

Rewards and Challenges in Caring for Older Adults with Multiple Chronic Conditions: Perspectives of Seniors' Mental Health Case Managers

Andrew Perrella
McMaster University

Carrie McAiney
McMaster University

Jenny Ploeg
McMaster University

ABSTRACT

Healthcare professionals play an important role in caring for older adults with multiple chronic conditions (MCC). Yet few studies have examined the experiences of working with this population, particularly among non-physicians. Twenty-two mental health professionals participated in focus groups to explore the experiences of caring for older adults with MCC. Challenges included a fragmented system, stigma, and knowledge gaps. Rewards included the challenges that complexity presented and human connections. Understanding health professionals' experiences in working with this growing population demographic can assist in the development of appropriate interventions to support providers that best meet the needs of older adults.

Keywords: multimorbidity, mental health, older adults, qualitative research

Andrew Perrella, Bachelor of Health Sciences Program, McMaster University, Hamilton, Ontario; Carrie McAiney, Department of Psychiatry and Behavioural Neurosciences, McMaster University and Seniors Mental Health Program, St. Joseph's Healthcare Hamilton, Hamilton, Ontario, ORCID ID 0000-0002-7864-344X; Jenny Ploeg, School of Nursing, McMaster University, Hamilton, Ontario, ORCID ID 0000-0001-8168-8449.

Andrew Perrella is now a student in the Faculty of Medicine at the University of Toronto. Carrie McAiney is now with the School of Public Health and Health Systems at the University of Waterloo and the Schlegel-UW Research Institute for Aging.

The authors extend their sincere thanks to the health professionals who participated in this research, and to the Aging, Community and Health Research Unit at McMaster University for their support of this project.

Correspondence concerning this article should be addressed to Carrie McAiney, School of Public Health and Health Systems, University of Waterloo, 200 University Avenue West, LHN 3728, Waterloo, ON N2L 3G1. Email: carrie.mcainey@uwaterloo.ca

RÉSUMÉ

Les professionnels de la santé jouent un rôle de premier plan dans les soins apportés aux personnes âgées souffrant de maladies chroniques multiples (MCM). Pourtant, peu d'études ont été menées pour évaluer l'expérience de terrain acquise par les professionnels auprès de cette population, particulièrement chez les non-médecins. Vingt-deux professionnels de la santé mentale ont participé à des groupes de discussion pour réfléchir sur l'expérience de soigner les personnes âgées atteintes de MCM. Parmi les obstacles identifiés figuraient au tableau la fragmentation du système, la stigmatisation et les écarts de savoir. Les récompenses comprenaient pour leur part les réponses apportées aux défis soulevés par la complexité et l'établissement de rapports humains. Une bonne compréhension de l'expérience acquise par les professionnels de la santé appelés à intervenir auprès de cette population croissante peut contribuer à développer des mesures d'intervention appropriées pour aider les fournisseurs de soins à répondre plus adéquatement aux besoins des adultes plus âgés.

Mots clés : multimorbidité, santé mentale, adultes plus âgés, recherche qualitative

INTRODUCTION

Multiple chronic conditions (MCC)—also known as multimorbidity—have replaced infectious diseases as the dominant healthcare burden (Marengoni et al., 2011). Prevalence estimates vary from 13% to over 90%, with variation attributed to differences in study populations, data collection methods, and disease classifications (Fortin et al., 2006; Ward, Schiller, & Goodman, 2014). In Canada, 24% of seniors reported having three or more chronic conditions (CIHI, 2011). The existence of MCC among older adults is associated with a number of negative impacts, including higher use of healthcare services (Banerjee, 2015; Barnett et al., 2012; Bayliss et al., 2015; O'Dowd, 2014), greater economic costs (Owen, 2004), polypharmacy (Marengoni & Onder, 2015; van den Brink, Gerritsen, Voshaar, & Koopmans, 2013), drug-drug interactions (Marengoni & Onder, 2015), and lower quality of life (Boyd et al., 2014; Marengoni & Onder, 2015).

Care of individuals with MCC has been described as challenging due to the lack of evidence-based guidelines for MCC, having to work within a fragmented system of care where communication and coordination is lacking, and in trying to provide care that is patient-centred, (Fried, Tinetti, & Iannone, 2011; Sinnott, McHugh, Browne, & Bradley, 2013). The management of multimorbid patients is further complicated in cases where there are coexisting mental and physical illnesses. The occurrence of mental illness is strongly correlated with the number of physical illnesses (Barnett et al., 2012), with mental illness being up to four times more prevalent in cases of multimorbidity (Gunn et al., 2012; Moussavi et al., 2007). Mental health problems can exacerbate disabilities associated with physical health conditions, and measures of quality of physical healthcare are often lower among those with MCC with comorbid mental health conditions (LeRoy et al., 2014).

