients and their next of kin at times lacked information about the MICM and the structure of municipal health care, which the researcher possessed. At the time, COVID-19 was spreading worldwide, and no one had any preunderstandings of its consequences. Therefore, reflexive thematic analysis was not considered to be suitable in the analysis described in Paper III.

8.1.2. Dependability

Dependability has been described as a criterion for evaluating the integrity of qualitative research and refers to the stability of data over time and across conditions (Polit & Tatano Beck, 2020). The research process should therefore be transparent so it can be replicated by others, thereby strengthening its dependability (Enworo, 2023). The evaluation of the integrity of qualitative findings is often accomplished through peer auditing (Stahl & King, 2020). The research process employed in the studies on which this thesis was based endured rigorous peer auditing. The choice of participants, recruitment strategy, and data collection and analytical methods was reviewed by the Swedish Ethical Review Authority and repeatedly by researchers at the University of Skövde and Jönköping University. Further, all of the research described in this thesis was peer-reviewed during the publication process for all four papers.

One challenge to the dependability of research involves the ways in which interviews are co-created between the researcher and the interviewee, and between the text and the researcher in the analytical process. It is therefore necessary to be aware of, and open about, the researcher’s preunderstandings (Graneheim et al., 2017). Therefore, the author of this thesis fully described her preunderstandings. The participants were informed that the author was a registered nurse with experience working in municipal health care, which could have affected the ways in which the participants related to the author of the thesis during the data collection period, thereby potentially influencing the dependability of the study. At times, healthcare professionals made
assumptions about information and experiences shared with the author of the thesis by stating ‘as you know’. The author of this thesis then had to ask the participants to elaborate on their own experiences regardless of whether what was meant was fully understood. Asking the participants to elaborate in this way lent greater depth and breadth to the collected data, consequently strengthening the dependability of the findings.

In the studies covered in Papers I and II, the dependability of the findings may have been influenced by the number of persons – including master’s students, senior researchers and the author of the thesis – involved in the collection of the data. Including more than one researcher in the analysis is one way to address issues of dependability, as the interpretative repertoires of researchers can vary (Graneheim et al., 2017). Having structure to the interviews through an interview guide has been found to contribute to higher dependability (Thorsteinson, 2018) and was accordingly used for the interviews presented in this thesis. The interviews were conducted either in person, over video calls or by telephone. Telephone and video interviews increased opportunities for long-distance participation and can be cost-effective (Gill & Baillie, 2018; Thunberg & Arnell, 2022). They have also been described as being compatible with in-person interviews in terms of the quality of data (Alvinius et al., 2023). However, technical difficulties may arise during video or telephone interviews, which may consequently degrade the quality of the resulting data (Thunberg & Arnell, 2022). Additionally, during telephone interviews, there is no video and therefore body language cannot be assessed (Gill & Baillie, 2018). During the interviews conducted by telephone or video in this study, no technical difficulties occurred, and the audio was of high quality.

8.1.3. Transferability

Transferability refers to the extent to which the qualitative findings can be transferred to other settings or groups (Polit & Tatano Beck, 2020). The ability of readers to determine whether the findings are transferable relies on a thorough description of the participants (Graneheim et al., 2017), the research context (Lincoln & Guba, 1985) and the analytical process, which, in this research, involved four distinct studies presented in four papers as well as in this thesis. Regarding ethical aspects, the description of the participants cannot be so explicit that it would risk exposing their identity (World Medical
Association, 2013). Furthermore, the geographical area defined for data collection was restricted, as was the area in which the MICM was first implemented. Descriptions that are too explicit could also risk exposing the participants’ identities. The data collected during the COVID-19 pandemic may have influenced the transferability of the findings but nonetheless provided unique insights into integrated care models during crisis situations, which the healthcare system may face in similar or different ways in the future.

The MICM has been implemented in larger regions and has been promoted nationally. Although the studies presented in this thesis convey findings about a limited group, should the MICM be implemented at the national level, the findings could become relevant at larger scales, especially with regard to the potential for similar challenges to emerge in the development of the MICM in other health care contexts. The complexity of health care for older persons receiving care at home is a worldwide phenomenon, and as such cross-border collaborations are needed to address such complexity (Swedish Government Official Reports, 2017:21; WHO, 2006, 2012, 2015b, 2017). The need to improve health care for older persons, which is the primary aim of the MICM, continues to increase (National Board of Health and Welfare, 2019a). However, the transferability (Lincoln & Guba, 1985) of the findings of this thesis to other contexts is a task for readers to judge.

8.1.4. Confirmability

Confirmability refers to the integrity of qualitative studies and the neutrality of their resulting data and interpretations (Polit & Tatano Beck, 2020). Confirmability can be determined when credibility, dependability and transferability have all been achieved (Lincoln & Guba, 1985). The inclusion of relevant theoretical, methodological and analytical approaches throughout the entire study is needed to determine how and why choices are made (Koch, 1994). The main goal is for the recruitment and description of participants, as well as the data collection and analytical process as described in the original papers included with this thesis, to provide readers with the ability to fully consider the confirmability of the research findings.
8.1.5. **Methodological choices of the analytical method**

Other qualitative analytical methods could have been used to address the research aims of the four studies described in this thesis. Some similarities existed in the aims and data collection methods, which could have been employed interchangeably in the four studies. The data for each of the papers determined which method of analysis that would be appropriate. For example, if qualitative content analysis had been used in the study described in Paper IV instead of reflexive thematic analysis, patients who were excluded from the MICM due to seeking other medical advice would not have been included. Here, the data were derived from field notes as well as interviews based on the author of this thesis’ preunderstandings. As another example, if thematic analysis had been used instead of phenomenography for the research presented in Paper II, the varied perceptions of the physicians about their role in the MICM would not have been adequately portrayed since thematic analysis does not focus on such perceptions. Other findings may, however, have been presented had other analytical methods been used.

