

Older Users' Perspectives on the Benefits of Preventive Home Visits

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Abstract

In this article we explore older people's perspectives on the benefits of preventive home visits (PHVs), after long-term follow-up. PHVs are health services intended to promote older people's health and independence, prevent disease, and postpone functional decline. We applied an explorative and descriptive design and analyzed qualitative research interviews of 10 PHV users who had received multiple visits for at least 6 years. We sought manifest and latent content in our analysis. The participants reported benefits falling within four main categories: to feel safe, to manage everyday life, to live well, and to be somebody. Two latent themes emerged: living with an underlying, realistic concern about an uncertain future, and striving to maintain oneself as a person. The perceived benefits of PHVs differed significantly from the outcome measures commonly used in randomized, controlled trials. PHV interventions should have a longitudinal approach and support each person's current needs and valued goals.

Keywords

community and public health; health care, users' experiences; health promotion; nursing; older people; research, qualitative

The majority of older people want to live at home for as long as possible (Fänge & Ivanoff, 2009; Sabia, 2008). Functional surroundings, good coping ability, sustained health, and functional ability are essential if older people are to remain independent (Norwegian Institute of Public Health, 2010; Oswald, Jopp, Rott, & Wahl, 2011). Improving older people's health is not only a major public health goal, but also a socioeconomic goal because of the demographic changes expected in all Western countries (Christensen, Doblhammer, Rau, & Vaupel, 2009; U.S. Centers for Disease Control and Prevention, 2013). Western society consequently needs interventions that can support older people's ability to remain at home and reduce or delay their need for more comprehensive health services (European Commission, 2013; U.S. Centers for Disease Control and Prevention, 2013).

Preventive home visits (PHVs) are outreach health services intended for home-dwelling, independent, older people. Generally speaking, the aim of PHV services is to promote health and independence, prevent disease, and postpone or reduce functional decline (Lofqvist, Eriksson, Svensson, & Iwarsson, 2012; Vass, Avlund, Hendriksen, Philipson, & Riis, 2007). Although the health care systems of most Western countries offer PHV services, the concept covers a plethora of very different interventions that vary in their scope, aim, and content; however, few

PHV interventions actually focus on health promotion (Hallberg & Kristensson, 2004; Markle-Reid et al., 2006) or include a health-resource perspective (Fagerström, Wikblad, & Nilsson, 2009).

It is challenging to measure the effects of health-promotive and disease-preventive initiatives because of their multifaceted, complex, and long-term nature. Still, researchers have published a number of systematic reviews and meta-analyses investigating randomized, controlled trials (RCTs) of PHVs (see, for example, Beswick et al., 2008; Bouman, van Rossum, Nelemans, Kempen, & Knipschild, 2008; Gustafsson, Edberg, Johansson, & Dahlin-Ivanoff, 2009; Huss, Stuck, Rubenstein, Egger, & Clough-Gorr, 2008; Liebel, Friedman, Watson, & Powers, 2009; Markle-Reid et al., 2006; Mayo-Wilson et al., 2014). The long-term effects of PHVs might not be seen in these reviews because of the relatively short follow-up times of the included studies (a maximum of 3 years). Differences in health care systems,

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samples, follow ups, outcomes, and heterogeneity and a lack of sufficient intervention descriptions in these RCTs result in conflicting results (Mayo-Wilson et al. 2014; Stuck, Egger, Hammer, Minder, & Beck, 2002). Even so, we maintain that PHV interventions can potentially positively affect some health-related dimensions; a multidimensional approach and repeat visits by specially trained professionals appear to improve PHV outcomes (Liebel et al., 2009; Lofqvist et al., 2012; Stuck et al., 2002; Vass et al., 2007).

RCTs are neither adequate nor sufficient for the assessment of multifaceted PHV interventions; qualitative research can provide a deeper understanding of the complexity of these interventions and help researchers understand what contributes to positive outcomes (Beswick et al., 2008; Clark, 2001). Existing RCTs of PHVs measure objective outcomes defined by researchers or health authorities, mainly with regard to morbidity, mortality, or socioeconomic measures such as hospital or nursing home admissions. Surprisingly, few studies exist related to PHV users' perspectives on PHV services, including which outcomes users view as being valuable. We found no studies about older people's perspectives on the benefits of PHVs in relevant electronic databases.¹ In a recent study from the Netherlands (van Kempen et al., 2012), older people's needs and expectations differed from the actual purpose of the PHV intervention. This fact underscores the need to include users' experiences in the development of PHV services and defining the outcomes best suited to measuring the effectiveness of PHVs.