Given the challenges associated with caring for individuals with MCC, there have been calls for research that explores providers' experience of caring for this population (Fried et al., 2011; Norris et al., 2008). To date, there has been some research conducted that explores the experiences of caring for individuals with MCC among primary care providers (Fried et al., 2011; Gill et al., 2014; Sinnott et al., 2013). However,

except for the work of Ploeg et al. (2017), we were unable to find any literature on the experience of other health professionals working with individuals with MCC. Understanding healthcare providers' experiences with MCC would significantly aid in the development of interventions to support those working with this population (Fried et al., 2011).

Health professionals who regularly work with individuals with MCC, especially those with comorbid mental health issues, are likely to have important insights into the care of this complex population. Case managers working with geriatric psychiatrists in tertiary (specialized) seniors' mental health teams are an example of such a group of providers. Specialized seniors mental health teams provide support to older adults with complex cognitive, mental health, and/or behavioural issues (Draper, Brodaty, & Low, 2006).

The purpose of this study is to investigate mental health case managers' perspectives on the challenges and rewards in caring for older adults with MCC where at least one condition is a mental health condition.

METHODS

This study was a sub-study of a larger qualitative study on the experiences of older adults, family members, and providers in managing MCC, part of the Aging, Community and Health Research Unit (ACHRU) at McMaster University (Ploeg et al., 2017). For the purposes of this sub-study, MCC was defined as having a mental health condition and at least two other chronic conditions.

A qualitative descriptive design (Sandelowski, 2010) was used to explore the study purpose. Qualitative description is an appropriate design because, as a relatively new area of inquiry, our goal was to describe participants' experiences working with this population.

Participants

Three seniors' mental health teams working in central Ontario were invited to participate in the study. The teams provide assessment, consultation, and short-term follow-up to older adults with cognitive, mental health, and/or behavioural issues. Individuals who are living in the community (own home, apartment, or retirement home) or in a long-term care home are referred to the team. Two of the teams primarily provide outreach service, while the third team is more outpatient-oriented. Clients are assessed by case managers and/or geriatric psychiatrists, and recommendations regarding further assessment, treatment, and management are provided to the client and family, family physician, and long-term care staff (where applicable). Case managers connect with services that clients are already receiving and help to link them to additional services according to their needs. Short-term supportive counselling and individual and group psychotherapy may also be provided.

Information about the study was shared with the case managers through email, with the support of the program manager. All case managers working with the teams were invited to participate. Case managers are health professionals and can have a variety of backgrounds including nursing, social work, and occupational therapy.

Data Collection

Focus groups were used to explore participants' perceptions of the rewards and barriers to caring for older adults with MCC including mental health conditions. This method enabled participants to elaborate on the issues discussed and build on each other's ideas, and allowed for the efficient collection of data (Leung & Savithiri, 2009). The latter issue was an important consideration because of the high clinical demand on the teams.

One focus group was held with each team (involving nine, three, and ten participants, respectively) from January 2015 to March 2015. Focus group questions were developed by AP and CM and probed the rewards and challenges associated with caring for older adults with MCC, based on current gaps in literature addressing these aspects of care (see Table 1). Focus groups were conducted by a trained research student (AP), supported by a supervisor (CM). Focus groups were digitally recorded, transcribed verbatim, and anonymized.

Data Analysis

Focus groups were analyzed using conventional content analysis (Hsieh & Shannon, 2005). This approach is appropriate for exploratory research as the coding categories come directly from the participants rather than pre-existing theory. Two researchers (AP, CM) independently coded focus group transcripts. They first immersed themselves in the data by reading and re-reading the transcripts. Key concepts were identified through line-by-line coding. The concepts were then combined into categories. AP and CM then met to discuss the codes and categories, and together developed the initial themes. The initial themes, along with accompanying quotes, were reviewed by a third researcher (JP). The final themes were determined by consensus of all three authors.

Methods to Enhance Rigour

While the three teams involved in this study are part of the same organization, each team is located in a different geographic location, with some differences in the populations served as well as the model of service. As a result, team members may have different viewpoints regarding MCC, which, therefore, served as a form of data triangulation. As well, having two investigators independently review and code transcripts, followed by a review by a third author, provided investigator triangulation. Member checking was used to ensure that the themes emerging from the analysis accurately represented case managers' experiences. Participants were provided with a summary of the themes emerging from the data and asked to indicate (1) if the themes accurately reflected their experience caring for older adults with MCC, and (2) if there were any important themes missing. Four participants responded to the member-checking request. All four agreed on the themes that had been identified and two individuals offered additional comments. One participant commented on the increased workload in healthcare and how this led to reductions in the amount of time that is available to spend with individual clients. The other participant commented on the increasing number of clients under the age of 65 with dementia and chronic health conditions who are presenting to the service.