8.2. **General discussion of the findings**

The aim of this thesis was to study the expectations, perceptions and experiences of registered nurses, physicians, patients and their next of kin of an integrated home healthcare model. The findings of the four papers will be discussed against the theoretical framework of person-centered care, the structure and goals of the MICM, and previous reports and research.

8.2.1. **Providing continuity in person-centered relationships**

The importance of the relationship between healthcare professionals and patients and their next of kin was a prominent finding in all four papers. This finding has also been described in previous research, where its importance to person-centered care for older patients has been highlighted (Edvardsson et al., 2020; Rushton & Edvardsson, 2018). Person-centered care is the value base of the MICM (Bradbury & Lifvergren, 2016; Norén & Segerberg, 2019) as well as of the current national reform; person-centered and integrated care, labelled in the papers as ‘local care’ (SALAR, 2018b). The building of relationships between healthcare professionals and patients and their next of
kin is therefore vital when evaluating the pursuit of person-centered care in the MICM.

Continuity influenced relationships between healthcare professionals, patients and their next of kin

The physicians viewed the MICM as the best way to work and as the future of health care for older patients with complex care needs because of its structure, which provides continuity and accessibility to physicians. For patients and their next of kin, personalized contact and continuity provide a sense of safety and reduced the sense of responsibility for health care. The continuity achieved by having the same healthcare professionals was considered an essential component in building relationships with patients, as expressed in previous research conducted in Sweden, Norway and the United Kingdom (Claesson et al., 2021; Corbett & Williams, 2014; Eide et al., 2022; Larsson Gerdin et al., 2023). Such continuity has also been shown to improve person-centered care for patients (Riley et al., 2020), which MICM had as its value base. In contrast, research on the Collaborative healthcare model, another integrated care model in Sweden that focuses on older patients, determined that continuity with the same healthcare professionals was not as important as accessibility (Hallgren et al., 2021). The Collaborative healthcare model focuses mainly on the acute needs of health care, whereas the MICM focuses more on long-term home health care. When viewing these two care models together, continuity can be considered important in long-term home health care, but less so in acute situations for older patients. One example of the importance of continuity in the MICM was the consequences of the lack of continuous home visits during the COVID-19 pandemic, which was observed to negatively influence the development and maintenance of relationships with patients.

Patients and their next of kin felt that having a designated healthcare professional they could call reduced their responsibilities in the provision of health care. These participants noted that their relationships were primarily with registered nurses, whom they met with more frequently than their physician. The registered nurses in this study, as well as in previous research conducted in Sweden, emphasized the importance of having a personal relationship with patients (Lindberg et al., 2022; Wälivaara et al., 2013). Still,
a scoping review on fundamental nursing from various perspectives argued that the relational needs of older patients receive less attention than their physical needs (Nordaunet et al., 2024). Some of the patients described a lack of personal contact with the registered nurses, attributing it mainly to nurse turnover or sick leave. The registered nurses, however, expressed no issues with nurse turnover. Still, as working conditions can be influenced by stress, the registered nurses in this study described the increase in sick leave during the pandemic, which in turn increased their workload. Turnover among registered nurses is a known challenge to achieving continuity in municipal health care, according to Swedish reports (Janlöv et al., 2023; National Board of Health and Welfare, 2023a, 2023b). Furthermore, this challenge became more formidable during the pandemic, with increased sick leave and increased stress among registered nurses working in home health care (Karakaya & Uçar, 2023; Tarvis et al., 2022). The pandemic may have accelerated turnover among healthcare professionals (Poon et al., 2022). Improvements in the work environment for the benefit of registered nurses should therefore be prioritized, as it could in turn improve the continuity of care for patients in the MICM.

Continuity of care in the current person-centered and integrated national reform has been defined as patients having a designated physician (SALAR, 2022), which the MICM provides (Norén & Segerberg, 2019). However, during the initial data collection period, some patients were concerned about the lack of relationships with their physician MICM. Concerns over the lack of physician contact among the patients were in some cases justified, especially with regard to the perceived lack of continuity by patients and their next of kin. Some had never met their physician, or had met with their physician once over a six-month period. The experience of continuity among patients and their next of kin was thus not aligned with the definition of continuity given in the national reform. Had the participating group of patients been admitted for longer than six months, their experiences might have been different. In contrast, registered nurses and physicians both described improved continuity with patients, which has been expressed as challenging in other health care settings such as primary health care (Janlöv et al., 2023; Swedish Agency for Health and Care Services Analysis, 2023:3). Differences in these experiences of continuity may be attributable to weekly rounds by
registered nurses and physicians, in which patients did not participate. While the patients did receive designated physicians with whom their registered nurses communicated, they did not meet with them as frequently as the registered nurses.

The registered nurses, patients and their next of kin, and even physicians themselves stated that physicians lacked the time needed to effectively provide health care, which in turn adversely impacted their visits with patients. Home visits were postponed, canceled or rushed. Thus, physicians need more time to focus on their patients in home health care in order to improve the MICM, an observation already made in previous research (Abass, 2022). Employing home healthcare physicians full-time or hiring more home healthcare physicians could improve the continuity of care for older patients in the MICM and potentially also strengthen relationships between patients and physicians.