In 2005, the Norwegian government called for studies of users' experiences of PHVs (Wyller & Pettersen, 2005). This study was part of a case study of PHVs in a Norwegian municipality, and we relied on these analyses to explore older people's perceived benefits of PHVs after long-time follow up.

Theoretical Perspectives on Health and Health Promotion

How one defines and understands health determines how health is promoted. A comprehensive understanding of health includes a dual, complementary relationship between objective components such as disease and subjective components such as well-being, coping ability, and social functioning (World Health Organization, 1986, 2006). Different theories and knowledge bases provide the foundation for knowledge of how to promote these components. Consequently, comprehensive health promotion to support the different factors inherent in older people's health should be based on various strategies (Mæland, 2011).

The traditional biomedical understanding of health is the absence of disease. To promote objective health is,

consequently, to prevent disease. Health professionals use pathogenesis, the biomedical knowledge of what leads to illness, in various preventive strategies to define risk factors for disease, to diagnose and treat existing disease, and to reduce the consequences of disease (Mæland, 2011). Even though disease negatively impacts older people's functional ability and quality of life (Marengoni, Von Strauss, Rizzuto, Winblad, & Fratiglioni, 2009), it is possible to prevent or delay the negative influence of a wide range of disorders later in life (Mor, 2005). Preventive disease strategies are therefore central to health promotion.

Within a subjective health perspective, health is understood as well-being, or a resource for functioning that can be strengthened and promoted despite a diagnosed disease (Mæland, 2011). Keyes' two-continuum model of mental health is one relevant theory in which the focus is on the well-being aspect of health (Keyes, 2005, 2007). In his model, Keyes emphasized how to promote well-being regardless of objective diseases. To guide this work, Keyes (2005) operationalized the concept of well-being to include indicators of emotional well-being, psychological well-being, and social well-being.

In Antonovsky's (1987) theory on salutogenesis, or what creates health, the focus lies on health resources and coping ability. Antonovsky (1987) described health as a continuum, whereon the degree of health depends on a person's ability to cope with challenges and strains, and whereon disease is one of several stressors that might reduce health. A person's ability to cope is dependent on what Antonovsky called a sense of coherence (SOC). Antonovsky described SOC as the confidence that makes it possible to make sense of what one experiences in life (comprehensibility), that resources are available to handle the demands one meets (manageability), and that these demands are challenges worthy of investment and engagement (meaningfulness). One can accordingly define the promotion of health as supporting a person's resources and strengthening his or her sense of comprehensibility, manageability, and meaningfulness (Antonovsky, 1987, 1996).

A growing focus has emerged on the use of health-promotive and health-resource theories in relation to care for older people. Examples of this focus include theories on resilience, self-transcendence, purpose in life, and SOC, which all correlate to aspects of older people's life strengths (Nygren et al., 2005). Fry and Debats (2010) integrated these and other related theoretical perspectives into a conceptual framework on the major sources of life strengths that contribute to well-being and health later in life. These sources include religion and spirituality, personal meaning in life, social contribution and serving others, faith and courage, autonomy, mastery over environment, perceived control, self-efficacy beliefs, self-esteem, self-acceptance, optimism, the ability to mobilize

social support, social connections and affectional ties, cultural environment, person–environment fit, and continuity in personal and sociocultural roles. These sources constitute possible domains whereby one can promote health and well-being for older people. The promotion of health must include a personalized approach, because older people consider and value the different aspects of health individually, and each person's resources interact to support well-being and coping in different and numerous ways (Fry & Debats, 2010).

Health personnel's use of various salutogenic and preventive strategies might promote different aspects of older people's health. Accordingly, such theoretical perspectives are relevant to the actual study. Through the theoretical perspectives described above, we became interested in determining what kind of health-promotive interventions older PHV users actually experience and value. The diversity of the perspectives contributed to our choice of an explorative study design and an inductive approach to data analysis. The theoretical perspectives also influenced the construction of the interview guide and are central in the last step of our analysis, which is a theoretical interpretation of the findings in the discussion.

