Health Professionals' Experiences with Health-Promotion Dialogues for Older Home-Dwellers in Norway – a Qualitative Study

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Article

Health Professionals' Experiences with Health-Promotion Dialogues for Older Home-Dwellers in Norway—A Qualitative Study

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Abstract: Home-dwelling older people without health services might develop health issues and challenges. To live longer at home and manage well, it is important to promote health-promotion towards this target group. One approach is through health-promotion dialogues conducted by healthcare professionals in the municipality. The aim of this study is to explore healthcare professionals' experiences who are conducting health-promotion dialogues to older home-dwellers over 75 years without services. Focus-groups were used to collect data, and a total of nine participants formed three focus groups. Thematic analysis was applied to analyse the material, which resulted in one major theme "The challenging dialogues" comprising three sub-themes, "Mobilise coping skills and health awareness", "Uncover vulnerability", and "The ambiguity of the dialogues". The findings were also discussed by using empowerment as a theoretical lens. The health-promotion conversation uses a resource perspective for elderly to remain independent in old age and can reveal vulnerability and underlying needs. The conversation purpose appears ambiguous for the target group, which leads to unclear service expectations and rejections of the offer. Nevertheless, it seems to be important that this health-promotion service to a larger degree addresses a clear purpose in order to meet the needs of the target group in a broader sense in the aging process.

Keywords: health-promotion dialogues; preventive home visiting; home-dwellers; empowerment; focus groups; thematic analysis

1. Introduction

The coming Norwegian generations are projected to live longer and to face old age having better finances, higher education, better health and with completely different material conditions compare to today's older generation [1]. Population projections indicate that Norway's population over 70 is expected to almost double by 2060 [2]. The 67-80 age group is increasing the most, while older people over 80 are expected to have a greater growth closer to the 2030 [3].

The increasing older population will be challenged by the expected reduction in the number of workers per pensioner linked to health services which are performed by healthcare professional [4]. In addition, old age entails increasing vulnerability and risk for diseases, functional decline and multimorbidity, causing a daily life with more complex care needs and health challenges [5]. The risk for developing frailty increases with age and, according to the Norwegian Directorate of Health [6], includes a quarter of all over 85. This development supports the importance for society to prevent and promote health earlier in old age aiming for well management as far into old age as possible for the target group [1]. This is in line with the international trend of developing age-friendly societies, which focuses on quality of life and good health for older people [7].

The described demographic development underpins to prioritise early intervention and before the age of 80. Early intervention in this target group is in line with policy recommendations related to preventive and health promoting services which underscore use of own resources, abilities, and opportunities to master their own everyday life [3]. More investment must be made in resource-

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oriented measures with the intention of promoting health and quality of life so that older people without health services can remain independent into the aging process [3,8]. In this regard, one measure is Preventive Home Visiting (PHV), which in Norway, started in the 1980s, although received increasing attention through later public documents [9] such as through the Coordination Reform [10], Public Health Act [11], and Report to the Storting "A full life – All your Life - A Quality Reform for Older People" [3]. The new report "Safely at home" also emphasises that the increase of older people indicates that more people also must remain independent in their own homes for as long as possible [1]. This indication supports investment in preventive and health-promoting services in the home, and strengthening measures on PHV in all municipalities is an important initiative in this sense. Several countries have gained long experiences with PHV; however, studies describe great variations regarding implementation, focus, and content across countries [12] and they are therefore difficult to compare [13]. In Norwegian municipalities, PHV has developed from individual mapping of possible functional impairment, need for help and prevention of injuries, to development towards the health-promoting aspect focusing on individual dialogues about resources and self-management, as well as health counselling and service information [14].

The measure *health dialogue*, also called *health-promotion dialogue*, stems from PHV with the aim of preventing illness and injury, as well as supporting health, functional capacity, and participation [15]. Health-promotion dialogue is an outreach and proactive effort aimed at residents who do not seek out the health service themselves and are offered to older home-dwellers 75+ without other health services [16]. The dialogue facilitates mapping of needs and uncovering of vulnerability factors which might contribute to reflections on handling one's own health and life situation in addition to planning the aging process to remain independent at home. The health-promotion dialogue provides tailored guidance on health-promotion lifestyles, as well as information on the municipalities' various offers and services [15]. The health-promotion perspective is expressed through focusing on resources and self-mastery to strengthen the individual's prerequisites for handling everyday life, in line with WHO's definition of health promotion [17].

