Preventive home visitation programmes for older people: the role of municipality organisation

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Abstract The organisational influence on benefits of preventive home visitation programmes for older people has escaped scientific evaluation. This study aims to investigate organisational structures and processes in relation to preventive home visits. As part of a randomised controlled trial investigating whether educational intervention towards municipality health care professionals could enhance active life expectancy, information of municipality leadership, home visit approach, strengths and limitations of communication within the organisation were obtained using individual and focus group interviews. Thirty-four municipalities in four counties participated. Data was systematically condensed using a phenomenological approach upon which general patterns were categorised into a theory-based formal typology of the

preventive home visitation management in the municipalities. Three distinct strategies for preventive home visitation programmes were identified. Eighteen municipalities were categorised as “Framework Management”, 15 as “Management by Rules” and one as “Project Management”. Small municipality size was associated with the “Framework Management” type. “Management by Rules” municipalities had higher population densities and their overall expenses for older people were higher. “Framework Management” municipalities used more resources on preventive home visits, communicated better, experienced less staff changing and had higher social capital than “Management by Rules” municipalities. Municipality structures and management processes of preventive home visitation programmes varied considerably in 34 Danish municipalities, but the majority could be categorised as using either a “Framework Management” or a “Management by Rules” strategy. Each strategy is associated with particular advantages and disadvantages, which may explain differences in the overall benefit of the programme between municipalities.

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Introduction

Preventive home visits to older people conducted by municipality-employed home visitors were introduced without specific guidelines by Danish legislation in 1996. They serve the dual purpose of supporting personal resources and networking and offering social support aimed at preserving functional ability. After the law had

been in force for a few years, many municipalities had come to recognize a need for more knowledge about the best way to carry out the visits and organise the programme. This study aims to address this need.

We conducted a controlled feasibility trial in 34 municipalities from 1999 to 2001 to evaluate whether a 3 year educational programme for home visitors and general practitioners (GPs) had an effect on relevant outcomes; i.e. functional ability, use of nursing homes and mortality. Randomisation and intervention were performed at municipality level; outcome was measured at the individual level (Vass et al. 2002). The main results were that intervention and self-selection to participate in the public preventive home visitation programme were associated with better functional ability after three years, mainly among the older women (Vass et al. 2004), and with lower rates of nursing home admission, predominantly in the 80-year-olds (Vass et al. 2005).

What remains unknown, however, is how organisational structures and processes shape functional outcomes in the older adults living in the municipalities. *Structure* may be defined as: “Characteristics that are attributable to an object or a situation that limits or frames processes or events and are usually fairly stable over time” (Bauer et al. 2003), e.g. “object” being the municipality and the characteristics being size or population density (urban/rural). Preliminary subgroup analysis showed that municipality structure was not related to functional ability of the older individuals (Holmberg and Fiil-Nielsen 2005). Thus, further analysis of the *processes* of the programme was needed to explain the variations. *Process* may be defined as: “Sequences of events that may demonstrate observable change over time” (Bauer et al. 2003). The processes deemed relevant to the effectiveness of a home visitation scheme, e.g. how the programme was actually carried out in terms of action, were expected to be explainable in terms of the governance strategy at the municipal level, where *governance* was the “Decision-making processes in public administration or within organisations” (Plochg et al. 2006).

It has been argued that preventive home visits cannot be assessed by means of randomised controlled trials as such services comprise a complex mix of uncontrollable, independent variables embedded in what is a social process more than a treatment programme (Clark 2001). Municipality employees were expected to implement preventive home visits incorporating inter-disciplinary coordinated follow-up. Since the preventive home visitation programme was part of 34 different local health and social cultures, we hypothesised that functional outcomes were associated with differences in governance strategies of the programme. Therefore, this study aims to investigate municipality organisational structures and processes in

relation to preventive home visits offered to older people as part of a national health promotion scheme.

Methods

Study design and study population

The study draws on supplemental data from a randomised controlled study on an educational intervention in a national preventive home visitation scheme (Vass et al. 2005). Study municipalities were included if they offered preventive home visits as prescribed by law, were able to facilitate fair or good rehabilitation and if GPs were able to participate by contract. Fifty of 81 municipalities in four counties met these criteria and were invited, and 34 municipalities agreed to participate. After the matched randomisation there were no differences in baseline characteristics between intervention and control municipalities, i.e. municipality size, population density, expenses per 75+ inhabitants, total number/staffing of preventive home workers. No demographic differences were seen between the participating 34 and the remaining 16 eligible municipalities (Vass et al. 2004, 2005).