Methods

This study was part of a larger case study on PHVs in a Norwegian municipality. We applied an explorative design with a qualitative, hermeneutical approach because of the lack of knowledge related to users' experiences of PHVs (Polit & Beck, 2012).

Setting

The study's setting was a Norwegian urban municipality with approximately 60,000 inhabitants. The context for the study was the Norwegian social democratic welfare state model, with its well-developed public health care and social services, which are mainly free of charge and provided on the basis of professional judgment of need. By law (Folkehelseoven, 2011; Helse- og omsorgs-tjenesteloven, 2011), all municipalities must offer essential health care services to their inhabitants, such as home health care, rehabilitation, and nursing homes. Health promotion and prevention is part of the municipalities' mandatory obligations, but each municipality is free to decide how to realize these obligations and what services to offer. The city used in this study was one of the first Norwegian municipalities to introduce PHV services in 1999.

Given the heterogeneity of the PHV concept, a short description of the PHV services in the actual municipality is necessary. Freely translated, the name of this service is "health-promotive and -preventive home visits to older

citizens." Ten experienced registered nurses, the majority of whom have formal higher education in geriatrics or psychiatry, provide the service. The stated aims of this PHV service include the promotion of older citizens' health, well-being, and safety, supporting their ability to live at home for as long as possible, and the reduction or delay of their need for more comprehensive health care services (Municipality of Drammen, 2009). PHV services are available to all home-dwelling citizens above the age of 75 years who are not users of regular home health care. All inhabitants meeting these requirements receive information about the service by mail, including the visiting nurse's name and contact information and a date for a proposed first visit. Unless contacted, the nurse will visit as scheduled, and between 75% and 80% of inhabitants permit the visit.

During the first visit, the nurse aims to establish a cooperative relationship with the PHV user and obtain a comprehensive picture of the user's health status, problems, and resources. The visitor does not use geriatric assessment instruments but instead uses a theme guide covering life history, physical and mental health, functional ability, nutrition, home, activities, and family and social network, which provides structure to the ensuing conversation. Using the information from this conversation, the visitor provides personalized support, practical help, and information, including information on the services or activities available for older people in the community, a recommendation that the user contact his or her general practitioner for medical consultation, a referral to other municipal health care services such as occupational therapy or physiotherapy, or the arrangement of contact with voluntary services. The visitor also gives advice and/or provides helping aids as needed for home safety or improved functioning. The same visitor meets the user again the following year or as often as deemed necessary. Each visitor records and stores his or her notes in an area exclusive to PHV services in the municipality's electronic patient journal system.

Participants

The study included 10 participants purposefully sampled from the municipality's list of PHV users.² We assumed that those individuals who availed themselves of this elective service for a period of many years perceived the service to be relevant, beneficial, and/or valuable. To capture long-term effects and ensure participants with extensive experience with PHVs, we included only those individuals with more than 6 years of experience with the service who were without cognitive impairment. A total of 370 PHV users met these criteria.

In this explorative study, we sought depth and variation as well as shared patterns regarding experiences and

opinions (Polit & Beck, 2012). We applied a maximum variation sampling strategy because its strength, particularly when the number of participants is small, is that “any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared dimensions of a setting or phenomenon” (Patton, 2002, p. 235). Differences in outcome exist in previous studies of PHVs with regard to gender (Vass et al., 2004) and length of follow up (Stuck et al., 2002). Accordingly, we stratified the participant list to ensure variation in gender and length of experience with PHV. We decided on a random selection within the strata to avoid selection bias, thus enhancing credibility (Patton, 2002).

A senior nurse from a different municipal health care service organized the stratification and created the initial sample of 10 participants. This nurse invited PHV users to join the study by phone and ensured, through inclusion, the planned stratification of participants. The nurse then gave the list of prospective participants to the first author, who sent written information about the study by mail to the prospective participants and contacted them by phone a week later to schedule an interview. Participants provided written consent to participate in the study prior to their interview.

