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Health and social care management for older adults with multimorbidity: a multiperspective approach

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Health and social care management for older adults with multimorbidity: a multiperspective approach

Multimorbidity, a condition common among older adults, may be regarded as a failure of a complex system. The aim of this study was to describe the core components in health and social care management for older adults with multimorbidity. A cross-sectional design included two methods: individual interviews and group discussions. A total of 105 participants included older adults with multimorbidity and their relatives, care staff and healthcare policymakers. Data were analysed using content analysis. The results show that seven core components comprise a multiperspective view of health and social care management for older adults with multimorbidity: political steering, leadership, cooperation, competence, support for relatives, availability and continuity. Steps should be taken to ensure that every older adult with multimorbidity has a treatment plan according to a multiperspective view to prevent fragmentation of their health care. This study provides relevant evidence developing a multiperspective model of health and social care management for older adults with multimorbidity.

Keywords: health care, management, multimorbidity, multiperspective, older adults, social care.

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Introduction

The ageing rate is increasing, and it is estimated that by 2050 the global proportion of the population 60 years or older will be 21% (1). The growing number of older adults with multimorbidity has been reported on a worldwide scale (2, 3). The prevalence of multimorbidity among adults 65 years and older ranges from 55 to 98% (4). Although there are varying definitions of chronic multimorbidity, a common definition is the presence of two or more chronic health problems in an individual (4, 5).

Multimorbidity is associated with adverse consequences including disability and functional decline, great institutionalised use of healthcare resources, poor quality of life, death and high healthcare costs (2–4, 6). Despite their suffering from multimorbidity, there is evidence that older adults with multimorbidity hold positive attitudes towards life and that they try to maintain their social role and preserve their autonomy to the greatest extent possible (7). At an emotional level, these patients vacillate between strength and anxiety; at a practical level, they focus on keeping their diseases under control (7).

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Consequences of multimorbidity mean that health care today is largely dedicated to the assessment and management of multiple and chronic diseases (5). Meeting the needs of coordinating such health care presents a significant challenge. The World Health Organization (8) underlined the importance of organising healthcare delivery systems to improve health outcomes and stressed the importance of healthcare management to address chronic disease management. Despite this, there is limited evidence supporting specific interventions for older adults with multimorbidity (2). Care for those with chronic diseases is not sufficiently proactive to prevent the multimorbidity or to avoid emergency care (5). Thus, multimorbidity may be regarded as the failure of a complex system (5).

Asplund and Sahlin (9) stressed that the risks and benefits of treatment for the oldest and most fragile patients are largely unclear and that the balance of scientific evidence is just as fragile as the care recipients themselves. At the same time, it is difficult to conduct research with populations that have complex problems. A review of interventions for improving outcomes in multimorbidity patients by Smith et al. (2) indicated that it is difficult to improve outcomes in this population. Thus, there is a need for further pragmatic studies and a shift in the healthcare management approach (5).

It is therefore important to describe the core components of health and social care management for older adults with multimorbidity from the perspectives of care recipients, their relatives, care staff and healthcare policymakers.

Aim

The aim was to describe the core components of a multiperspective view of health and social care management for older adults with multimorbidity.

Materials and methods

Design

The study was performed during 2011 using a cross-sectional design with two methods: individual interviews (10) and group discussions (11). Data were analysed using content analysis (12). The study was approved by the Regional Board of Research Ethics, Uppsala (Dnr 2010/099).

Setting and sample

In Sweden, there are three political assemblies: the municipal, county council or regional assembly, and the national parliament (13). The political steering for health and social care is governed by two main laws: the Health and Medical Services Act and the Social Services Act.

The setting was a medium-sited town in an urban area of Sweden. The sample included 105 participants (Fig. 1) who gave informed consent to participate. To reach a multiperspective understanding of older adults with multimorbidity, the sample included care recipients (n = 20), their relatives (n = 13) and the chairperson of the Relatives Association (n = 1), direct care staff (n = 41) and healthcare policymakers (n = 30) who were involved with planning and providing healthcare services for older adults with multimorbidity.