The term *empowerment* refers to a positive view on peoples' individual resources and their capacity to act and "make a difference" [18]. As an actively acting subject, individuals can do their best under given conditions [19]. Empowerment can be understood as a process where individuals and groups are encouraged to mobilise power to gain increased self-confidence, better self-image, increased knowledge and skills, and more power, management, and control over one's own life. Such a process can enable the individual to realise their own resources, coping strategies and opportunities to make various forms of lifestyle changes [20,21].

Empowerment processes can be considered a framework for health promotion [22]. This means that the individual takes responsibility for their own health, is recognised for their competence the person has about themselves and contributes to taking care of their own health (ibid). An empowerment process is thus the conceptualisation of individuals to optimise health and meaningfulness in life [23] which also have been described as a "coming from within" approach directing individual solution and growth [24].

The knowledge of models for executing PHV and health-promotion dialogues is scarce. There is also limited research on outcome and user focus on the significance of the measure, in addition to exchange experiences between municipalities. Furthermore, there is a call for knowledge on how health promotion dialogues influence health, quality of life, and everyday mastering in older people [9]. Based on existing knowledge, the aim of the study is to explore health personnels' experiences with health-promotion dialogues to older home-dwellers over 75 years and the potential in such dialogues.

2. Materials and Methods

2.1. Study Design

The study has an explorative design with qualitative methods, and data were collected through focus group interviews. Focus group approaches provide good insight into themes lacking

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knowledge [25]. The methodological strength lies in using the group dynamics as a means of producing more complex data through joint exchange of opinions which will highlight different understandings and attitudes. In addition, the approach enables exploration and clarification of the informants' perspectives, which cannot be achieved through individual interviews [26].

2.2. Sample and Data Collection

The sample represents health personnel with different professions and a minimum of 2 years of experience with preventive and health-promotion approaches to older people, preferably related to health-promotion outreach approaches towards older people without services. The sample consisted of a total of nine participants, including two nurses and seven occupational therapists from four different municipalities. The sample was divided into three focus groups. Participants were recruited through direct contact with four existing measures offered through four municipal services, and potential participants indicated their interest from there. The interviews were conducted during spring 2021. The article is based on a previous master thesis at VID Specialized University in Oslo, Norway.

Due to the COVID pandemic, the interviews were conducted via digital platforms. The focus groups were grouped of participants from the same workplace divided into different parts of Norway. The composition of the focus groups can thus be considered relatively homogeneous, as the informants in each group largely knew each other from before, however, probably facilitated appropriate group dynamics [27].

2.3. Analysis of Data

The data was analysed through thematic analysis (TA), which is suitable for describing and going in-depth into one or more themes. Our approach was inspired by the six-step model described by Braun and Clarke [28]. The purpose is to identify and report patterns through themes from the empirical material related to the research questions [28,29]. The analysis starts with thorough reading of the material informing the early phase of the analysis in search of meaningful content and possible patterns. Subsequently, preliminary codes were proposed based on interesting features identified through an inductive approach to the data material. The next step was development of preliminary themes based on previous analysis steps. Based on research questions, themes and sub-themes were defined and developed further before the findings were projected.

It is of significance to identify the meaning behind any theme, which is being given clear and identifiable distinctions between them [28,29]. The relationship between codes, themes and different levels of themes and sub-themes was thoroughly assessed, interpreted, and adjusted through repeated and mixed movements between the different steps in reflexive processes, which Braun and Clarke [30] describe as reflexive TA. Themes do not however emerge from data but appears as "interpretative stories about the data". TA is thus a reflexive process rather than a step-by-step manner of analysing data.

3. Results

The main theme comprising the findings revolves around the multiple challenges associated with the dialogues and is divided into three related sub-themes. Our informants outlined challenges related to motivating older people to engage their faculties and attention towards their own health, encountering difficulties in uncovering vulnerability, and a lack of clarity regarding the purpose of the dialogues for several potential recipients within the target group. The overview of theme and sub-theme is presented in Figure 1.