While the experience of continuity in relationships between healthcare professionals and patients varied, relationships with assistant nurses were notably consistent. Previous research has described how friendships can be created between patients and assistant nurses (Lam & Baxter, 2023). Although assistant nurses were not included in the data collection for this project, all participants viewed them to be central to the MICM. Therefore, assistant nurses may be of significance to future research in this area.

To be seen as a person and not only a patient

Patients in this study experienced to have relationships with healthcare professionals that allowed them to share their personal narratives – a crucial part in initiating partnerships in person-centered care (Britten et al., 2020; Ekman et al., 2011). The findings revealed that building relationships was connected to the ability of the healthcare professionals to acknowledge patients as a person by engaging them in conversations about other subjects. These findings are in line with previous research conducted in Sweden and the United Kingdom (Corbett & Williams, 2014; Olsen et al., 2022; Åberg et al., 2020). For example, the findings demonstrated that registered nurses and physicians avoided home visits during the COVID-19 pandemic, which consequently led to health care becoming need-oriented rather than person-centered and based on relationships. Another example is how much home
visits benefit physicians and registered nurses by allowing them to gather more information about their patients. Seeing patients as a person is an essential principle of person-centered care (Britten et al., 2020; Ekman et al., 2011) and is thus aligned with the current national reform, which is person-centered and focused on the provision of integrated care via the MICM.

8.2.2. Differences in the provision of health care

Differences in the provision of health care in the MICM among participating municipalities, as well as in comparison to other healthcare organizations, were noted. These differences can be viewed in light of equality in health care according to Swedish law (Swedish Code of Statues, 2017:30) as well as with respect to the third part of person-centered care ethics – *just institutions* (Ekman, 2022). Both the Swedish law and person-centered care have relevance to the provision of health care in the MICM (Bradbury & Lifvergren, 2016; Norén & Segerberg, 2019) and in the national reform – person-centered and integrated care (SALAR, 2023).

The provision of health care is dictated by primary health care

Differences in the provision of health care within the different municipalities that had implemented the MICM were attributed by the participants to primary health care. Similar findings were reported in a previous study on the MICM (Abass, 2022). One example of this is how physicians perceived that the allocation of resources differed in different municipalities, which could be extended to explain the varying percentages of physicians working in the MICM. Time was frequently noted by physicians as an important resource, with some stating they had sufficient time, while others desired more work hours in the MICM. The number of work hours allocated to physicians is ultimately dictated by individual primary healthcare centers. Differences between municipal MICMs could be related to *just institutions* in person-centered care. *Just institutions* refer to the capacity of the healthcare system to ensure the fair and appropriate provision of health care (Ekman, 2022). This suggests that some municipal MICMs would need to improve to be considered just institutions. Differences were also observed in the structure of the MICM (Norén & Segerberg, 2019) which allowed for various interpretations of the role of the home healthcare physicians. Municipalities rely on primary
healthcare centers for physician support (Government Offices of Sweden, 2020:142), despite the overall lack of physician support at both the municipal and national levels (SALAR, 2021a; Swedish Agency for Health and Care Services Analysis, 2023:3). To ensure continuous health care for older patients at home, registered nurses and physicians requested that they belong to a single organization, which could possibly be achieved in several different ways as per previous research. One option is for the national government to assume responsibility for all health care. Another option is for municipalities to assume responsibility for primary healthcare centers (Enlund, 2020). Yet another option would be to allow municipalities to employ their own physicians (Lillsjö et al., 2023), which is currently being investigated (Government Offices of Sweden, 2023:98).

Differences in resources in the provision of health care for older patients

Differences were observed in the provision of health care in the MICM compared to other healthcare organizations, according to both physicians and patients. Several countries are currently enacting changes in the structure of their provision of primary health care, similar to the current reform in Sweden. One scoping review of studies from 15 countries recognized how these changes most frequently include multidisciplinary teams (Henderson et al., 2023). This finding is in line with the structure of the MICM. The review also found that health inequalities from the patients’ perspective were only addressed in a minority of cases, with a lack of knowledge about inequality for older persons in changes to primary health care was argued in the scoping review. This thesis has contributed insights via the perspectives of participants. In person-centered care, a just institution occurs when each patient, each next of kin and each healthcare professional senses justice at a fundamental level (Ekman, 2022). Physicians and patients who experience injustice in comparison to other healthcare organizations could indicate that to have the preconditions to strive to improve person-centered care in the health care system must continue.

Quality health care on equal terms for the entire population has been enshrined in a Swedish law regulating health care (Swedish Code of Statutes, 2017:30). In a previous Norwegian study, inequalities experienced by older persons in
terms of access to health care were found (Kvæl & Gautun, 2023). During the COVID-19 pandemic, older patients and healthcare professionals were often overlooked while other groups were prioritized (Bianchetti et al., 2020; Cesari & Proietti, 2020; Ghezeljeh et al., 2022). In contrast to this research, some physicians have expressed the benefit of patients admitted to MICM in receiving health care in the home compared to patients at the primary health care center. Other physicians have claimed that patients admitted to primary healthcare centers have more advantages than those admitted to the MICM. For example, patients admitted to the MICM often lack access to medical equipment easily available to patients at primary healthcare centers. At the national level, those with the greatest need for health care are prioritized over those whose need is not as severe, according to Swedish law (Swedish Code of Statues, 2017:30). As many older patients have complex and extensive needs, they should receive additional healthcare resources.

8.2.3. **Teamwork is the dreamwork**

Collaborations between several professionals is vitally important to the provision of high-quality care and is a central aim of the MICM (Norén & Segerberg, 2019). Collaboration and teamwork in the MICM are important to discuss since coherent health care through cross-organizational collaborations is one of the goals of the MICM. Furthermore, collaborations have been a recurring theme in definitions of integrated care (Zonneveld et al., 2018) demonstrating their significance.