The care recipients were selected using the registry systems at local hospitals. Inclusion criteria were age 75 years or above, being hospitalised three or more times in the previous 3 months, and having three or more diagnoses in their medical record according to the Swedish version of the International Statistical Classification of Diseases and Related Health Problems (ICD-10-SE). In total, 249 care recipients met these inclusion criteria and 10% of those identified were randomly selected and invited to participate. Of the 25 care recipients invited, 20 participated; the remaining five did not participate because of hospitalisation or transfer to a nursing home, or because they declined.

Thereafter, care recipients were contacted by letter and after that by phone by one of the investigators. The care recipients (n = 20) were 11 men and nine women, with a mean age of 79 years (range, 76–83 years). They had three to nine medical diagnoses (mean = 4.5). The care recipients lived alone (n = 9) or with their spouses (n = 11).

The relatives (n = 13) were selected by the care recipient who were asked whether they had a relative who was important to their health and care and was familiar with their situation. The relatives, 10 women and three men, were contacted by phone and all agreed to participate. The mean age of relatives was 80 years (range, 43–90 years). Six relatives lived with their next of kin in their own homes, six with their spouses, five with their children and two with a close friend.

Well-established channels of communication with local municipal service associations and county councils were used to inform care staff and healthcare policymakers about the study and to invite their participation. Respondents were asked to volunteer to participate in group discussions, and they were assured that results would be presented anonymously. Volunteering direct care staff (n = 41) included registered nurses, enrolled nurses, home care assistants, nursing students and the chairperson of the Relatives Association in the selected region. All but one were women. Healthcare policymakers (n = 30) were executive municipal managers and local politicians, 12 of whom were women.

Data collection

The care recipients and relatives were interviewed separately in their homes for 60–90 minutes (10). All interviews were recorded and transcribed verbatim. The goal in conducting individual interviews was to promote free expression and discussion about potentially sensitive issues and to avoid forcing participants to follow the pace of a group discussion.

The care recipients were interviewed using open-ended questions and semi-structured questions were used with their relatives. The care recipients were asked to talk about living with multimorbidity, and how they handled this in relation to available healthcare services. The following semi-structured questions for the relatives were constructed after processing the literature and discussing the interview questions with colleagues at a seminar. (i) Can you talk about your situation as a relative?; (ii) Based on your perspective, can you talk about health and social care functions – how you would like to have them?; (iii) Can you talk about what it is like to receive help from various healthcare contacts (inpatient care, primary care, specialist care, assisted living, rehabilitation, etc.)?

Supplementary questions were used as needed including the following. (i) Can you give examples?; (ii) What do you think about this?; (iii) Can you elaborate on that and tell me more?; (iv) (After participants had pointed