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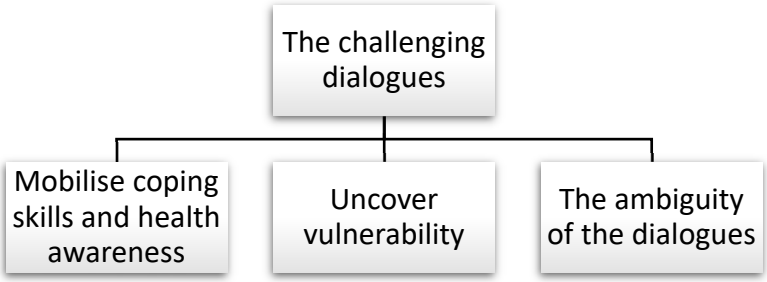

Figure 1. Overview of theme and sub-themes.

3.1. Theme: The Challenging Dialogues

Important notes for health personnel throughout the dialogues were to explore resources, coping skills, and awareness towards own health. Further, the participants described the significance of the dialogues eliciting reflections on uncovering vulnerabilities in the older persons linked to sensitive topics. The analysis also showed how the intention of the health-promotion dialogue could appear unclear to those who received the offer. It may seem that the recipients' understanding of such a health-promotion measure may be perceived as ambiguous based on unclear information of the offer.

3.1.1. Sub-Theme 1: Mobilise Coping Skills and Health Awareness

The informants described the dialogues to retrieve individual resources in the older person. The role of health personnel was to contribute to identifying the "person in the situation" by talking about sources of meaning and mastery in life. Statements such as "mobilising one's own power" and "finding the resources, watering them and making sure they grow and become stronger" denoted their view of their own role in the dialogues related to a health-promotion view. The participants' understanding of their own role revolved around getting to know the individual, and exploring the person's characteristics, values, and interests, as well as wishes and needs for old age.

The intension appears to thematise safeguarding one's health by facilitating active aging in accordance with needs. For the participants, it was important to show active presence in the dialogues and to emphasize the individual's own wishes and needs. Seeing the person in the situation through active listening, focused attention and interest is considered the central approach for establishing a space of trust in the dialogues, as one of the informants described:

It is incredibly exciting to knock on a door, and you don't know who is standing behind the door. When I worked with rehabilitation, (the philosopher) Kierkegaard was of help through the "art of helping", which is about the fact that to help someone else, you need to find him where he is, and start from there. I try to keep that in mind." (Participant 2)

Some of the participants described the health-promotion dialogues as the first meeting with the municipality's services for many in the target group, a fact that required trust in the relationship. The participants also used a facilitated dialogue guide as a starting point for the conversation revolving around individual health situation and needs. A successful first meeting could increase the chances that those who accepted the offer would make contact again in case of future needs.

It is not important for us to get through everything we're supposed to. Sometimes it is just about putting everything aside and talking about what they want to talk about. (Participant 6)

The dialogues served as a kind of framework around the question "what is important to you?", a question which has been implemented in the national primary health care sector aiming for a health-promotion perspective in healthcare professionals towards all users. It appears central that the dialogues can shed light on older people's own perspectives, plans and goals for good aging processes. In addition, they focus on maintaining and optimising well-being, coping and quality of life.

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To emphasize the question "what is important to you?" together with the participants' active presence and holistic view of health shows a clear person-oriented angle in the health-promotion dialogue, which is to explore potential needs in the person:

…for me, a health-promotion dialogue is about trying and figuring out where to start. After all, we have these topics from the dialogue guide, then it is a matter of trying and discerning within which of these topics we can have an opportunity to help shine a light on which they can work on a bit." (Participant 2)

3.1.2. Subtheme 2: UNCOVER VULNERABILITY

Several participants emphasized that they had acquired increased expertise on topics affecting mental health in old age, which made them better equipped to recognise vulnerability factors. Identification of the person's needs was a core topic and could lead the health dialogue towards physical and mental health, family relationships, social network, diet, sleep, fall prevention, illness, etc.

Some participants also described the significance to dare and ask the challenging questions related to sensitive topics such as transition phases, grief processes, depression challenges, sexuality, lack of relations, loneliness, and old age. The quote below highlights how one participant expressed particular attention related to recognition and disclosure of vulnerability factors as a step ahead of an assessment based on individual needs:

Therefore, I made an effort in relation to statistics with regard to thinking about who represents vulnerable groups that it is important that I was with, and with whom that I can make a difference. That's important." (Participant 6)

The health-promotion dialogue provided an opportunity to uncover several vulnerabilities in the residents. A term for how the dialogue could be used to explore opportunities, needs, and ambivalence associated with one's health and lifestyle changes was the phrase "rolling with resistance", as described by one of the participants:

For me, it means starting from what that person has inside of them both in terms of personality and hobbies, interests and finding out what that person has liked to do, likes to do now, and trying to build on that." (Participant 7)

3.1.3. Sub-Theme 3: The Ambiguity of the Dialogue

The information leaflet designed for the dialogue became the starting point for conversations about health and life situations. One of the informants emphasized the importance of the dialogue thematising understandings of old age and opportunities to explore attitudes to one's own aging process. Several of the participants described how the health-promotion dialogues touched upon a wide range of health-related topics, about which there had been greater awareness, such as sleep, alcohol consumption, and networks, in addition to relationships, sexuality and identity issues.