The sampling procedure resulted in 5 participants (3 women, 2 men) with 6 to 8 years of PHV experience and 5 participants (3 women, 2 men) with 9 to 11 years of PHV experience. The sample included 6 widowed, 1 divorced, and 3 married participants. The age range was 81 to 91 years, with a mean age of 85.5 years. Two participants were in good physical condition and had only minor health concerns; the remaining participants had various degrees of physical restrictions, predominantly caused by musculoskeletal or neurological problems, and used rollators (rolling walkers) or canes when walking. Three participants were in a rather frail physical condition because of multimorbidity and had problems walking up and down stairs and outdoors. Two participants suffered from minor mental problems and 2 had advanced vision or hearing impairments.

Qualitative researchers use a small purposeful participant sample, whereby the sample size is determined by informational considerations (Patton, 2002). When applied here, this sampling strategy resulted in a sample of study participants with unique and diverse experiences of the PHV service, as well as shared patterns that “cut through the noise of variation” (Patton, 2002, p. 243). The 10 participants in this study all met the criteria for being considered information rich on the research topic (Morse, Barrett, Mayan, Olson, & Spiers, 2002). The sampling procedure allowed for the inclusion of more informants, if needed, from the perspective of data saturation. Our analysis of the last four interviews resulted in

only one new category, and the data from the last two interviews merely confirmed the existing categories, which indicates data saturation (Polit & Beck, 2012). We consequently considered the 10 participants to constitute an appropriate sample with regard to the study purpose.

We presented the study to the leaders of the municipality’s health care department, research and development unit, and members of the PHV team. After positive feedback, the municipality’s director of health care and social services granted us formal permission to conduct the study.

Data Collection

The first author collected the data through qualitative research interviews. Qualitative research interviews have an open, conversational form with a loose structure but a clear purpose. The aim of this data collection style is to understand the meaning of the interviewed person’s experiences through an interpretation of what is said and how it is said (Kvale & Brinkmann, 2009). The interviews took place in the participants’ homes and lasted between 45 and 105 minutes. A semistructured interview guide designed to allow the interviewer to elicit answers to the study’s research questions covered the following themes: expectations of the service, opinions on the organization of the service, opinions on the content and structure of the visits, assessment of the visitor’s professional competence, perceived benefits of PHVs, critical comments, and the potential for improvement.

Each interview started with an open question to allow the participants to focus on what he or she perceived to be important: “Please tell me about your experiences of PHV.” The interviewer’s use of supplementary and follow-up questions ensured a thorough inclusion of all themes. During the interviews, the interviewer strove to continuously examine her understanding of the participants’ comments by verifying her interpretation of what the participants meant with the participants themselves (Kvale & Brinkmann, 2009). We did not perform member checking because it is not recommended as a verification procedure (Morse et al., 2002). The interviewer taped the interviews and wrote down spontaneous thoughts and impressions immediately after each interview.

Data Analysis

Either the first author or an office assistant transcribed the interviews verbatim. All authors then analyzed the text inductively with regard to manifest and latent meaning content within a hermeneutical tradition, following Kvale and Brinkman’s (2009) three levels of interpretation: (a) self-understanding, (b) common sense understanding, and (c) theoretical understanding. The first author conducted the first steps of the analysis; all authors contributed to the

categorization and comprehensive interpretation of the data. We analyzed each interview separately, starting with a thorough listening to the interview and reading of the interview text to get a grasp of the interview experience as a whole. Initially, we excluded irrelevant parts of the text and sought to normalize the language as preparation for further analysis. Then, the text was condensed without altering the participants' meaning content, representing the participants' self-understanding (Level A). We grouped the resulting condensed meaning units by relevance and sorted through several steps, stopping once we had organized each interview into categories. Then, we looked at all of the interviews together and merged the categories describing perceived benefits. After further sorting and abstraction, representing a critical interpretation of what the text was about, we conceptualized 10 subcategories into four main categories.

These four main categories represented the manifest content or common sense understanding of the material (Level B). The latent content is a result of a comprehensive interpretation of the various parts of the text with meaningful content and hints and clues, in relation to the entire text. The two latent themes constitute a shared background for the manifest content of the benefits of the PHV service. In the discussion section, we analyze the findings in relation to relevant research and theory (Level C) to obtain a deeper and more comprehensive understanding of the meaning content in the data (Kvale & Brinkmann, 2009).

Ethical Considerations

The Norwegian regional committees for medical and health research ethics granted ethics approval for the study. Following the Declaration of Helsinki (World Medical Association, 1983), we gave the participants written information about the study and all participants granted their informed consent prior to being interviewed.