Many municipalities wanted to participate in the study to facilitate the implementation of the national legislation. The main reason for declining to participate in the study was that the leader of the home visitation scheme did not accept the risk of becoming a control municipality. Other municipality home visitation leaders argued that they did not want to be restricted to the study intervention way of performing the home visits and therefore declined participation. Finally, some municipalities did not yet fulfil the state law obligation of offering the home visits from 1996, even though the recruitment took place in autumn 1998.

Intervention

Intervention was designed to be feasible in routine primary care, easy to implement if proven beneficial, and should be tested in multiple primary care settings with respect to generalisability. Intervention should not intervene with how the preventive programme was organised in the municipality, but focus on how to perform the assessments and follow-ups of the home visits.

Active life expectancy was expected to be improved through *education* and training of home visitors and their local GPs. The education introduced a simple tool to discover early signs of functional decline, and to support interdisciplinary follow-up. Continuously, the importance of avoiding ageism was underlined. The educational intervention has been described in detail elsewhere (Vass et al. 2002).

Qualitative analysis of preventive home visitation programme

During the ongoing process evaluation in the study period from 1999 to 2001, both visitors as well as leaders answered questionnaires and were interviewed about all aspects of the organisation and management of the programme. This information was used to design a strategy to obtain further information (Fig. 1).

The municipalities were ranked according to the percentage of non-disabled older people at the end of the intervention period (Avlund et al. 1995, 1996). Two of the “best” and two of the “worst” municipalities were singled out for in-depth interviewing of home visitors, taking into account size and county affiliation in order to capture possible cultural and demographic differences. A semi-structured interview technique was used (Bauer and Gaskell 2003). The interviews were carried out by the second and third author (RH and HFN). The main topics on the interview-guide were: Overall management and organisation of the programme, leadership, approach to the visits, strengths and limitations of the management, tools and instruments used in the visits and communication within the organisation.

Furthermore, at the annual convention meeting for Danish preventive home visitors, a focus group interview was arranged with eight visitors representing seven of the remaining 30 participating study municipalities. The above-mentioned topics were used as starting points for a discussion in the group (Bauer and Gaskell 2003).

All interviews were taped and transcribed. The data material was analysed by systematic text condensation

inspired by Giorgi (1985) and modified by Malterud (2001). The analysis process was carried out in four steps. First, all the interviews were read several times to get a general sense of the entire data material. Second, the interviews were reread once more with the aim of discriminating “meaning units”. Attention focused on different aspects of management processes. Third, these aspects were condensed through a systematically coding process. Fourth, three formal categories were introduced: (a) governance, (b) production, and (c) learning.

Lastly, an analysis of the content of each formal category was conducted using the substantive set of categories from the coding of the interviews. General patterns were fitted into a formal typology capturing the management strategies in the municipalities (Holmberg and Fiil-Nielsen 2005). This typology was based on two concepts expounded in Giddens’ structuration theory (Bryant and Jary 1991) and Mintzberg’s organisational theory (Mintzberg 1989). Giddens’ theory implies that structure emerges as a sedimentation of the rules created by repeated patterns of behaviour. Thus, structure and actions are mutually constitutive. Since the home visitation programme was relatively new, the sedimentation process was considered to be somewhat immature, leaving the whole organisation to be viewed as a relatively flexible pattern of action. Organisational communication, leadership, compassion and commitment from employees were all considered intrinsic motivational factors that shaped the way work was performed. Mintzberg’s theory underlines the influence of context on the performance of organisations. A given type of organisational arrangement has advantages and disadvantages in solving different kinds of tasks. The

Fig. 1 Derivation and categorisation of municipality typology

performance of the organisation will depend on, whether the organisational approach fits the nature of the task. Therefore, the municipal organisation will have to adapt to the job at hand in order to reach satisfactory results. Even different public expectations as part of a local cultural prerequisite may influence how the task is organised.