Table 1
Focus Group Questions

1. The main focus of this research is on older adults who have a mental health condition and at least two other chronic conditions. Approximately what proportion of the clients you see would fall into this category?
2. What are some of the challenging aspects of working with older adults who have multiple chronic conditions? What, in particular, makes them challenging?
3. What do you find rewarding about working with older adults who have multiple chronic conditions?
4. Are there some areas of this work where you would think you would benefit from some education or professional development? If so, in what areas?
5. How would you say your own case management practice has changed over the years of working with older adults who have multiple chronic conditions? If it hasn't changed, do you think it eventually will?
6. Are there any other comments you'd like to share to help us better understand what it's like to work with older adults who have multiple chronic conditions?

Source: Authors' compilation.

Ethical Considerations

Ethics approval was provided by the Hamilton Integrated Research Ethics Board (HIREB) at McMaster University (Project Number: 14-782-S). Written informed consent was obtained from all participants at the time of the focus groups.

RESULTS

A total of 22 individuals participated in the three focus groups. The majority (91%) were female. Participants represented the following professional backgrounds: nursing, occupational therapy, social work, addictions, and music therapy. Because of the relatively small size of the teams and the potential to identify participants, additional demographic characteristics were not collected.

Focus group discussions explored the challenges and rewards of working with individuals with MCC. Themes emerging in each area are described below and summarized in Table 2. Quotes are provided to illustrate each theme, and are denoted by team (T1, T2, and T3 for Teams 1, 2 and 3, respectively).

Challenges

Four themes emerged which described participants' perceptions of the challenges of caring for older adults with MCC: (a) organization of care, (b) stigma, (c) knowledge and education, and (d) complexities of MCC treatment and management (see Table 1).

Organization of care. The first theme related to the ways in which healthcare for older adults is organized, and the challenges that this posed. Supporting the multitude of needs that individuals with MCC face was made more challenging because of the way the healthcare system is organized. Participants made numerous references to "siloe care," wherein individual chronic conditions are addressed by healthcare

Table 2
Summary of Themes from Focus Group Discussions

Area	Themes
Challenges	Organization of Care
	Stigma
	Knowledge & Education
	Complexities of MCC Treatment and Management
Rewards	The “Puzzle”
	Human Connection
	Making a Difference

Source: Authors' compilation.

providers (e.g., specialists) without an understanding of “the whole picture,” including patient’s co-morbidities, medications, or lifestyle.

A person is a whole person, not just a specific illness, or one illness. There’s lots of things going on that interplay. (T1)

Participant 1: What I find is a big challenge is that these people [clients] have already seen the cardiologist, the family doctor, the respirologist, diabetic nurse, and I’m the only one that knows that they’re drinking every day.

Participant 2: I agree. (T3)

As one participant stated, “We don’t just learn about them in silos, but we treat them in silos.” (T3)

Participants described how the silos that result from the way care is organized has a negative effect on communication between providers. This serves as a barrier to sharing information among providers.

Everybody works in silos [agreement from the group] and so it’s difficult to get people to talk back and forth. (T1)

The siloed approach to care is also noted in relation to their mental health issues. There is a lack of understanding among providers, as well as patients and families, of the potential interaction between physical and mental health conditions. As a result, the two groups of conditions are often considered separately.

When a mental health issue comes up, it seems that the healthcare providers and the patients and families don’t really put together the fact that knowing about their physical condition and their chronic [mental] health problems is just as important. (T1)

Providers additionally described the challenges of organizing care that integrates both physical and mental health conditions.

It's important for us to know what are the other chronic conditions, and how are the recommendations that we're making [as a mental health team] going to affect the balance. (T1)

... we're really trying to move the client forward or stabilize them. In order to do that, when you've got medical conditions plus a mental health condition, and we're sharing care with a number of other services, trying to get that balance so the client isn't delirious, or is well enough to be able to engage in activation, and to be out in the community and be socializing again—because those things are really important for their mental health. It becomes very difficult. It slows down the process and makes it very hard for the patient. (T3)

Due to the multiple individuals involved in the care of a single client, participants described difficulties in coordinating care and treatment. The resulting breakdown in communication created “fragmented” healthcare for older adults, described by one participant as “just spinning your wheels...and having the same conversation over and over again.” This can lead to challenges for case managers who are trying to understand the client's full history, particularly when they have trouble accessing this information.