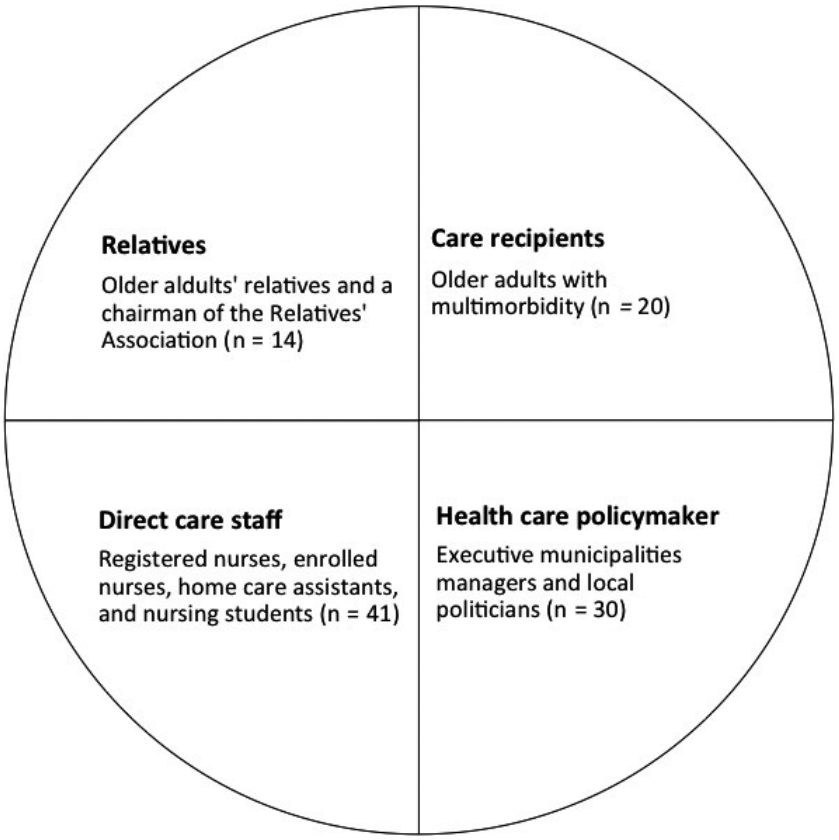

Figure 1 The study sample included a multiperspective to describe the core components of health and social care management of older adults with multimorbidity.

out shortcomings and problems) Do you have any suggestions for improvements?

Care staff and healthcare policymakers participated in group discussions for two hours in a conference setting. The group discussions were conducted according to the World Café Method (11) used previously as an example by Prewitt (14). This method aims to combine the perceptions of people from different perspectives to form a multiperspective view through creating collective understanding and group consensus through knowledge exchange.

Four data collection steps were involved. Step 1 was an introduction to the research project and method. Step 2 was the presentation of an authentic patient case focusing on an older adult with multimorbidity, which was designed to create mutual understanding and a common starting point. In Step 3, participants (n = 72) were divided into 10 groups with 6–7 participants in each, including a mix of care staff and healthcare policymakers. The groups were asked to discuss healthcare improvements based on the presented case and their own experiences, from their own perspective, as well as considering the perspectives of other contributors to health care for older adults with multimorbidity. A secretary was appointed in each group. In Step 4, the proposed healthcare actions from each group were documented and groups discussed their 172 proposals. The proposed healthcare actions were then ranked in a prioritised list.

Data analysis

Data were analysed using qualitative content analysis (12). The analysis has an inductive approach; in other words, the categories are not determined in advance, but emerged through the analysis. This analysis goes from meaning units, condensed meaning units, codes, and categories about condensation, in other words shortening the text while preserving the core. The condensed text is abstract to codes through a process of description on a higher logical level. To strive for objectivity is about doing this oscillation between parts and whole, not to digress.

First, the texts from care recipients, relatives, direct care staff and healthcare policymaker were read in their entirety several times to acquire an overall understanding of the content related to the study aim. Second, each interview and text from group discussion was analysed and meaning units describing the health and social care management for older adults with multimorbidity were identified and reduced to condensed meaning units. Next, these condensed meaning units were abstracted to codes and the analysis went on to compare the content of the different codes to discern similarities

and differences. Finally, the coded data from care recipients, relatives, care staff and healthcare policymakers with similar content were grouped and abstracted to internally homogeneous and externally heterogeneous categories. This process resulted in seven categories containing codes from all groups of participants. The authors continuously discussed the analysis process to achieve consensus. Table 1 shows an example of the data analysis.

Results

Core components of health and social care management for older adults with multimorbidity resulted from content analysis: political steering, cooperation, leadership, competence, support for relatives, availability and continuity (Fig. 2).

Table 1 An example of the data analysis

Condensed meaning unit	*Code*	*Category*
It is important with fewer numbers of care staff and not so many different care staff	Continuity among care staff	Continuity
It is vital to have one physician responsible for the patients		
At care planning, should all actors participate	Continuity in care planning	

Political steering

Political steering in healthcare management was considered crucial**.** Healthcare policymakers ought to plan and manage health and social care organisation in a way that creates opportunities to meet optimally the needs of older adults with multimorbidity. There is a need for economic governance with resource reallocation from institutional care to municipality care. Participants felt that it was important that the responsibility for home care move from the county councils to the municipalities, which was seen as requiring changes in healthcare legislation and social services. Current laws were considered to have led to a polarisation of health care and social care, counteracting each other's aims, and thereby contributing to unclear accountability between organisations and hindering a multiperspective approach. Participants emphasised that the existing agreements between principals should be followed. If the principals were not in agreement, the participants required a clear system of sanctions for breaches.