**Collaborations between registered nurses and physicians in the provision of home health care**

Teamwork in the MICM between municipally registered nurses and home healthcare physicians employed by primary healthcare centers was the most prominent collaboration. The nurses stated having difficulties remembering how they worked prior to the implementation of the MICM and their collaborations with home healthcare physicians. They could not imagine working any other way. Teamwork such as this is in line with the second part of person-centered care ethics: *aiming for a good life with and for others* (Ekman, 2022). For the registered nurses, the accessibility and continuity of care that accompanied teamwork with a home healthcare physician improved their work satisfaction, a finding also
provided in previous research on cross-organizational collaborations (Park et al., 2014; Watanabe et al., 2023). However, cross-organizational collaborations have previously been regarded as posing challenges to medical decisions made by older patients, which are attributable to difficulties in information sharing and miscommunication (Lillsjö et al., 2023; Modin et al., 2009; Vatnøy et al., 2019). In contrast, other research on physicians working in home health care during the COVID-19 pandemic demonstrated that they were still able to focus on the core tasks of health care (Wachtler et al., 2023). However, the pandemic did negatively influence teamwork in the MICM as communications were made by telephone or video calls, consequently leading to misunderstandings. Collaborations were also adversely impacted by lack of access to patients’ medical records between different organizations, culminating in concerns over missed information as well as deep frustration. Similar challenges have been identified in previous integrated care models (Grol et al., 2021; Ploeg et al., 2019). Thus, one solution would be to provide home healthcare physicians and registered nurses with all medical records they need to more effectively provide quality care to patients.

The physicians had different perceptions about their role in the team – i.e. as a spider in a web or as a consultant. The registered nurses also felt that they were at the center of the MICM. The roles of team members in the MICM could therefore be considered to be not fully defined. Previous research on teamwork in integrated care has argued that establishing clear roles for each team member is crucial for successful collaborations (Asakawa et al., 2017; Carrigan et al., 2023; Montano, 2020). However, regardless of differences in their perception of their roles, both registered nurses and physicians expressed that they had trusting relationships with each other, made possible by the structure of the MICM. They also noted how much time it took to build trusting relationships and yet how crucial they were to providing quality health care in cross-border organizational collaborations, a finding in line with prior research (Kirst et al., 2017; Lillsjö et al., 2023; Modin et al., 2009; Vatnøy et al., 2019). Previous research on teamwork in integrated care (Eika & Hvalvik, 2022; Grol et al., 2021; Montano, 2020) also reported results aligned with the experiences of the physicians in this study, who expressed the desire for physical proximity, shared educational experiences and teambuilding with the registered nurses. Building relationships between healthcare professionals in
cross-organizational collaborations such as the MICM requires changes in the structure of work. There is also a need for healthcare organizations to value registered nurses and physicians by giving them more time, continuity, proximity and teambuilding experiences as a possible way to continue to improve teamwork.

**Teamwork with several healthcare professionals**

Being part of an integrated care team was experienced by the registered nurses and physicians as belonging to something larger than themselves or their professions, a perception in line with previous research on integrated care teams internationally (Aerts et al., 2020; Asakawa et al., 2017; Singh et al., 2018). Working in teams was viewed as the best way to work with older patients with complex care needs since quality health care from several professionals was accessible according to the registered nurses and physicians. These findings are in line with previous research on integrated care models (Bradbury & Lifvergren, 2016; Mateo-Abad et al., 2020; Trankle et al., 2020; Törnfelt et al., 2021). However, the registered nurses also noted how they wanted physicians to participate in teamwork with other professionals more often. Some physicians regularly met with all of the healthcare professionals within their municipality, while others mainly collaborated with registered nurses. During the COVID-19 pandemic, team meetings between registered nurses and other municipal healthcare personnel were held through video meetings or were cancelled. Viewed in light of the second part of person-centered ethics – *aiming for a good life with and for others* (Ekman, 2022) – collaborations with other professionals were seen as lacking and could thus be improved in the MICM. Teamwork in the MICM was understood to be multidisciplinary in nature, with team members having one professional with whom they communicated regularly (Mandy, 1996). Both registered nurses and physicians desired to be employed by the same organization, as they expressed how this would increase the likelihood of creating interdisciplinary teams in which different professionals could collaborate and communicate (Körner, 2010; Sheehan et al., 2007) and make joint decisions for patients (Sheehan et al., 2007). While the physicians found working as a home healthcare physician to be enjoyable, the role was also perceived as lonely without colleagues with whom they could discuss.
Physicians employed at the municipal level would therefore likely benefit from collegial exchanges, a topic that should be explored in future research.

8.2.4. The influence of the MICM on patient participation

The participants stated that certain structures in the MICM influenced patient participation, which is a right according to Swedish law (Swedish Code of Statues, 2014:821) and one of the goals of the MICM (Norén & Segerberg, 2019). The provision of the MICM at home increased the possibility for patients to participate in their own health care, but could also lead to a loss of control. There is a current political direction of providing health care for older persons at home which is currently conducted (Swedish Government Official Reports, 2017:21). The home is therefore important arena in relation to the health care provided in the MICM.