When you've a patient who's got a very complicated medical history, it sometimes takes a lot of time to get the information because we can't always get it online. But to get information from the hospitals or the family physicians or other physicians is really difficult. But it's very important in terms of your assessment, having that medical information. (T3)

Participants also described that the family physician plays a key role in the coordination of care for those with MCC, and will often determine the outcomes that are achieved.

... it comes down to the strength of your family physician [collective agreement]. When you have a really good family physician, who can take in that information, seek out the answers and coordinate it all, from a medical perspective, we have far better outcomes. And we have physicians who don't do that... (T3)

Frustration may arise with providers who fail to adequately coordinate care.

Some of them have—and I'll say this with reservation—doctors who are really not very good at coordinating. And we depend on them to coordinate with the specialists and the kind of consultations we're doing. (T3)

Stigma. Clients seen by the teams were described as being subjected to a “double stigma”—that is, stigma arising from both mental illness and age. Living with addiction was also something that led to stigma. Participants indicated that these stigmas pose challenges in terms of access to, and coordination of, care.

It's a segment of society that is doubly stigmatized. Not just are they old, but they have mental health conditions, and so, they don't feel that they're entitled to people's time. (T1)

There are all these sorts of assumptions and pictures in your head when you hear the word geriatric that aren't necessarily pleasant and welcoming. (T3)

Overcoming the stigma proves challenging when it has ingrained itself in the mindsets of providers, patients, and families for an extended period of time.

Sometimes people have sort of a preconceived notion of what something means, that, especially, mental health conditions. They don't want to talk about them at all, or even a medical condition; they'll have a preconceived notion of what that means. And it gets difficult to educate sometimes. (T1)

In some cases, stigma affected clients' ability to access services and receive the supports they needed.

What I've seen is lack of services and resources available. And part of it is due to some level [of] ageism [that] is present. (T2).

The participants also spoke about the added stigma associated with clients who had addiction issues and how this stigma created more fragmentation for clients with MCC.

I find that there's such a stigma and bias, especially with regards to the older adult population with regards to addiction. I have that conversation with health professionals who don't have the patience or understanding of addiction. So I think "fragmented" is a mild way of putting it. (T3)

Knowledge and education. Participants identified that acquiring education regarding MCC—for themselves as well as their clients—was a challenge. Participants explained that their busy clinical workloads, and having their offices located in diverse geographic regions, makes accessing educational opportunities difficult. Case managers often found themselves supplementing their knowledge through discussions with colleagues (e.g., intake meetings) or other clinicians, but indicated that additional learning opportunities would be beneficial.

We have a lot of situations where we just have to learn on the job. Google is our best friend. So if we had something that was a little bit more readily available, so that we could stay ahead of it instead of always trying to catch up. (T3)

We're with physicians, and you hear them, and you pick up from them. When I started, every intake meeting was an education session. (T1)

The need for clients and family members to be educated about their conditions was also described by participants. This lack of understanding on behalf of their clients presented challenges for participants in terms of providing care for older adults with MCC including mental health conditions.

I think too though, that with the client themselves, sometimes there's lack of knowledge. You go there, and sometimes people aren't really even aware of all their diagnoses totally, and their medications and why they're taking them. It's getting the information, and the education, and knowledge of the people themselves that can present some challenges. (T1)

Complexities of MCC treatment and management. Participants described that the complexities associated with MCC made treatment and management of those conditions more challenging. These complexities included the multiplicity of medications that individuals receive and their potential interactions. They also described complexities of managing both physical and mental health conditions concurrently and complicated treatment plans.

Participants described the challenges associated with managing multiple medications and trying to find optimal treatment regimes. Medications for mental health issues, and their potential interactions and side effects, were of particular concern.

Right off the top, medications: Just in terms of interactions, the amount, like, kind of the polypharmacy that goes along with having all of the chronic conditions—and then, trying to treat their mental health condition with a medication that doesn't interfere. (T2)

... a lot of the people that we see are taking medications that might have been appropriate to combat issues that were more of a focus in years past. So you see them on anticoagulants that they probably shouldn't still be on because now the risk-benefit conversation has changed significantly. And there's far more risk for them to take a drug like Coumadin because they're not getting monitored as strictly as they should be while they're taking it. (T1)

Medication adherence in clients with MCC was also identified as challenging, especially for those living with dementia.