Organisations and activities for older adults with multimorbidity need to be characterised by long-term decision-making, with organisations permeated by multiperspective, equitable health care with a focus on the individual. Participants felt it was important that health and social care should work from a health perspective in addition to a disease perspective. Preventive care should be used, for example, to identify high-risk groups.

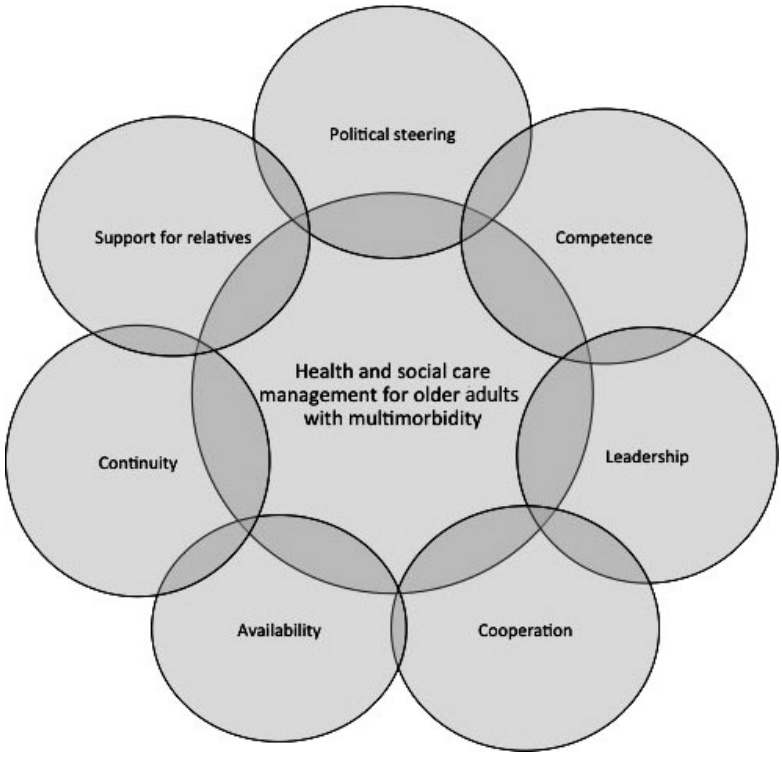

Figure 2 The core components of a multiperspective view of health and social care management for older adults with multimorbidity.

Participants pointed out the importance of increasing older adults' choices and their involvement in decisions about their own health and social care.

> ... I've been sick for 18 years and have some experience. It's crazy, I've written to those in charge. No, there are lot of laws and oddities, here and there, that are in the way. But we then ... (Care recipient)

Leadership

The results pointed to clear leadership as a core component in health and social care management for older adults with multimorbidity in meeting their needs in an optimal manner. The organisational characteristics that were considered necessary to meet the needs of older adults with multimorbidity were long-term leadership, continuity and flexibility.

> ... how do they think, those people in charge? Do they talk to each other? No, everyone just does their own part. Why don't they ask the old folk or us relatives? 'What can we do for you to make you feel good?' Someone should take care of this ... (Relative)

Cooperation

The need for cooperation in health and social care was highlighted through several suggestions about what is needed and how cooperation should be organised. Various forms of coordination functions were recommended by the participants, such as care coordinator for older adults, case manager and different team, such as cooperation team, multiprofessional team and team consisted of professional from the whole healthcare chain. It was emphasised that teams should both perform and coordinate health and social care for older adults and coordinate resources efficiently. With such a system, there would also need to be clear and relevant communication and collaboration between the different actors.

Participants pointed out that facilitating cooperation would require common care planning meetings with caregivers and a care coordinator for older adults to have an active role on the team. Participants proposed having common medical records for inpatient and outpatient care and plans based on individual needs. In this way, all actors could be prepared for a care recipient's hospital discharge without delays or deficiencies in care recipients' health and social care needs. In sum, older adults and their relatives are demanding a holistic and completely responsible health and social care system.