Asking about alcohol habits was not something we did before as it was too personal. (…) We realised that it was a very important topic to talk about with those we visited and now we are doing it. (…) We ask just as much about their alcohol habits as how much water and liquids they take in." (Participant 1)

The age-specific limits for the target group had been adjusted up and down between the ages of 75 and 80 following evaluation of feedback from the recipients of the offer. The age variations are due to feedback that the offer was perceived as irrelevant of potential recipients. The participants consistently experienced that many recipients felt that this health service comes too early in the age course, and several older people were described as not having the need and therefore declined. The participants seemed to understand the recipients that they perceive themselves as able-bodied, thus perceive the offer as not very relevant.

It was a consistent opinion that many older people who agreed to the interview had assumed that the offer would have exclusively disease and injury prevention purposes, thus in line with understandings of the traditional preventive home visit (PHV). They could also have expectations related to wound care and drug-related clarifications.

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My predecessor was a nurse and wore blue plastic covers on the outside of her shoes, and immediately sent some signals that gave a completely different focus: "Can you look at this wound?" There are many people who think we come home to remove carpets, but that's really the last thing we do." (Participant 4)

The offer is aimed at older people living with a health condition that is not yet perceived as limiting their quality of life and life expression, and these unfortunately happily declined.

That is what is positive about the outreach part of the business, that you have the opportunity to approach before it starts to go down (…). I also find that some of the 77-year-olds whom we seek out refuse our offer. And I think that has a lot to do with the fact that you're not there mentally, that you understand your own potential situation in a few years' time as you start to get older. (Participant 5)

There were many who declined – probably for various reasons, such as the experience of functional freshness, lack of information, and unclear expectations regarding the purpose of the conversation. Several of the participants believed that such a health-promotion measure should be able to meet needs to a greater extent. The municipalities represented in this study offered health-promotion dialogues to residents over the age of 80, except from one municipality with an age limit of 78 years. At the same time, some of the participants wished that the offer should cater to even younger age groups than the current target group to a greater extent, indicating that such a measure should also take care of broader needs in the aging process, such as transition phases, for example in the event of the loss of a partner, or how to be a relative of people with dementia.

We have something to gain in terms of being able to catch vulnerable older people earlier health than when they turn 80. I think that there is a potential that is socially and economically profitable as well. (Participant 3)

Several participants experienced that older people who expressed scepticism and ambivalence towards the offer in advance experienced the dialogues as useful afterwards. According to the participants, there was a significant proportion in the target group who did not see the need for such a health-promotion and preventive measure, presumably before they knew what the offer's intention, content and utility entailed.

4. Discussion

We found how the health-promotion dialogues can increase older people's awareness of potential health challenges and opportunities for coping. Further, we found that vulnerability can be revealed through the dialogues with healthcare professionals, which also affect the older person's experiences of own health and life situation. In addition, we found the dialogues to be experienced as ambiguous by many recipients. The findings raise several challenges in the health-promotion dialogue. These findings will be discussed related to the opportunity space of health promotion and in relation to the overall mandate of the health-promotion dialogues.

4.1. The Health-Promotion Opportunity Space

Our informants emphasized a resource focus in meetings with the target group through the facilitated dialogue guide by highlighting a focus on the older person's coping and awareness of their own health. The dialogue also actualised thoughts about planning one's own old age and wishes related to retirement. The resource focus approach is recognised in how health-promotion healthcare services for older people are supposed to include customised training, advice, support, and guidance on lifestyle and self-management [3,31]. The significance of such a focus is confirmed in a Norwegian study on the target group's experiences with health-promoting dialogue. The recipients expressed security of being confirmed as valuable, and the dialogue provided them to gain faith in their ability to preserve own health [16]. This is in line with our findings of the dialogues to contribute to increasing the older person's responsibility for their own health and the significance of the fact that healthcare professionals in such outreach services should stimulate the older person's awareness and understanding of their own situation in order to experience increased control over action alternatives. To strengthen their prerequisites to be able to handle everyday activities in line with their own goals and wishes is part of the overall health-promotion policy towards older people [3,15]. These prerequisites follow individual objectives in the health promotion work, which includes increasing personal knowledge, mobilising, and utilising the resources, abilities, and opportunities the person

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possesses in terms of coping with everyday life. This approach aligns with the empowerment mindset of individual involvement and user participation [24] which in turn aims to strengthen the individual's opportunities to take responsibility for improving their own health and life situation [5,32,33].