Medication adherence is an issue, because we deal with clients who have cognitive impairment, so if they're not remembering to take their medications properly, then they're not feeling well. And that just complicates their [clinical] presentation. (T3)

Conditions such as chronic pain and mobility limitations also complicated treatment. The participants explained that these conditions made following recommendations difficult for clients. This challenge further exacerbated their chronic conditions.

With mobility being so poor, they often have difficulty following through with the recommendations that would be necessary for recovery from many physical kinds of things. And then that just feeds upon itself and their mood [collective agreement]. (T2)

And there really aren't a lot of good solid treatments for pain. So chronic pain will also impact on mental health, and mobility, and lack of getting out there and wanting to do things. (T2)

Rewards

In addition to the challenges that MCC could present, participants were also asked about the potential rewards of working with clients with MCC. Three themes emerged as rewards of caring for older adults with MCC: (a) the "puzzle," (b) human connection, and (c) making a difference (see Table 1).

The "Puzzle." Participants described that taking a holistic approach—by looking at the whole individual—allowed them to understand the needs of those with MCC and develop appropriate care strategies. The terms "puzzle" and "detective" were often used to describe their work, noting that the complexity of their clients' conditions proved to be highly rewarding and helped to enhance their skills.

I think it's just like all the reasons why it's challenging are the same reasons why it's rewarding because you can just put those pieces of the puzzle together. (T1)

When you're the detective, and you get to find all the things out, and pull it all together...that's the most rewarding part...and challenging, at the same time [collective agreement]. (T2)

One provider emphasized the importance of looking at the person as a whole:

I think this is one of the first programs that offers some people that ability to not have their life looked at in silos, because we are looking at the whole person. Even though we're seniors' mental health, I say to people that we look very closely into your physical health because we can't just discount that and focus on the one issue. (T1)

The complexity of the issues seen by the participants was also rewarding because it led to enhancements in their own skills and knowledge. As two participants describe:

It's giving me the opportunity to continue to grow as a person as well as a professional because managing some of these complexities is difficult. (T3)

I can always learn something. There's always new things coming down the pipe. There's always new treatments, new regimes, new parameters. (T2)

Human connection. Another rewarding aspect of this work was the opportunity to develop meaningful connections with their clients and their co-workers. Having the time to develop these connections helped to make their work more meaningful, despite the challenges associated with their jobs. Participants described how the structure of their practice (e.g., longer consultations due to the complexity of the clients they cared for) afforded them the opportunity to establish rapport with their clients. They attributed great value in listening to client's stories, using the terms "heart-warming," "heartbreaking," and "inspirational" to describe their encounters.

I always love going to people's homes, and listening to their stories and learning about their life. And I feel pretty privileged and blessed to be able to do that. (T2)

For me, it's all about giving people the opportunity to tell their story; that is the most therapeutic thing I have to offer. (T2)

Participants also described the connection that develops among co-workers and colleagues as a result of the work they do with this population.

I think another wonderful aspect of this work is the relationships we build amongst ourselves, as well as with our colleagues in the community. We share the same desire to care for people. (T3)

Making a difference. Finally, although addressing mental health needs in conjunction with physical conditions remains a challenge, participants described that the opportunity to make even "small differences" for clients and their families was highly rewarding. They also suggested that what a "meaningful outcome" is may need to be reconsidered for this population.

One of the things I've seen already a number of times, watching other people's work, is the dramatic difference that the right intervention can make in somebody's life. (T1)

And we're able to come in and with the resources, limited resources, but still able to sort out the puzzle and then see how somebody can really improve. (T1)

Participants also describe the impact of connecting with and assisting families.

I find it very rewarding to work with families. If you can help the family to understand and pull together the support for the patient, and connect them with others in the community that can help and support them... The rewards in this job are proportionately small, but sometimes they make a big difference for the family and patients. (T3)

Participants described what a "meaningful outcome" was in this population, and that outcomes for these complex clients might be different than in other populations.

The little gains are what you celebrate, as opposed to the big gains. (T2)

With these types of people, they're not going to get better... So our definition of what our outcomes are [is] different. If we can make symptoms better managed, or improve quality of life, then that's a big success. (T3)

And when somebody just listens to what's important to them... them living another 15 years may not be what they want. It's how they live that next year or two that's important. (T1)

Even just to see somebody smile—that hasn't smiled in a long time—that can be rewarding. (T1)

In fact, feeling "listened to" and valued were meaningful outcomes described by some of the participants:

They think [they are] a bother to us, so it's kind of rewarding when you're able to go in and say, "No you are entitled," and they feel like they belong again. (T1)