A synthesis was formed from these two theoretical perspectives and on this basis we interpreted and selected the three organisational sub-processes most important to preventive home visitation: governance, production and learning (Holmberg and Fiil-Nielsen 2005). The processes “governance” and “production” were singled out based on Mintzberg’s analysis of action coordination and production in different types of organisations (Mintzberg 1989). The preoccupation with coordination of action has since evolved into an important research agenda under the heading “Governance”. The term is used with reference to this research agenda. The process of “learning” was singled out based on the analysis of learning organisations by March and Olsen (1987).

These sub-processes appeared to be mutually interdependent and coexisting; thus, specific governance strategies were closely related to specific ways of production and learning. The empirical findings supported that the different sub-processes were part of the same sequence of events, e.g. an action carried out in the municipality as part of the home visitation programme would typically carry aspects of both coordination and production or coordination and learning, etc. Thus, the clear distinction between sub-processes is analytical. At the same time, this relation between the sub-processes allowed us to characterize three types of management for preventive home visitation.

This three-item typology was used for designing a questionnaire with 16 selected issues concerning governance, production and learning. The questionnaire was used for a structured telephone-interview with a home visitor in each municipality to categorise the municipalities (Table 1).

The reliability of the categorisation was assessed by letting professionals representing different academic cultures (i.e. political science, public health, and economy) perform blinded categorisation of the telephone-interview answers.

Municipality structure variables

Several structure variables were directly available from StatBank, Denmark (<http://www.statistikbanken.dk/statbank5a/default.asp?w=1400>): *municipality size* was described as small when it had less than 10,000 inhabitants, medium between 10,000 and 20,000 inhabitants and large when there were more than 20,000 inhabitants. *Population*

density was classified as urban versus rural, where rural was defined as the biggest town in the municipality having less than 3,000 inhabitants. *Municipality rate of 75+ year-olds living in the municipality* and *total municipality expenses per 67+ year-olds living in the municipalities in 1999*.

Other structural variables gathered by the research team during the study period included:

Municipality staffing of preventive home visits measured as hours per 100 75+ persons living in the municipality. The *municipality offer of home visits per 75+ per year*. Information about the presence of an *independent preventive home visitation staff department*, and information whether the preventive home visitor function included an integrated inspector function for home help allocation.

Social capital was measured using the number of private older people’s organisations and expressed trust by older people living in the community (Putnam 2002). An ordinal scale adding organisations (1 < 3, 2 = 3 and 3 > 3) with reported trust by the council for senior citizen’s chairman (1 no, 2 yes, 3 yes, indeed) in every municipality was used. Information about *organisational communication* was obtained from the questionnaires distributed to the preventive home visitors. Communication was categorised as poor versus good or very good. The same applied to the level of *preventive home visitor support provided by the leader*, which was described as high versus moderate or low. *Visits per 75+ living in the municipality* were calculated from registered visits. *Staff changing* was defined as a job shift versus no shift by at least one preventive visitor during the study period.

Ethics

The study complies with the Declaration of Helsinki and was approved by the relevant Regional Research Ethical Committees.

Results

The qualitative analysis allowed us to distinguish between three distinct types of municipality organisation of preventive home visits to older people: “Framework Management”, “Management by Rules” and “Project Management”.

In municipalities managing the visitation scheme predominantly by rules, the programme supervisor strategy consisted of both formulating and issuing specific goals and setting up procedures to attain these goals. The mode of care production was highly reliant on standard operating

Table 1 Interview guide for categorisation of municipality typology (G, P, and L referring to Governance, Production and Learning sub-processes, respectively)

Municipality number:		
How long have you been employed as a preventive home visitor?	Years	
Have significant changes in the organisation of the preventive home visitation scheme taken place since 2001?		
1. Is a written specification of the objectives available? (G)	Yes	No
2. Who has formulated these objectives? (G)	Prev. home. vis.	Prev. leader
3. Do you use interview guidelines during the visits? (P)	Yes	No
4. Are the contents and the assessments standardised? (P)	Yes	No
5. Does the invitation letter specify in writing the date of the first visit? (G, P)	Yes	No
6. Has your leader laid down guidelines for how to contact the target group? (G)	Yes	No
7. Do you have fixed procedures for follow-up and management plans? (P, L)	Yes	No
8. Do you have standards for how long time visits must last? (P)	Yes	No
9. Do you have competence to distribute/grant and make referrals, and for what? (aids, home help, etc.) (G, P)	Yes	No
10. How is the work reported? (P, L)		
11. How is new knowledge implemented? (L, G)		
12. How do you prioritise specific areas of intervention? (G, P, L)		
13. How much priority do you give to courses and how is knowledge shared? (L)		
14. Who decides which courses to take? (G, L)		
15. Do you find the home visit work clearly defined through rules? (G, P)	Yes	No
16. Do you find that there is room for personal judgement in routine work? (G, P)	Yes	No