Results

Manifest Content

Our analysis of the interviews revealed considerable diversity in the participants' reported benefits from the visits. Even though 2 participants described only one positive benefit, the majority of individuals reported several benefits. We categorized the help and support the visitors provided, resulting in four main categories and 10 subcategories, as seen in Table 1.

To feel safe. All of the participants considered the first main category, to feel safe, to be the most important benefit of

Table 1. Manifest Content: Categories and Subcategories of Perceived Benefits From Preventive Home Visits.

Main Categories	Subcategories
To feel safe	To have a contact person To be looked after
To manage daily life	To be aware of risk factors and factors that promote health Help with continuing daily activities at home Help and support for overview and control, and the preservation of autonomy To be prepared for future needs
To live well	Help maintaining relationships Help with continuing meaningful and joyful tasks
To be somebody	Help sustaining a role and upholding a preferred self-image Confirmation of value

the PHV service. There are different aspects of this main category, which can be divided into two subcategories. The first subcategory was to have a contact person, indicating a trusted person within the municipality's health care system users could call. A typical participant statement was, "The most important? You can write SAFETY in big letters. I know who to call, and I am certain that I will get help the day I need it. It cannot be any better" (Woman [W], age 87). Several participants used the word "when," not "if," when referring to the need for help—confirmation that health problems are an expected part of aging. Even if participants most often linked the safety of having a contact person with future problems, this subcategory could also relate to present, everyday life, as one participant expressed: "She gave [me strict] orders to call her if there is anything I am wondering about. It is a fine arrangement, because it makes me feel very much safer" (W, 91). Several participants appreciated the predictability of the service; they knew the visitor would come as planned. If there was no urgency, the participants would write down their question and save it for the next home visit. Two participants—1 man and 1 woman—spontaneously claimed that men, in particular, profited from the regularity of the visits, because men seek help less often than women, and more rarely have intimate friends with whom they can talk about health problems and worries.

The second subcategory was to be looked after. Regardless of the users' condition, the visitors cared for and kept an eye on them: "The most important is the safety—you know, that someone cares and looks after you and checks that the head is still functioning; that is very reassuring. And knowing you are within the municipality's system" (Man [M], 82). Even if a participant functioned well in everyday life and had regular contact

with close relatives who lived nearby, the competence of the nurses made a difference. These visits were a safety mechanism for illness detection, for not being forgotten by the authorities, and if necessary someone to advocate one's need for more help. Some participants indicated that safety had implications for their health:

The most important is the certainty that she will come when it gets serious. That you know for sure, that you get help when that day comes. Then you can relax. And therefore it might take longer until you actually need help. (M, 87)

When asked, "What could be health promotive in these visits?" one participant answered, "Hmm... Health, then you think of the body, don't you, the arms and legs. But I will return to safety. That is also health. And feeling safe is very, very important. You understand that, don't you?" (W, 87). The visitors helped several of the frailer participants obtain personal safety alarms, which added to participants' feeling of safety. If users fell or became ill and could not reach the telephone, they could activate the alarm button on their bracelet and the municipality's alarm central would respond.

To manage daily life. The second main category, to manage daily life, was another significant domain related to help and support, and had four subcategories. The first subcategory was to be aware of risk factors and factors that promote health. Even if some participants managed their everyday life well, they appreciated advice and information related to how to stay fit, prevent falls, or make their home safer, for instance. During visits, conversations related to different health-related aspects also functioned as a reminder and impetus for users to engage in primary and/or secondary preventive activities:

She advised me to try to be more active, not sit so much. And that is a good advice, because it is so easy to get passive, even if I know it is unwise. So I try to follow the advice every day, because I know the recommendation came from her heart. (W, 82)

The second subcategory was help with continuing daily activities at home. The majority of participants experienced various degrees of physical deterioration, and adjustments to their usual way of living were necessary. Users received personalized counseling, advice, and practical help, including assistive devices to facilitate the basic and instrumental activities of daily living (IADLs), as well as home modifications. The visitors provided assistive devices as needed, and supplemented the devices according to changing needs over time because of disease or physical decline. The participants greatly valued this help:

She understands my problems and has suggested a number of assistive devices that I neither knew existed nor knew that I could get. I could not have managed without those helping aids. Thanks to them, I can now live close to normal. (W, 82)

Visitors could provide some common assistive, security, or fall-prevention devices within a day or two. If users needed more elaborate assistive devices or home modifications, the visitors referred them to the municipality's physiotherapists or occupational therapist services. These therapists gave users expert assessment and advice or helped users apply for relevant devices or learn new technics to manage IADLs. Both the visitors and physiotherapists encouraged users to exercise to maintain functional ability, and recommended senior training groups run by municipal physiotherapists. The visitors also provided information and help with regard to additional services, such as "meals on wheels" or the voluntary visitor service, which provides social support and/or help with shopping, and so forth. The participants also received information about and advice on minor health problems, which helped them manage their situation and spared them from contacting their primary physician. Help could also take the form of psychosocial support, helping users maintain hope and confidence or overcome difficult memories or traumatic losses:

We talk about how life has been—nerves and all that. You could have written a book on what I have gone through. So when she comes, I have somebody to talk to about my problems, and that really helps me. (W, 89)

The third subcategory was help and support for overview and control and preservation of autonomy, which encompasses users' psychological ability to stay in charge of their own lives. The majority of users valued autonomy highly, and several participants reported that the PHV nurses shared relevant knowledge that helped them remain autonomous. Some participants mentioned that information on legal rights or helping aids was important; others valued information on social activities:

I somehow got another feeling toward everything, because of what she told me. She informed me about a lot of things I could do or take part in, if I wanted. And I wouldn't have known that if she hadn't told me. What possibilities I have. (W, 91)

The fourth subcategory was to be prepared for future needs. Several participants appreciated the possibility of contacting and getting help from their visitor—not if, but when needed. Participants stated that conversations with visitors could center on aspects of health, information on their legal rights as seniors in the municipality, how and where to get helping aids, or

how to apply for additional municipal services. Such conversations helped participants mentally and practically prepare for future needs.

To live well. The third main category, to live well, held various meanings for the participants and had two subcategories, with some overlap. In their interviews, participants revealed they received personally targeted approaches and help from visitors. The first subcategory, help maintaining relationships, was an important theme for several participants. One participant, who appreciated her close relationship with her children and grandchildren, stated,

We do talk a lot about health; we sure do, because that's why she comes, isn't it? You cannot always complain and grumble over your health problems to your own family, 'cause then you risk [that] they stop visiting. You see, I have a friend, and she just gushes it all over her kids, and they just hate to go home to their mother. That's why I prefer to talk to the visitor about my health problems. (W, 81)

Two participants mentioned that they received help reestablishing contact with friends and/or relatives. One participant felt lonely after moving to another part of the municipality, but her visitor organized practical help on a regular basis to help her visit the service center in her previous neighborhood: "It really means a lot to me to be able to join those dinner meetings, to keep in touch with old friends and neighbors" (W, 89). Another participant wanted to reestablish contact with a grandchild who lived in another part of the country. The visitor helped reestablish a close relationship through practical and emotional support and initiative, for which the participant expressed her warmest gratitude. Visitors also helped participants establish new social relationships: "She told me about different activities for the elderly, and I chose to join the weekly senior workout. That is actually one of the most important things for me now. I meet so many nice people there" (W, 91).

The second subcategory was help with continuing meaningful and joyful tasks. Visitors used counseling, information, and helping aids to enable participants to continue with tasks that the participants described as both meaningful and a source of pleasure and joy. One visitor recommended that a participant, a former blue collar worker, join a carpentry workshop at a service center:

At the workshop we do small jobs for others. We get tasks from the volunteer's central or the nursing home, and we fix and repair things. That makes me feel that I contribute back to the municipality. To be part of the carpentry workshop is one of the best things that has happened to me, and I think it's like that for the other guys, too. If they stop that activity I believe eight to ten guys will just collapse. (M, 81)

Another participant received help with applying for an electric four-wheel-drive mobility aid that made it possible for him to visit old friends and get out in nature for recreational purposes. Still another participant received helping aids that made it possible for him to continue some of his usual chores around the house and garden. For the female participants, the help was often related to housework or cooking and allowed them, in turn, to help family members, neighbors, or friends. One example of receiving help to continue with a joyful task involved a participant who received a stair lift and an electrical wheelchair so that she could continue to visit the theater and attend concerts. Another participant received reading aids:

Since I was a little girl, I have loved to read, and then not to be able to, because of my vision problems—oh, I missed it so. But she informed me about the help I could get from the Association for the Blind and Partially Sighted, and now I have got this new reading tablet as well as a device for audiobooks. It is marvelous! (W, 91)

To be somebody. The fourth main category, to be somebody, included two subcategories that express mutually connected aspects and reflect a wish for dignity, value, and self-esteem. The first subcategory was help sustaining a role and upholding a preferred self-image. This subcategory is closely connected to social functioning and, consequently, the aforementioned main categories: to manage daily living and to live well. A quotation from one participant illustrates this interconnectedness. She loved to bake and always made cakes for anniversaries and other special occasions until vision problems made baking impossible. She received special helping aids to facilitate baking and related during her interview, not without pride, that

To be able to continue with baking means a lot to me. I do not feel totally outdated any longer. I used to bake a special cake, which is always a success. I delivered one last Sunday for a 60th anniversary. And I made cookies for my son-in-law, to take with him to Spain. So really, it says a lot that you can continue with some of the things you used to. (W, 91)

The second subcategory was confirmation of value. Participants often received confirmation as a result of a maintained role in relationships with family and friends, which the visitors supported in a multitude of ways. When users were able to contribute, other people recognized and confirmed their value as human beings. Visitors also provided confirmation of users' value when they informed users of their lawful rights; for example, their entitlement to helping aids. Even how the visitors spoke to or responded to users could confirm their value. One participant commented directly on this matter when

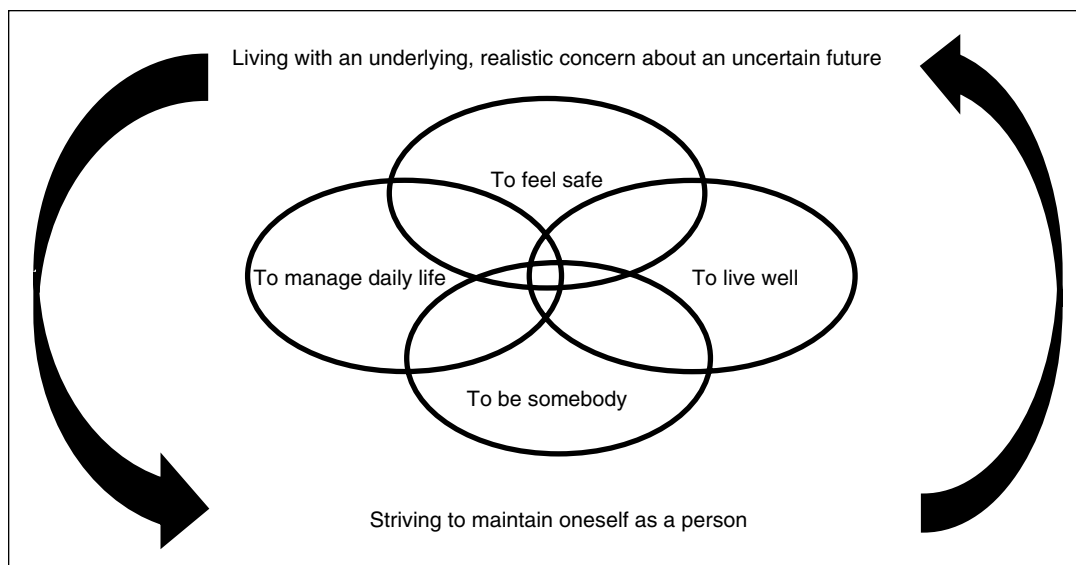


Figure 1. Latent and manifest content: Categories of perceived benefits from preventive home visits against the background of the two latent themes.

asked, “Are there other things with the visits that are important?”:

Yes. That I am not just sitting here and am forgotten, but that someone makes me feel that I still have something to contribute. That I’m not just a nothing, not just a weak human being who sits here, but I still mean something. She is very good at communicating that. It makes me feel that... I am somebody. Not just a frail old woman who sits moping, but that I am somebody. I want to be somebody as long as I can. (W, 82)

Latent Content

We identified two latent themes in the material representing the participants’ main concerns. In these latent themes, we see an underlying tension in the lives of older people; the themes consequently constitute a background for the manifest content seen in the study, presented in Figure 1. The first latent theme was “living with an underlying, realistic concern about an uncertain future.” Participants’ statements directly or indirectly revealed that they feared losing their independence and autonomy, and that they feared loneliness. The participants often presented these fears in the form of anecdotes about friends or relatives undergoing physical or mental deterioration, making such fears realistic and relevant to themselves.