And when I explain the brain structure behind addiction, you can see [...] a weight being lifted that they've carried for many years. They see: "Now there's somebody that gets it." That aspect of "I'm not here to tell you how wrong you are, how bad you are, and how much you need to change." I'm here to help you with this challenge that you've been facing. So even just giving somebody that message is a really rewarding part for me. (T3)

DISCUSSION

MCC has been described as "the most common chronic condition experienced by adults" (Tinetti, Fried, & Boyd, 2012, p. 2493). Yet there is still much to be done to better understand MCC, to enhance the way healthcare systems and the structures within them are coordinated for those with MCC, and to educate current and future health professionals to better care for an aging population. Indeed, healthcare professionals play an essential role in the care, treatment, and well-being of individuals with MCC. However, little is known about their experiences in caring for this diverse and complex population. The current study makes an important new contribution to the literature as this is one of two studies, to our knowledge, that has explored the experiences of non-physician mental health professionals in caring for the elderly with MCC.

One key aspect of this research is its focus on the co-occurrence of mental and physical chronic conditions. Research to enhance our understanding of those with physical and mental health conditions has been identified as a priority within the MCC field (LeRoy et al., 2014; Norris et al., 2008). In our study, participants spoke to the challenges associated with treatment in those with both mental and physical health conditions. Specifically, they discussed challenges related to medications, including the need to weigh the pros and cons of continuing the use of medications because of the potential effect on new chronic conditions that have developed. Participants also identified challenges related to patient self-management. For example, individuals with dementia or other cognitive impairments may have difficulty following through on medication regimes. As well, physical conditions such as poor mobility may inhibit individuals to follow-through on care recommendations such as exercise, leading to exacerbations in physical and mental health conditions. Finally, stigma associated with mental health conditions further challenges care. Participants reported that clients and/or family members may be reluctant to talk about mental health conditions, and providers may not consider, or may even dismiss, physical health conditions in the presence of a mental health condition (e.g., addiction). Research has found stigma to be present more often in those with co-occurring mental and physical health conditions (Bahm & Forchuck, 2009). Other studies have also shown that stigma can negatively affect health (Bahm & Forchuk, 2009) and decrease the likelihood of seeking treatment (Sickel, Seacat, & Nabors, 2014).

The issue of complexity cuts across a number of themes that emerged in this research. Participants reported that the level of complexity of the clients they serve has increased—this includes individuals living at home as well as those in long-term care. Participants also reported that the nature of MCC makes treatment and management of those with MCC complex, as most care guidelines focus on individual chronic conditions. Despite these challenges, complexity was also one of the key factors that made working with seniors with MCC rewarding.

The challenges of caring for the complexities of MCC speak to the need to have care organized differently. The siloed approach to care that is currently in place within the healthcare system simply does not work—and is detrimental—for those with MCC. Clinicians need to look at the “whole person” when assessing, treating, and managing conditions, and to operate within a system that supports better provider-provider as well as patient-provider communication. Research on frailty, a condition that is different from, but shares similarities with, MCC also suggests that a different approach to the provision of care for older adults is required. Specifically, that care should involve a holistic approach and aim to enhance functioning and independence (Villacampa-Fernández, Navarro-Pardo, Tarín, & Cano, 2017). These system-level shortcomings have been identified by others. For example, Roughead, Vitry, Cughey, and Gilbert (2011) identified the need for the systematic integration of those involved in caring for older adults in order to properly manage MCC. Sinnott et al. (2013) found that specialists “did not consider the wider harms and benefits of organ-specific intervention” (pg. 3) and Tinetti et al., (2012) noted that in cases of MCC, fragmentation based on clinical setting and on disease condition pose barriers to care. Salisbury (2012) suggested that this fashion of siloed care has been brought upon by the “industrialization of medicine,” wherein chronic disease management is increasingly being provided in disease-specific clinics governed by checklists based on national guidelines. Improving access to client information requires that there is fluid—rather than fragmented—communication among providers. The challenge now is to identify and test specific changes and interventions to improve care for those with co-existing chronic conditions.

The need for education was also identified in the focus groups, specifically education for healthcare providers regarding the interactions among conditions and the implications for treatment and management. Others have also identified the need for education related to MCC (Barnett et al., 2012; Salisbury, 2012; Sinnott et al., 2013). However, these recommendations have been suggested for family physicians. Our study advocates for education related to MCC among other health professionals (e.g., case managers) as well.