Hierarchy’s influence on participation

Some of the patients experienced a loss of autonomy when they felt they could not participate in their own health care, such as having symptoms ignored or not being allowed to manage their own medications. These findings are in line with previous research on older patients who expressed a loss of autonomy when not being invited to participate (Lothian & Philp, 2001; Sánchez-García et al., 2019). However, the physicians viewed it as essential for patients to have the autonomy to make decisions themselves. The structure of the MICM was experienced as hierarchical, such as when physicians described being the medical authority who at times disregarded patients’ wishes in favor of medical safety. There is thus a need for hierarchy in the MICM. The sense of hierarchy among the patients and their next of kin could however be lessened by permitting patients to participate in the planning of the provision of their health care. Collaborating when making healthcare plans is part of the MICM and is aligned with principles of person-centered care (Britten et al., 2020; Ekman et al., 2011; Ekman et al., 2015; Gyllensten et al., 2020) the value base of the MICM. According to the registered nurses and physicians, medical healthcare plans are created in collaboration with their patients. However, none of the patients could recall participating in the creation of their medical healthcare plan. Participation in such plans is a right according to Swedish law.
(Swedish Code of Statues, 2014:821) and is one of the goals of the MICM in need of improvements.

Patients and their next of kin experienced a lack of information about what the MICM was and expressed the desire to have access to their medical records, which could be related to the description of cognitive disadvantages presented in person-centered care (Kristensson Uggla, 2020) and can be viewed as an obstacle to strive for improving person-centered care in the MICM. To strive for improving person-centered care, it has been argued that systematic organizational changes at all levels are required (Rosengren et al., 2021; Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2017; Silverglow et al., 2022) since documentation systems in health care are rarely designed to include the patients’ perspectives (Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2017) and even less so to involve patients in documentation (Ebrahimi et al., 2021). Providing patients access to all of their medical records should also be prioritized since it is their legal right (Ministry of Health and Social Affairs, 2008:355; Swedish Code of Statues, 2017:30).

The structure that led to the hierarchy experienced by participants in this study could potentially hinder the strive for person-centered care (Ekman, 2022; Kristensson Uggla, 2020). Such institutional disadvantages could be understood by patients in the MICM as gatekeeping by healthcare professionals. Gatekeeping filters patient flow (Forrest, 2003) through prioritization based on clinical assessments (Suhonen et al., 2018). Patients and their next of kin experienced healthcare personnel as gatekeepers for professionals who were higher in the structural hierarchy. There were also concerns among the patients and their next of kin about being allowed to seek out medical advice outside the MICM, which could be considered a form of gatekeeping from other healthcare organizations. Gatekeeping in health care has previously been researched in other healthcare contexts (Brekke et al., 2007; Christensen et al., 2023; Fry & Stainton, 2005; Holmström & Dall'Alba, 2002; Purc-Stephenson & Thrasher, 2010; Sripa et al., 2019). However, few studies exist on gatekeeping in home healthcare, therefore providing an interesting opportunity for further studies in this area.
The home as an arena for participation

Providing health care within patients’ homes was described as allowing for increased patient participation. The registered nurses experienced being a guest in the workplace, and since the provision of health care was in the patient’s home, it improved the likelihood of patients participating. The physicians stated that providing health care in patients’ homes added a unique dimension to the provision of health care. Patients also appeared to be more compliant concerning health and medical advice when at home. When the narratives of patients and their next of kin served as the driving force in the provision of health care at home, it initiated a person-centered partnership (Ekman et al., 2011). Furthermore, providing health care at home was equated to spending less time travelling to healthcare centers and was associated with an overall easier daily life for patients and their next of kin. The importance of the home supports previous research that has argued that physicians conducting home visits to patients are able to understand their everyday lives in a broader sense (Modin et al., 2010). The isolation of older patients in their homes during the COVID-19 pandemic was noted by registered nurses and physicians, in line with previous research (Dunford & Brooke, 2022; Johansson-Pajala et al., 2022; Parlapani et al., 2021; Sørbye et al., 2022; Zaninotto et al., 2022). The home is therefore considered especially important for older patients during crisis situations since they are likely to be confined to their homes to a greater extent.

While the providing health care in the home increased the possibility of participation, some patients experienced becoming passive in their own health care when being ignored or having their will disrupted during the meeting with health care professionals in their home. Receiving health care within homes can potentially increase the sense of power – and powerlessness – among older patients (Gillsjö et al., 2011; Kristensson et al., 2010). The sense of powerlessness may be connected to person-centered care and how caring for another person renders them passive (Britten et al., 2020; Ekman et al., 2011; Gyllensten et al., 2020; Schuster, 2006). Patients becoming passive has been observed in other studies, in which patients felt a loss of control when being ignored or having their will disrupted while meeting with healthcare professionals in their home. In previous research, a sense of control was argued to be crucial for older patients receiving home health care (Nyende et
al., 2023; Olsen et al., 2022), whereas a loss of control and lack of participation adversely influenced their sense of safety (Silverglow et al., 2021). Finding ways to encourage patients to be more active parties to their own health care in the MICM should therefore be a priority in the strive to improving person-centered care.
9. Conclusion

This thesis provides knowledge about the expectations, perceptions and experiences of registered nurses, physicians, patients and their next of kin about the MICM. Furthermore, it provides unique insights into an integrated care models during a crisis situation.

The healthcare professionals expressed how the MICM was the best way to work in home health care, and patients and their next of kin expressed a sense of relief when being admitted to the MICM. Continuity and seeing the patient as a person was vital to building trusting relationships in the MICM. The physicians and registered nurses expressed increased continuity of care since the implementation of the MICM. For patients and their next of kin, there were variations in the experiences of continuity. Building relationships with patients and their next of kin was connected to being in the homes of patients and the capacity of healthcare professionals to view patients as persons. These realizations could be seen as initiating partnerships in person-centered care. In the MICM and in the current national reform – person-centered and integrated care – person-centered care is the value base. Continuing to aim for continuity and building relationships to strive to improve person-centered care is therefore preferable.

