

# Improving Quality of Care in Older Adults with Multi-Morbidity: The Need for a Shift towards Individualised Patient-Centred Goals

John Ford\*

Academic Clinical Fellow in Public Health, University of East Anglia, Norwich Medical School, Norwich, UK

## Current Challenges

Living with chronic disease and polypharmacy is now common place for older adults. Advances in medicine, improved diagnostic testing, reduced disease thresholds and changes in health seeking behaviour mean that approximately 66.2% of over 50 year olds live with three or more chronic diseases [1].

This results in complex care needs, unplanned hospitalizations, and multiple health and social services interactions. But more importantly, from a patient perspective multiple medical problems reduce functioning, social interaction and mental wellbeing [2]. Furthermore individuals face the challenge of navigating through multiple different services.

Improving quality of care in this myriad of multi-morbidity, polypharmacy and health services is challenging and requires a tailored approach.

## Establishing What Constitutes Quality

What constitutes high-quality patient-centred care for older people with complex medical and social needs? No specific guidelines have been published. Generic standards are useful, but the emphasis is different. For example, the Institute of Medicine's definition of quality is care that is safe, effective, patient-centred, timely, efficient and equitable [3]. While we could argue that all these are equally important in older adults with multi-morbidity, certain criteria become increasingly important. Multiple health services interactions put efficiency at danger, drug-drug and drug-disease interactions makes maintaining safety challenging and the pressures of clinical guidelines and local targets puts patient-centred care at risk.

The Quality Outcomes Framework (QOF) in the United Kingdom measures technical quality of care. While its ambition to improve the standard of care is welcome, it biases healthcare towards technical quality and unintentionally reduces the priority of softer indicators, such as patient-centred care. In addition it rewards adherence to single disease standards without attention to multi-morbidity or patient preferences.

The recently published National Institute of Health and Clinical Excellence (NICE) quality standards are of particular importance to older adults with multi-morbidity [4]. These aim to "provide the NHS with clear commissioning guidance on the components of a good patient experience" and include standards such as making patients aware that they have the right to choose, accept or decline treatment and that patients should have opportunities to discuss their health beliefs. These guidelines are refreshing and put patient-centeredness squarely at the forefront of quality.

## Achieving Patient Centeredness

First and foremost clinicians should seek to understand how an older adult's medical problems affect their functioning, social engagement and priorities. In older adults, attaining individualized patient-centred goals, which are tailored to the preferences of each

patient, should take greatest importance. Healthcare provided should match these patient-centred goals. This should lead to improved patient satisfaction, compliance and quality of life. Greater use of advanced care planning will be crucial [5].

Patient-specific goals are required because each patient, clinician and decision-maker will have different preferences. It is too easy for health professionals to assume what decision a patient would make. A seemingly rational decision from a doctor's perspective may not be rational to a patient [6]. Older adults with multi-morbidity will have preferences in terms of the degree of functionality, long term prevention, polypharmacy and acceptable threshold of number needed to treat (NNT) [7]. Each individual patient will differ in their preferences. Some may be risk averse and reassured by preventative interventions, while others may value short-term improved functioning, over long term benefit.

However, caution is needed since individuals are likely to value immediate health gains over reduced future risks. Time preferencing may affect a patient's priorities. Moreover a patient may not be able to understand the impact of a serious disability (i.e. hemiplegia secondary to a stroke) and therefore may underestimate or overestimate the associated morbidity. Discussing future risks and benefits is difficult and the drive to improve communication skills is not unwarranted. In turn this should avoid reflexive referral to single disease specialists.

## Future Opportunities

With the establishment of clinical commissioning groups in the UK, primary care is ideally placed and skilled to champion this kind of quality care. Quality of care assessment should not only focus on technical QOF-related quality, but also softer indicators, such as shared decision making, patient experience and patient-specific goals. Outcomes such as the percentage of patients who die in their preferred location are likely to be useful indicators. Secondary care should be proactive in providing specialist support, such as community outreach services and educational services.

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\*Corresponding author: John Ford, Academic Clinical Fellow in Public Health, University of East Anglia, Norwich Medical School, Norwich, UK, Tel: 01603 591269; E-mail: [John.ford@uea.ac.uk](mailto:John.ford@uea.ac.uk)

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