The purpose of the dialogues was also to establish a mutual and safe relation aiming to uncover needs that were put forward by the older person themselves. Several of our informants considered their task to convey openness about topics that were considered difficult to talk about, e.g. physical and mental health, family relationships, social network, etc. Health-promotion dialogues might provide older home-dwellers a feeling of not being forgotten [34] and an experience of increased safety because one is noticed early in old age and was provided "an open line" towards the healthcare service when necessary [16]. However, the dialogue might be more useful for people in vulnerable life situations or with reduced social network and thus provide the opportunity to also accommodate psychosocial support [32]. Nevertheless, when a health-promoting dialogue provides the opportunity to establish a personal relationship between an older home-dweller and the municipality's service, a connection is established which the system would otherwise not have encountered [34].

Our informants considered it crucial to build trust during the dialogue, which became a key prerequisite for discovering vulnerability characteristics in the older person with subsequent needs assessments. This central finding is confirmed in several studies emphasizing the importance of spending time when building trust in the relationship, and supporting emotions to create security so that the older persons dare to share sensitive information about their own everyday life and health issues [16,33,35]. A trusting relationship underpins a dialogue about needs and health resources [36], although it takes time to develop a safe and trusting relationship. Older person could be less talkative which might challenge the possibility of building trust in the conversation. At the same time, it may also happen that healthcare professionals find it challenging to ask the intimate questions in fear of humiliating the older person [37]. Despite this issue, a Norwegian study found that several older persons, who accepted the offered dialogue, also wanted follow-up consultations [16]. These studies confirm that repeated conversations with the same healthcare professional over time will develop trustworthy relationships.

However, our informants also reported on older home-dwellers who appraised the dialogue offer to be of little use to them because they considered themselves as active and able-bodied. Further, some potential recipients were described to decline due to an expectation of a disease-oriented focus of the dialogues' content in relation to e.g. wound care and drug management. This finding describes a rather common misunderstanding of the dialogues being a first step towards initiating home care services. The issues of unclear purposes and aims reflects the ambiguity of the health-promotion dialogues will form ambiguous focus and unclear expectations in the target group [36]. Behm, Ivanoff [38] confirm that skepticism towards the content of the dialogues may be due to a lack of familiarity with the purpose of the health-promoting perspective, which in turn will influence the understanding of the dialogue. When potential recipients believe that the dialogue focuses on disease prevention and not health promotion, it might result in a lack of attention to questions related to personal health or future situation which in turn might prevent a satisfactory benefit from the offer [36,37]. The described misunderstandings about the content and purpose of the dialogue can shed light on the complexity inherent in the application of health-promoting dialogues to the target group. It may also be related to the fact that attention has not been directed towards the health-promoting work related to older people's health until recent years [39].

Our informants described skepticism towards the offer before they knew and understood the dialogue's content. The lack of understanding the health-promotion purpose underlines the significance, but also the challenges, of communicating health policy aims on health promotion towards the target group on different levels of the society. The described ambiguity of the dialogues' purpose underlines the municipalities' challenges to communicate the health promotion mission more clearly towards the individual older person. In addition, the lack of clarity is reinforced due to the fact that the older population comprise a large and heterogeneous group with divergent needs

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and with health challenges appearing at different stages of old age. From a health-promotion perspective, it is important to ask each individual what is meaningful in life with the aim of encountering their own motivation to preserve health. Such knowledge must be seen as essential regarding how to approach the target group. It is also in line with the empowerment approach of participation and involvement [24] where the user is recognized to be in charge of their own life and is encouraged to make a difference using their resources [18].