Differences in the provision of health care provided in the MICM in the different municipalities were understood to result from organizational prioritization of individual primary healthcare centers and individual physicians working in the MICM. These differences were possible in the structure of the MICM as regulations require physicians to work in municipal home health care, but not to what extent. The participants compared the provision of the MICM to other healthcare organizations. Some physicians expressed advantages for patients in the MICM, while others expressed the opposite. Those with the greatest need for health care should be prioritized over those who have less need, according to Swedish law. This may indicate that since older patients have complex and extensive needs, they should receive additional health care resources. Therefore, the implementation of the MICM with a focus on older persons with extensive healthcare needs is in line with Swedish law concerning the provision of equal health care.
Teamwork was the dreamwork of the MICM, in which collaborations occurred between registered nurses and home healthcare physicians. It took time to build trusting relationships, in which in-person meetings and continuity of care were considered crucial. Collaborations between several professionals was described by the participants as vital to providing high quality care, for which the MICM is aimed. It was, however, rare for home healthcare physicians to participate in teamwork with professionals other than registered nurses. The healthcare professionals desired to be employed by the same organization. Such a change could increase the likelihood of creating interdisciplinary teamwork with different professionals through a high level of collaboration and communication. However, physicians working as a home healthcare physician may lack collegial support if employed by the municipality.

There were structures in the MICM that influenced patient participation – a legal right and one of the goals of the MICM – both positively and negatively. The structure of the MICM was described as hierarchical and was understood by patients as gatekeeping by healthcare professionals, especially with respect to access to medical records. Providing such access to patients should be prioritized, as should the provision of health care within patients’ homes, a positive advantage of the MICM which encourages patients to recount their narratives and stimulate the initiation of the person-centered partnership. Patients’ homes were considered to be central during the COVID-19 pandemic since the patients were confined there due to pandemic-related restrictions. The physicians and registered nurses both stated that being in the patients’ homes gave them unique insights into patients’ situation in the context of their home. The patients and their next of kin were relieved to not have to travel as much to healthcare centers and to receive health care at home.

This thesis was composed during the COVID-19 pandemic, providing unique insights into an integrated care model during a crisis situation, which the health care system will likely face in similar or different ways in the future. The MICM was hailed as the best way to work in home healthcare, with patients and their next of kin noting how it made their lives easier. The suggested improvements to the MICM outlined below are therefore meant to further develop an already appreciated integrated care model and to prepare it for future crisis situations.
10. Relevance and clinical implications

- The MICM was considered to be the best way to work in home health care. To continue to provide health care in the form of the MICM would be preferable.

- Building trusting relationships is central to the provision of care and is especially important in crisis situations. Developing trusting relationships can be accomplished by prioritizing the continuity of care. Integrated care models require resources in the form of time to build relationships and establish the continuity of care.

- The provision of health care provided in the MICM differed in different municipalities, which was likely attributable to the current structure of the MICM. Clearer guidelines about the roles of home healthcare physicians can increase collaborations between primary healthcare centers and could decrease differences in the provision of health care provided in the MICM.

- Teamwork is the dreamwork in the MICM and is central to providing quality health care. Belonging to the same organization could benefit collaborations and increase access to information. However, physicians may lack collegial support if employed by the municipality.

- The structure of the MICM was experienced as hierarchical. Providing patients with access to their medical records and engaging them in the development of their healthcare plan should be prioritized.

- Partnerships in person-centered care could be facilitated in informal settings such as the home of the patient. Homes could thus serve as an important arena in which to strengthen patient narratives in the pursuit of person-centered care. Patients’ homes become even more central in crisis situations that require isolation, such as the COVID-19 pandemic.
11. Future research

- Assistant nurses were considered to be those who knew the patients best and with whom the patients and their next of kin experienced the greatest continuity of care. As assistant nurses did not participate in this project, future qualitative studies could include them concerning integrated home health care.

- Differences in the provision of health care in the MICM implemented in different municipalities and in comparison, to other healthcare organizations, were described as potentially leading to inequalities and injustice. This issue warrants further research attention in integrated health care and in the context of the current national reform regarding person-centered and integrated care.

- There was a clear desire for registered nurses and physicians to be employed by the same organization in order to continue to build on the dreamwork of teamwork. Several approaches have been suggested to fulfil this desire, with each offering its own benefits in terms of both qualitative and quantitative research in the future and with respect to guidance for decision makers.

- Gatekeeping in home healthcare, previously studied in other contexts, was also found in the current study. Insights related to the hierarchical structures within the MICM merit further qualitative research due to their potential influence on the sense of autonomy and participation experienced by patients and their next of kin, as well as on the working conditions of healthcare personnel in integrated home health care.

- This thesis contributes knowledge about person-centered care in integrated care models. To further expand such knowledge, a deductive analysis based on experiences of person-centered care within an integrated home care model could be performed. This research could be of value for the MICM, the Swedish national reform pertaining to person-centered and integrated care, and several integrated care models with the same central values.
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Appendix 1

Appendices

Appendix 1.

Semi-structured interview guide – registered nurses and home healthcare physicians

Demographic data: Age, gender, profession, active years within the professions, previous professions?

*Tell me about your experiences/perceptions of providing health care in the mobile integrated care model.

*How do you experience/perceptions collaboration with assistant nurses, home healthcare professionals, registered nurses and home healthcare physicians.
  *Is there anything you would like to change? If so, what?

*What support can you give patients and their next of kin in their daily lives?
  *How is health and well-being supported (physical, psychological, social)?
  *How is meaningfulness supported in the care provided?
  *How is autonomy supported in the care provided?
  *How are the patients’ own abilities supported in the care provided?