procedures. The mode of organisational learning consisted in setting up standard procedures.

In municipalities based on framework management, general goals were set up by the leader, leaving the practitioners to define the specifics. The mode of production was individual application of standard solutions, leaving room for flexibility. The mode of learning consisted in the continual development of the home visitation programme through experience and the sharing of knowledge.

In the “Project Management” municipality, governance was the product of a dialogue between the programme supervisor and the home visitors. The mode of production was innovation through small-scale projects. The mode of learning was closely related to the production mode in as much as the projects continually generated new knowledge.

None of the municipalities examined fell into what could be characterised as a “pure” category, but they were all distinguishable and could be characterised as falling predominantly into one of the three categories. Inter-person reliability in the typology categorisation was acceptable with agreement in 90, 87, and 83% when assessed by a professional representing political science, public health, and economy, respectively.

Among the 34 municipalities examined, 18 were categorised as “Framework Management”, 15 as “Management by Rules” and one as “Project Management”. Further analysis was therefore restricted to the “Framework Management” and “Management by Rule”

types. Of the 18 “Framework Management” municipalities, nine had been allocated to intervention and 9 were control municipalities. Of the 15 “Management by Rules” municipalities, eight had been allocated to intervention and 7 were control municipalities. The one “Project Management” type was a control municipality.

Descriptive comparison between municipality typology and selected structure variables is shown in Table 2. There were fewer small “Management by Rules” than “Framework Management” municipalities, and their population densities and overall expenses for older people were higher. “Framework Management” municipalities had higher rates of 75+-year-olds, used more resources on preventive home visits, communicated better, experienced less staff changing and had higher social capital than “Management by Rules” municipalities.

Discussion

The main result of this study is that from a theory-based formal typology point-of-view, the qualitative analysis identified three distinct management strategies for preventive home visitation schemes. Of all the 34 participating municipalities, 33 fell into the categories “Management by Rules” or “Framework Management”.

Prevention of functional decline as part of home visitation programme is known to depend on the level of

Table 2 Characteristics of “Management by Rules” and “Framework Management” municipalities

	Municipalities <i>n</i> = 33	
Register data	“Management by Rules” <i>n</i> = 15	“Framework Management” <i>n</i> = 18
Size small/medium (10,000–20,000)/large	6/4/5	11/4/3
Population density; urban versus rural, % urban	47	22
Municipality rate of 75+-year-olds, %	12.3	14.1
Total municipality expenses per 67+-year-olds living in the municipalities (€ 1999)	8,544	8,275
Data gathered by the research team during the study period		
Municipality staffing of preventive home visits (hours per week/100 75+)	3.76	4.39
Independent preventive visitor staff department, %	60	67
Integration of preventive home visitor function with the home help allocation, %	40	28
Social capital, (derived from number of organisations for elderly, and trust in the community, ordinal scale, 6 highest)	4.13	4.94
Preventive home-visitor-reported organisational communication (% poor)	36	6
Preventive home-visitor-reported “good support from leader” %	60	83
Visits per 75+ living in the municipality	0.29	0.22
Number of visits offered per year	1.8	1.7
Staff changing (at least 1 preventive visitor shifted during study period) %	47	28

follow-up, the degree of interdisciplinary coordination and timing within the primary care sector (Stuck et al. 2002, Elkan et al. 2001). Municipality organisation and management of the scheme obviously therefore may be of importance for beneficial outcomes.