Another reason for different perceptions in the target group on health-promoting dialogues can be linked to different perceptions of the concepts of aging and old age which might describe reasons for declining the offered dialogue. One of our informants emphasized the importance of addressing understandings of old age through the health-promotion dialogues. Behm, Ivanoff [38] found how older people to either perceive the dialogue as too early in the aging process or as irrelevant to their own life situation. They also found experiences of fear and uncertainty related to negative thoughts about their own health. Such perceptions might be interpreted as displacement mechanisms causing non-uptake of important and relevant information and influences from healthcare professionals. Further, they could also illuminate how fear and uncertainty might be linked to negative thoughts about health causing an unpreparedness for information dissemination concerning future health needs. Attitudes in older people towards the aging process can influence their physical and psychological health, where positive attitudes are associated with making health-promotion choices despite reduced functional level or illness [40,41]. To highlight understandings about the aging process and informing about what affects health and disease processes can in turn influence prerequisites for managing one's health situation [38,40–42] and will be core arguments in the need to clarify the purpose of the health-promotion dialogues.

4.2. The Health-Promotion Mandate

Our informants conveyed the importance of seeing the resources in each older person and building on these through the dialogue about the person's prerequisites for remaining independent in old age which are reflected in policy recommendations on active aging. Ambitions to promote active aging through health-promotion dialogues are challenged when discussing where the boundaries of a person's influence over his own health are drawn. Nor is it given that the individual has sufficient resources and skills to be able to preserve their own health [5]. These arguments are contrasted by the heavy health-promotion emphasis on old age through the very concept of World Health Organization [43] framework on *active aging* comprising the pillars *health, lifelong learning, participation and security*. In that regard, critical questions might be raised about the scope and relevance of such "active" approach when meeting the individual older persons in their homes. The arguments for the significance of active aging have been used rhetorically in several national and international white papers through decades, also regarding necessary measures to meet the future pressure on the welfare state [44]. Such policy goals have been a counterweight to the traditional assumption of decline, degeneration, and withdrawal as normal features of aging [45]. In this regard, the Norwegian researchers Blix & Ågotnes [44] question the rhetoric arguments based on a discourse analysis of some recent Norwegian public documents, which govern both the content and goal of the Norwegian welfare state, e.g. the report "A full life – All your Life - A Quality Reform for Older People" [3]. The discourse analysis brought forth three findings underpinning ideals of how the older person should take responsibility for the goal to age well designed as imperatives: *Be physically active and healthy, be self-reliant, be productive*, resulting in an overall finding focusing on political and economic assumptions: *Be a conscious consumer rather than a passive care recipient*. Their findings could also be read between the lines when assessing the purpose of the health-promotion dialogues. Furthermore, Blix and Ågotnes [44] found an implicit understanding that everyone, regardless of age, has an equal opportunity to take on this responsibility. They express a particular concern that such rhetoric can be read almost as a moral obligation on the part of the individual rather than that one can actually turn it down. Particularly the latter argument seems to add further complexity towards challenges in the complex dialogue picture, although is out of scope in this paper. Nevertheless, these arguments shed light on the challenging empowerment idealization of individualism and

individuals' responsibility of optimising health and meaningfulness in life for older people. The different individual abilities need to be addressed, not only on structural and political level, but also on an individual level, such as through providing the health-promotion dialogues.

5. Conclusions

This study revealed several challenges related to the provision of health-promotion dialogues. Although the dialogues contributed to mobilise coping skills and health awareness among those receiving the offer, the informants needed to focus on how to establish trustful relationships with the older persons. The dialogues also uncovered vulnerabilities, needs and issues that the older persons were unaware of. The most challenging aspect of the dialogues was the ambiguity caused by unclear purpose, but also unclear expectations from the potential recipients towards the dialogues, which often resulted in rejection of the offer. There are several reasons for the ambiguity. However, the dialogues should, to a larger extent, clarify its health-promotion purpose towards the target group, indicating to avoid being associated with the home care services, which might make older people unnecessarily sceptic. The health-promotion mandate in such services might be interpreted as rhetoric in white papers on active aging arguing for a healthy and active population taking responsibility for their own health during the course of aging was also described as a challenge. Such rhetoric also shed light on the challenging empowerment idealization of individualism when optimising healthy and active aging.

Health-promotion dialogues could contribute to identifying and mobilising coping skills, increasing awareness towards own health, and uncovering vulnerability. This offer provides a link between a potential service user and the health service which otherwise would be overlooked, and it facilitates for early intervention and prevention of developing health issues. The knowledge of health-promotion dialogues is scarce and further research is needed, particularly related to reduce perceptions of ambiguity in the target group.

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