*In what way do you adjust your care towards the needs of patients and their next of kin?
  *What does it look like?
  *How could it be improved?

*In what way do you encourage participation by patients and their next of kin in the health care you provide?
  *What does it look like?
Appendix 1

*How could it be improved?

*How are patients and their next of kin involved in developing health care?
  *What does it look like?
  *How could it be improved?

*What ethical aspects can you see in the health care provided to the patients and their next of kin surrounding participation?
  *What does it look like?
  *How could it be improved?

*How do you experience/perceive the quality of the health care provided?
  *How do you perceive the work with maintaining and developing the quality of care?

*What do you do to make patients and their next of kin feel safe?

*Describe what you do to make patients feel better and enhance their well-being? Feeling at home within the home?

*What effect do you think the mobile integrated care model has on the patients’ and next of kin’s sense of well-being? Home?

*Are there correlations between the sense of home and the sense of well-being? *In what way?

Question added in the third phase of data collection, with the resulting data incorporated in Paper III.

*What effect has the COVID-19 pandemic had on your work in the mobile integrated care model?
Appendix 2

Semi-structured interview guide – patients before meeting the home healthcare physician

**Demographic data:** Age, gender, marital status, professional life, social situation and social service – how long, to what extent, and which service? Home health care – how long, to what extent, which type of health care, pharmacy list?

**Describe why you are using the mobile integrated health care model with a home healthcare physician.**

**Describe your thoughts about using the mobile integrated health care model with a home healthcare physician.**

- Expectations/apprehension surrounding the mobile integrated health care model with a home healthcare physician?
- What experiences did you have of health care previously (within/outside of the home)?

**What support do you hope to gain from the mobile integrated health care model with a home healthcare physician in daily life?**

- How can your health and well-being (physical, psychological, social) be supported?
- How can your sense of meaningfulness in life be supported?
- How can your participation and autonomy be supported?
- How can your integrity be supported?
- How can your own ability be supported?

**Describe your sense of safety in your life.**

- What makes you feel safe?
Appendix 2

- How do you expect your sense of safety to be influenced by the mobile integrated health care model with a home healthcare physician?

Describe what significance your home has to you. What is a home to you?

Describe your sense of home within your home.

- What in your home has meaning to you for your sense of home within your home?
- To what extent do you feel at home in your home?

Describe your sense of well-being in your home.

- What in the home is of significance for your sense of well-being?
- To what extent do you feel well-being in your home?

Do you experience a sense of loneliness in your home?

- If yes – is the loneliness self-chosen? Involuntary? Possibilities to influence?

What are your thoughts on using digital tools in daily life and in contact with healthcare providers?

- Expectations and apprehensions?

To what extent are you using digital tools in your everyday life?

How has your life changed during the COVID-19 pandemic?

Did COVID-19 influence your health care before using the mobile integrated health care model with a home healthcare physician?

- If yes, in what way?
Appendix 3

Semi-structured interview guide – next of kin before meeting the home healthcare physician

**Demographic data:** Age, gender, marital status, professional life, social situation, social service for relatives – how long, to what extent, and which service? Home health care – how long, to what extent, and which type of health care?

**Describe why your relative is using the mobile integrated health care model with a home healthcare physician.**

**Describe your thoughts about your relative using the mobile integrated health care model with a home healthcare physician?**

- Expectations/apprehension surrounding the mobile integrated health care model with a home healthcare physician?
- What experiences did you have of your relative’s health care previously (within/outside of the home)?

**What support do you hope your relative will receive from the mobile integrated health care model with a home healthcare physician in their daily life?**

- How can their health and well-being (physical, psychological, social) be supported?
- How can their sense of meaningfulness in life be supported?
- How can their participation and autonomy be supported?
- How can their integrity be supported?
- How can their own ability be supported?
- How can your well-being as next of kin be supported?
Appendix 3

Describe your sense of safety in your life in relation to your relative’s health care.

- What makes you feel safe?
- How do you expect your sense of safety to be influenced by your relative receiving health care through the mobile integrated health care model with a home healthcare physician?

Describe what significance your home has to you. What is a home to you?

Describe your sense of home within your home.

- What in your home has meaning to you for your sense of home within your home?
- To what extent do you feel at home in your home?

Describe your sense of well-being in your home.

- What in the home is of significance for your sense of well-being?
- To what extent do you feel well-being in your home?

Does your relative experience a sense of loneliness in their home?

- If yes, is the loneliness self-chosen? Involuntary? Possibilities to influence?

What are your thoughts about using digital tools in daily life and in contact with healthcare providers?

- Expectations and apprehensions?

To what extent are you using digital tools in your everyday life?

How has your contact with your relative changed during the COVID-19 pandemic?

Did COVID-19 influence your relative’s health care before using the mobile integrated health care model with a home healthcare physician?
Appendix 3

- If yes, in what way
Appendix 4

Appendix 4

Semi-structured interview guide – patients six months later

**Demographic data:** Age, gender, marital status, professional life, social situation, social service – how long, to what extent, and which service? Home health care – how long, to what extent, which type of health care, which type of medical healthcare plan, pharmacy list?

**Describe your experiences of the mobile integrated health care model with a home healthcare physician.**

- How is the help you are receiving working? Social care? Home health care (registered nurse)? Home healthcare physician?
- What significance does the mobile integrated health care model with a home healthcare physician have for your life? What influence?
- Is there anything you would like to change?