> ... there are too many situations in which the right hand does not know what the left hand is doing. There is no order and it's messy ... they lose test results and referrals (to specialists). There is so much to keep track of, it's a good thing my wife has worked in health care and understands how things work. But what about when she no longer has the strength? There should be a staff member to do this .... (Care recipient)

Competence

Competence among all professionals who work with this population is important to meet these older adults' unique and complex healthcare needs. Participants indicated that increased competence may lead to an improved understanding and a willingness to promote cooperation, availability and continuity of health and social care. Through expanding competence, the quality of interventions may improve so that older adults receive the help they need in both the short and long term. According to the participants, increased competence would both reduce mistakes in their health and social care and increase the focus on preventive interventions that would maintain health and functions towards coping with daily activities and self-care.

> ... he's been in an ambulance at least six times over the last six months, but his heart is so restless. But I'm optimistic that it will get better now that we have a physician who knows about older people's issues ... and he has shown me that I should weigh Erik regularly, and if he gains weight, the physician will then increase his diuretic so Erik doesn't get so tired and his breathing so heavy. You know his legs were so swollen that he could no longer walk .... (Relative)

Support for relatives

Support for relatives is an important resource within successful health and social care management for older adults with multimorbidity, and greater direct and indirect support for relatives is needed. Participants suggested that care coordinators and multiprofessional teams could support relatives' caregiving activities and also include relatives as part of care teams. Participants knew that municipalities were responsible for providing support to informal caregivers, but more comprehensive support was considered necessary. The relatives themselves are often older and have health problems. They expressed the importance of respite care for relatives who need relief from often extensive and round-the-clock work. Indirect support for relatives that the relatives felt were necessary included the categories of political steering, clear leadership, cooperation and availability aimed to optimally meet the needs of older adults with multimorbidity, as well as increased competence to work with older adults among all professionals working in health and social care with this patient population.

> ... I don't know how much longer I can take care of my husband ... he has fallen several times and become so angry at me when I say that he should take his medicine. We quarrel quite often and it takes all my strength since I'm sick myself. The last time I ended up in the hospital and it was so nice to escape everything at home, but I wish I could escape more often, that he could have a place at some home sometimes and I can get a bit of rest and a break from all the responsibility .... (Relative)

Availability

Availability in several forms was considered essential in health and social care for older adults with multimorbidity. Home care was central and consisted of multiprofessional teams that were continuously available. For many reasons, including avoidance of emergency room trips, the availability of physicians for home visits was also considered important. If necessary, it would be optimal if the physician could provide direct admission to a hospital ward without the need for emergency room admission. Availability implied being able to easily access care staff via a direct phone number and that care staff would communicate with the patient in a way they could understand and with relevant information. Participants emphasised the importance of a sympathetic encounter and avoiding long waits in the emergency room. Such improvements might prevent older adults from delaying seeking help until it is too late.

> ... I should have sought help earlier but I thought my legs were swollen because I slept poorly. The physician didn't have time to see me and I was so tired and had difficulty breathing so could not get out of bed. And it's so tedious to call and not get through ... and the emergency room should be avoided ... you can be sitting there for hours and I have so much pain everywhere. Finally, I called my kids and said I couldn't bear it any longer, so they called the ambulance .... (Care recipient)

Continuity

The results showed that continuity was crucial to health and social care for older adults with multimorbidity. A number of proposals were put forward for improving continuity, such as greater cooperation and availability within health and social care. Participants reported that different forms of cooperation could include common planning of health and social care to create a core group of care staff, thereby reducing the number of different care staff patients were required to see. It was also considered important to increase knowledge among care staff, physicians, registered nurses and enrolled nurses about these patients' situations and encourage relationships on a personal level.