One of the unique aspects of this study is that it explored the rewards associated with working with older adults with MCC and not simply the challenges. In addition to the satisfaction that can come from working through the complexities presented by individuals with MCC, participants described the significance experienced in being able to connect with clients by hearing their stories. Participants also identified that our perspective on what outcomes are considered “important” in this population needs to shift, with more time being placed on what clients themselves identify as their goals for care. This latter finding supports the increasing emphasis on identifying and utilizing patient-reported outcomes in both research and care (Holroyd-Leduc et al., 2016; Weldring & Smith, 2013). In fact, Holroyd-Leduc and colleagues (2016) argue that patient-reported outcomes are particularly important in situations involving MCC and increased frailty.

Strengths and Limitations

The key strength of this study is that it is one of the first, to our knowledge, that has explored the experiences of non-physician health providers in caring for individuals with MCC. It is also the first to exclusively explore the challenges and rewards of caring for older adults with co-occurring physical and mental conditions. As the population continues to age and the occurrence of MCC increases, we need to move away from the traditional siloed care approach to one that is more holistic and reflective of patients’

unique needs. Understanding the experiences of providers in caring for individuals with comorbid mental and physical health conditions will assist us in this endeavour.

A limitation of this study is that it involved providers from three outreach/outpatient teams from one organization, which may limit transferability of findings. That said, the three teams work in different geographic regions and the healthcare experiences in these different areas may vary. As well, the practice model of one of the teams has a different focus than the other two teams (outpatient vs. outreach); thus, the populations served are somewhat different. These factors help to make the findings more broadly applicable. A second limitation was the relatively small number of study participants. Future studies involving a greater number of healthcare providers and providers from diverse organizations and settings would provide a more fulsome understanding of the experiences of caring for individuals with MCC including mental health conditions.

CONCLUSION

This study is one of the first to examine the challenges and rewards of caring for older adults with coexisting mental and physical health conditions among non-physician health providers. The broader care system makes the job of health providers more complex because of the siloed approach to care and the resulting challenges in communication and care coordination. However, it is the complexity of the care that also brings rewards, requiring providers to take a holistic view of individuals in order to best support them. Opportunities for making strong connections with clients, families, and other providers, as well as shifting perspectives on what outcomes are considered meaningful, are all aspects of this work that providers find rewarding. By better understanding the experiences of healthcare providers caring for individuals with MCC, as well the experiences of clients with MCC and their families, appropriate interventions can be developed for this growing population.

REFERENCES

- Bahm, A., & Forchuk, C. (2009). Interlocking oppressions: The effect of a comorbid physical disability on perceived stigma and discrimination among mental health consumers in Canada. *Health & Social Care in the Community*, 17(1), 63–70.
- Banerjee, S. (2015). Multimorbidity—Older adults need health care that can count past one. *The Lancet*, 385(9968), 587–589.
- Barnett, K., Mercer, S. W., Norbury, M., Watt, G., Wyke, S., & Guthrie, B. (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: A cross-sectional study. *The Lancet*, 380(9836), 37–43.
- Bayliss, E. A., Ellis, J. L., Shoup, J. A., Zeng, C., McQuillan, D. B., & Steiner, J. F. (2015). Effect of continuity of care on hospital utilization for seniors with multiple medical conditions in an integrated health care system. *The Annals of Family Medicine*, 13(2), 123–129.
- Boyd, C. M., Wolff, J. L., Giovannetti, E., Reider, L., Weiss, C., Xue, Q. L., ... Rand, C. (2014). Health care task difficulty among older adults with multimorbidity. *Medical Care*, 52(S3), S118–S125.
- Canadian Institute for Health Information (CIHI). (2011). Seniors and the health care system: What is the impact of multiple chronic conditions? Retrieved from https://secure.cihi.ca/free_products/air-chronic_disease_aib_en.pdf
- Draper, B., Brodaty, H., & Low, L-F. (2006). A tiered model of psychogeriatric service delivery: An evidence-based approach. *International Journal of Geriatric Psychiatry*, 21, 645–653.