**What support do you receive from the mobile integrated health care model with a home healthcare physician in daily life?**

- How is your health and well-being (physical, psychological, social) supported?
- How is your sense of meaningfulness in life supported?
- How is your participation and autonomy supported?
- How is your integrity supported?
- How is your own ability supported?
- How is your next of kin supported?
Appendix 4

In what way is the health care you receive adapted to your needs? What can be improved?

In what way do you participate in the health and social care you are receiving? What can be improved?

Describe your experiences of meeting the home healthcare physician and registered nurse.

- Have any other professionals participated? Which? Experiences?

Describe your experiences of meeting where the medical healthcare plan was created?

- Who participated?
- Describe your participation in the creation of the medical healthcare plan.
- To what extent do you feel the medical healthcare plan is being followed?
- If there are no medical healthcare plan, why?

How do you experience the quality of health care provided by the personnel in the mobile integrated health care model with a home healthcare physician?

- Personnel – home healthcare physician, registered nurse, physiotherapist, occupational therapist, assistant nurse delegated to provide health care.
- What can be improved in the quality of care you are receiving?

Describe the significance of receiving health care within your home via the mobile integrated health care model with a home healthcare physician.

What influence has the mobile integrated health care model with a home healthcare physician had on:
Appendix 4

- Your sense of home? How is your sense of home supported by the health care received? What can be improved?
- Your sense of well-being? How is your sense of well-being supported by the health care received? What can be improved?
- Your sense of loneliness? How is your sense of loneliness alleviated by the health care received? What can be improved?
- Your sense of safety? How is your sense of safety supported by the health care received? What can be improved?

To what extent are you currently using digital tools in your everyday life as opposed to before you were receiving health care via the mobile integrated health care model with a home healthcare physician?

- Which digital tools have been used in your daily life and what healthcare contacts have you made since your involvement in the mobile integrated health care model with a home healthcare physician?
- What are your experiences of the digital tools used to support healthcare contacts and the health care you receive in the mobile integrated health care model with a home healthcare physician?

What was it like answering questions with a digital tool during the data collection of this study?

Has your view of digital tools changed?

- If yes, in what way? What can be improved?

To what extent has COVID-19 influenced the health care you receive via the mobile integrated health care model with a home healthcare physician?

- In what way?
Appendix 5

Semi-structured interview guide – next of kin six months later

Demographic data: Age, gender, marital status, professional life, social situation, social service – how long, to what extent, and which service? Home health care – how long, to what extent, which type of health care, which type of medical healthcare plan?

Describe your experiences of your relative using the mobile integrated health care model with a home healthcare physician?

- How is the help they are receiving working? Social care? Home health care (registered nurse)? Home healthcare physician?
- What significance does the mobile integrated health care model with a home healthcare physician have for your life? What influence?
- Is there anything you would like to change?

What support do you and your relative receive from the mobile integrated healthcare model with a home healthcare physician in daily life?

- How is your relative’s health and well-being (physical, psychological, social) supported?
- How is your relative’s sense of meaningfulness in life supported?
- How is your relative’s participation and autonomy supported?
- How is your relative’s integrity supported?
- How is your relative’s own ability supported?
- How are you supported?
Appendix 5

In what way is the health care you receive adapted to your relative’s needs? What can be improved?

In what way is the health care received in the home adapted to your needs? What can be improved?

In what way does your relative participate in the health and social care you are receiving? What can be improved?

In what way do you participate in the health and social care you are receiving? What can be improved?

Describe your experiences of meeting the home healthcare physician and registered nurse.

- Have any other professionals participated? Which?
- Experiences?

Describe your experiences of meeting where the medical healthcare plan was created?

- Who participated?
- Describe your participation in the creation of the medical healthcare plan.
- To what extent do you feel that the medical healthcare plan is being followed?
- If there are no medical healthcare plans, why?

How do you experience the quality of health care provided by personnel in the mobile integrated healthcare model with a home healthcare physician?

- Personnel – home healthcare physician, registered nurse, physiotherapist, occupational therapist, assistant nurse delegated with providing health care.
- What can be improved in the quality of care you are receiving?
Appendix 5

Describe the significance of receiving health care within your home via the mobile integrated healthcare model with a home healthcare physician?

What influence has the mobile integrated healthcare model with a home healthcare physician had on:

- Your sense of home? How is your sense of home supported by the health care received? What can be improved?
- Your sense of well-being? How is your sense of well-being supported by the health care received? What can be improved?
- Your sense of loneliness? How is your sense of loneliness being alleviated by the health care received? What can be improved?
- Your sense of safety? How is your sense of safety supported by the health care received? What can be improved?

What influence has the mobile integrated healthcare model with a home healthcare physician had on your relative:

- Your relative’s sense of home? How is your sense of home supported by the health care received? What can be improved?
- Your relative’s sense of well-being? How is your sense of well-being supported by the health care received? What can be improved?
- Your relative’s sense of loneliness? How is your sense of loneliness being alleviated by the health care received? What can be improved?
- Your relative’s sense of safety? How is your sense of safety supported by the health care received? What can be improved?
Appendix 5

To what extent are you currently using digital tools in your everyday life as opposed to before your relative was receiving health care via the mobile integrated healthcare model with a home healthcare physician?

- Which digital tools have been used in your daily life and which healthcare contacts have you made since using the mobile integrated healthcare model with a home healthcare physician?
- What are your experiences of the digital tools used to support healthcare contacts and the health care you receive via the mobile integrated healthcare model with a home healthcare physician?

What has it been like answering questions with a digital tool during the data collection of this study?

Has your view of digital tools changed?

- If yes, in what way? What can be improved?

To what extent has COVID-19 influenced the health care you receive via the mobile integrated healthcare model with a home healthcare physician?

- If yes, in what way?