Each organisational approach had its own advantages and disadvantages. The municipalities managing the programme predominantly by rules were reliant upon standard operating procedures. The advantage of this approach was reliability and homogeneity in the provided service, which ensured that every person in the target group was offered the same service. The disadvantage was that standardisation inhibited the ability to provide individualised service according to the needs of a specific situation. The “Framework Management” municipalities enjoyed the advantage of being able to provide individualised flexible services even in complex situations. However, the disadvantage was that not all citizens could expect the same service and, more important, that this type of organisation required a very high level of skill and competence because the home visitors had to be able to handle highly complex tasks with little guidance. This underlines the need for education and professionalism. The “Project-managing municipality’s” advantage was a high capacity for continuous development and adjustment of the provided services. This ability may, however, have been obtained at the expense of stability and continuity in the service. The continual introduction of new ways of doing things generally ignores the fact that it takes some time for any

initiative to produce effects in this field—too much development too fast. Furthermore, it is very costly. Staffing had to be high in order to organise the programmes in this way and the marginal effects may not reflect the added expenses.

Governance of the preventive programme was associated with care management in general; e.g. how the visits were conducted, how the staff communicated and worked together, and how integrated knowledge learnt through the visits was implemented. Management may even shape the patterns in how local community factors affect older people’s autonomy, quality of life, and functional ability. Thus, high trust in the community and a dense organisational structure supporting older people’s needs (Putnam 2002), collectively defined as social capital, was associated with the “Framework Management” typology. Other structural variables may also reflect different priorities and how such priorities influence the dynamics and professional attitudes towards older people. In preliminary aggregated analysis, several municipality variables were tested for association with beneficial functional outcomes without any significant correlations. Small municipality size was associated with “Framework Management”. Smaller municipalities may experience shorter communication routines between the visitors and their leader, which could promote a good grasp of integrating the programme into the ordinary home care system. Teamwork, collaboration and support from the leader appeared to constitute the key attributes to an organisational quality culture.

A major strength of the present study is that it deployed a tool for distinguishing between different approaches to preventive home visitation programmes that were based on detailed process information available from all participating municipalities. All home visitors as well as leaders were highly motivated for contributing information for this new national health promotion initiative, which clearly underlines its high internal data validity. Everybody spoke out without reservation about how they worked.

The study enjoyed the quantitative strength of reliable outcome estimates owing to comprehensive municipality register data, and the qualitative strength of a precise categorisation of the participating municipalities.

A qualitative approach always involves the challenge of making sound inference and valid generalisations. Differences rooted in individual and social contexts must always be taken into account, but we have no reason to believe that the visitors did not inform honestly about all aspects of the programme. Answering the questions implied no personal risk whatsoever as these interviews were performed 4 years after the intervention ended. The possibility of organisational changes existed, but comparison with process evaluation data from the intervention period confirmed that only minor management changes had occurred in the municipalities. Specific and highly discriminating questions addressing the categorisation procedure, e.g. “Do you use interview guidelines during the visits?” or “Has your leader laid down guidelines for how to contact the target group?” were similar in 2001 and 2005, underlining that no major changes had taken place.

Only few studies have adopted a feasibility design for evaluating the effects of preventive home visits, and none have investigated how the organisation of preventive home visits influences the effects of in-home assessments of older people. Municipality management strategies as well as structural variables are needed to evaluate the effectiveness of a national home visitation programme for older people as differences in these strategies carry clear advantages and disadvantages with them. The typology developed in this paper makes such an analysis feasible.

At the outset, the study was not designed to evaluate how the organisation of the municipalities influenced older people’s functional ability. We knew that there was considerable variation among municipalities in how they organised the programme and the intervention study was randomised at the municipality level. Accordingly, the matching sought to balance known and unknown contextual municipality confounders. We did not know which management strategy the municipalities used at baseline, but it turned out that the two main types presented in this paper fell randomly into the intervention and the control

group. Differences in management of the programme may be associated with the functional ability of the older people living in the municipalities. Further multilevel analyses will be done since more knowledge is needed to understand the “black box” of community contextual influence on these health promotion issues.

The typology developed in this paper contributes to a methodological understanding of how preventive home visits to older people are organised in Danish municipalities. As the typology is generic in nature it is not logically limited to the analysis of the home visitation scheme. The usefulness of the developed typology to analyse other related public health programmes must be established empirically, but the basic model may provide a guide to describe and analyse municipality organisational processes in public health programmes.

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