- Fortin, M., Bravo, G., Hudon, C., Lapointe, L., Dubois, M. F., & Almirall, J. (2006). Psychological distress and multimorbidity in primary care. *The Annals of Family Medicine*, 4(5), 417–422.
- Fried, T. R., Tinetti, M. E., & Iannone, L. (2011). Primary care clinicians' experiences with treatment decision making for older persons with multiple conditions. *Archives of Internal Medicine*, 171(1), 75–80.
- Gill, A., Kuluski, K., Jaakkimainen, L., Naganathan, G., Upshur, R., & Wodchis, W. P. (2014). "Where do we go from here?" Health system frustrations expressed by patients with multimorbidity, their caregivers and family physicians. *Healthcare Policy*, 9(4), 73.
- Gunn, J., Ayton, D., Densley, K., Pallant, J. F., Chondros, P., Herrman, H. E., & Dowrick, C. F. (2012). The association between chronic illness, multimorbidity and depressive symptoms in an Australian primary care cohort. *Social Psychiatry & Psychiatric Epidemiology*, 47, 175–84.
- Holroyd-Leduc, J., Resin, J., Ashley, L., Barwich, D., Elliott, J., Huras, P., ... Muscedere, J. (2016). Giving voice to older adults living with frailty and their family caregivers: Engagement of older adults living with frailty in research, health care decision making, and in health policy. *Research Involvement and Engagement*, 2(1), 23.
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288.
- LeRoy, L., Bayliss, E., Domino, M., Miller, B. F., Rust, G., Gerteis, J., & Miller, T. (2014). The agency for healthcare research and quality multiple chronic conditions research network: Overview of research contributions and future priorities. *Medical Care*, 52(S3), S15–S22.
- Leung, F. H., & Savithiri, R. (2009). Spotlight on focus groups. *Canadian Family Physician*, 55(2), 218–219.
- Marengoni, A., Angleman, S., Melis, R., Mangialasche, F., Karp, A., Garmen, A., ... Fratiglioni, L. (2011). Aging with multimorbidity: A systematic review of the literature. *Ageing Research Reviews*, 10(4), 430–439.
- Marengoni, A., & Onder, G. (2015). Guidelines, polypharmacy, and drug-drug interactions in patients with multimorbidity. *British Medical Journal*, 350, h1059. doi:10.1136/bmj.h1059
- Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V., & Ustun, B. (2007). Depression, chronic diseases, and decrements in health: Results from the World Health Surveys. *The Lancet*, 370, 851–58.
- Norris, S. L., High, K., Gill, T. M., Hennessy, S., Kutner, J. S., Reuben, D. B., ... Landefeld, C. S. (2008). Health care for older Americans with multiple chronic conditions: A research agenda. *Journal of the American Geriatrics Society*, 56(1), 149–159.
- O'Dowd, T. (2014). Depression and multimorbidity in psychiatry and primary care. *Journal of Clinical Psychiatry*, 75(11), e1319–e1320.
- Owen, M. (2004). Disease management: Breaking down silos to improve chronic care. *The Case Manager*, 15(3), 45–47.
- Ploeg, J., Matthew-Maich, N., Fraser, K., Dufour, S., McAiney, C., Kaasalainen, S., ... Emili, A. (2017). Managing multiple chronic conditions in the community: A Canadian qualitative study of the experiences of older adults, family caregivers and healthcare providers. *BMC Geriatrics*, 17(1), 40.
- Roughead, E. E., Vitry, A. I., Caughey, G. E., & Gilbert, A. L. (2011). Multimorbidity, care complexity and prescribing for the elderly. *Aging Health*, 7(5), 695–705.
- Salisbury, C. (2012). Multimorbidity: Redesigning health care for people who use it. *The Lancet*, 380(9836), 7–9.
- Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, 33(1), 77–84.
- Sickel, A. E., Seacat, J. D., & Nabors, N. A. (2014). Mental health stigma update: A review of consequences. *Advances in Mental Health: Promotion, Prevention and Early Intervention*, 12(3), 202–215.
- Sinnott, C., McHugh, S., Browne, J., & Bradley, C. (2013). GPs' perspectives on the management of patients with multimorbidity: Systematic review and synthesis of qualitative research. *British Medical Journal Open*, 3(9), e003610.
- Tinetti, M. E., Fried, T. R., & Boyd, C. M. (2012). Designing health care for the most common chronic condition—Multimorbidity. *Journal of the American Medical Association*, 307(23), 2493–2494.
- van den Brink, A. M., Gerritsen, D. L., Voshaar, R. C. O., & Koopmans, R. T. (2013). Residents with mental-physical multimorbidity living in long-term care facilities: Prevalence and characteristics. A systematic review. *International Psychogeriatrics*, 25(04), 531–548.
- Villacampa-Fernández, P., Navarro-Pardo, E., Tarín, J. J., & Cano, A. (2017). Frailty and multimorbidity: Two related yet different concepts. *Maturitas*, 95, 31–35. <http://dx.doi.org/10.1016/j.maturitas.2016.10.008>

- Ward, B. W., Schiller, J. S., & Goodman, R. A. (2014). Multiple chronic conditions among U.S. adults: A 2012 update. *Preventing Chronic Disease, 11*, E62.
- Weldring, T., & Smith, S. M. (2013). Patient-reported outcomes (PROs) and patient-reported outcome measures (PROMs). *Health Services Insights, 6*, 61.