> ... I've been quite ill lately, but the care staff take care of me. I'm known to the physicians and nurses because I come to the same place ... my hematologist is absolutely wonderful ... she takes care of my diabetes, too, though she does not need to. Then I have Mary and Britta (home care assistants) to help me at home ... they are really good .... (Care recipient)

Discussion

Discussion of the results

Akner (5) pointed out the need for pragmatic studies describing the core components in health and social care management for older adults with multimorbidity, which was our aim here. This study shows that political steering, leadership and cooperation are significant core components in health and social care management for older adults with multimorbidity. These needs confirm previous research showing that multimorbidity is associated with a large number of prescriptions, referrals and hospital admissions, greater expenditures, significant institutionalised use of healthcare resources and higher healthcare costs (2, 3, 6). Marengoni et al. (4) also reported that older adults with multimorbidity need a more holistic care approach, continuous collaboration across specialties, and professional and organisational boundaries, including both medical care and social services. Therefore, policymakers should plan and manage health and social care organisation in a way to meet optimally the needs of older adults with multimorbidity, in a cooperative way that saves resources.

The participants in this study indicated that current Swedish healthcare and social service laws (13) had led to a polarisation of health care and social care, counteracting each other's aims, and thereby contributing to unclear accountability between organisations. We believe that if the core components of political steering, leadership and cooperation work well, they will promote availability and continuity, which we found to be essential of health and social care management for older adults with multimorbidity.

It was considered important that a health perspective should be gained rather than simply a disease perspective. Preventive care should be used, for example, to identify high-risk groups. Marengoni et al. (4) also emphasised the importance of identification of preventive strategies and better treatment for older adults with multimorbidity. Participants in this study believed that, through increased staff competence, health and social care could become safer and more preventive and empower older adults. A high level of competence is

required for health and social care to become safe and cost-effective (15, 16).

However, the current situation is alarming, as there is a serious shortage of registered nurses with specialist competence in municipal elderly care. An appropriately safe level of staffing is required for safe health and social care; in other words, the number of skilled staff should be properly balanced against patients' needs (15). There is a direct relationship between safe staffing levels and the effects on patient morbidity and survival; likewise, there is strong empirical evidence of a correlation between inadequate nurse staffing and undesirable patient results such as medication errors and decreased satisfaction with care (15). Thus, safe levels of staffing in health and social care for older adults with multimorbidity are essential.

Good safe health and social care is also the best support for relatives (17). Participants in this study pointed out the importance of support for relatives. If the relatives cannot cope with their situation, the health and social care systems may face collapse (17). Therefore, care staff duties should include responding well to relatives and offering them support, so they feel secure and are able to cope with their situation and reduce their risk of ill health.

This study provides strong arguments for changing and adapting current health and social care for the growing number of older adults with complex health problems and treatments. Further research should develop and test methods that would make a difference for older adults with multimorbidity and their relatives.

Discussion of the methods

To achieve trustworthiness, the analysis process was discussed to reach agreement, and was also discussed with colleagues at several seminars. The intention was to describe clearly the method and results with descriptive quotations. The investigators strived to reach dependability by an open dialogue about judgements about data collection, as well as similarities and differences of collected data. Power-based relationships may have been an issue within group interviews; for example, enrolled nurses were less talkative at the beginning, which may have been due to their reluctance to speak in the presence of the executive municipal managers and local politicians. To overcome this, the investigators stressed that everyone's input was valued equally because it shed light on healthcare management from different perspectives. Given the study design, generalisations beyond this study should be made with caution. Nevertheless, these findings have an important value and are relevant to clinical practice.

Conclusions

This study provides core components regarding management of health and social care for older adults with multimorbidity and contributes to a multiperspective model for health and social care. The core components are political steering, cooperation, leadership, competence, support for relatives, availability and continuity. Steps should be taken to ensure that every older adult with multimorbidity has a treatment plan according to a multiperspective view to prevent fragmentation of their health care.

Acknowledgement

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Author contributions

Martina Summer Meranius designed the study and collected the data. Martina Summer Meranius and Karin Josefsson analysed the data. Karin Josefsson and Martina Summer Meranius prepared the manuscript.

Ethical approval

This study was approved by the Regional Board of Research Ethics at Uppsala.

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