The second latent theme was “striving to maintain oneself as a person.” The stories the participants told about themselves, about who they had been and who they were striving to remain, reflect this theme. Participants expressed this theme through wishes and utterings about

what was important to them as individuals and in small “success stories” about how they managed to preserve their self-image, role, dignity, and feelings of value, despite limitations and losses caused by the aging processes or illness.

Discussion

The purpose of this study was to explore older people’s perspectives on the benefits of PHVs, after long-term follow up. Here, we discuss these benefits in relation to the presented theories related to health and health promotion and relevant literature.

Participants considered the first main category, to feel safe, to be the most important benefit of PHV. This result was consistent with the findings seen in another study within the same research project of older people’s experiences after a first PHV (Tøien, Heggelund, & Fagerström, 2014). Safety is a basic need throughout life, and the participants perceived that their future health was threatened. We found that the participants perceived PHV visitors to be professional and caring people whom they trusted to help them manage future health demands and everyday health challenges. Researchers reported similar findings in a Swedish study, wherein three prerequisites comprised the foundation for older home-dwelling people’s feelings of safety in everyday life: feeling healthy, having someone to rely on, and feeling at home (Pettersson, Lilja, & Borell, 2012).

In this study, the participants perceived that PHVs influenced safety, thereby increasing their trust in their available resources for coping. This experience is quite

similar to the concept of manageability and, accordingly, indicates an increase in the participants' SOC, as defined in Antonovsky's (1996) theory on salutogenesis. This link between safety and coping capability is seen in the quotation from "M, 87" in the last part of the "to feel safe" section (under "Results"); the researchers who conducted a Swedish study also confirmed this link (Pettersson et al., 2012). An increased coping capability directly supports older people's ability to manage upcoming demands in life and allows them to live an independent life.

In addition, a correlation exists among a person's measured SOC, mental and physical health, and quality of life (Eriksson & Lindström, 2006, 2007). The quotation from "W, 87" in the last part of the "to feel safe" section (under "Results") shows that health is contingent on safety, not vice versa. This fact is consistent with findings from a study on the meaning of mental health from the perspective of elderly women (Hedelin & Strandmark, 2001). In this study, the researchers identified trust and confidence in the future to be one of the essential components of health, including their conviction that they would receive support from others if needed. This finding indicates a two-way relationship between the concepts "promote health" and "strengthen safety." Given that visitors contribute to older people's feelings of safety, PHV interventions have the potential to support independent living and promote health, both directly and indirectly.

The content of the second main category, to manage daily life, involved support for health, understood as functioning and coping, which are critical for independent living. The benefits that the participants reported included elements of primary, secondary, and tertiary prevention, and therefore correlate with the common understanding of the main aims of the PHV service. Participants considered a certain level of physical functioning to be critical, but the majority of these very old people emphasized help with compensating for functional deficits more than preventive initiatives.

Similar to a study by van Kempen et al. (2012), it was remarkable how little the participants focused on objective success criteria connected to disease and disease prevention. The advanced age of the participants might partly explain these findings, and their focus on compensatory strategies corresponds to Baltes and Carstensen's (1996) theory of selective optimization with compensation. In Baltes and Carstensen's developmental life-management theory, an aging person will strive to adapt to unavoidable decline and loss of resources to preserve essential values and needs (Baltes & Carstensen, 1996; Baltes & Lang, 1997). Our findings also correspond to the findings observed in a Finnish study: Optimal health for older people can be understood as an older person's ability to use his or her health resources despite disease

and the aging process (Kulla, Sarvimäki, & Fagerström, 2006).

We clearly observed in the interviews that participants possessed the cognitive and psychological prerequisites for managing daily life. The information and support given by PHV visitors can add to older people's ability to understand and make sense of what is happening, and provide a basis for informed choices and autonomy. This understanding relates to comprehensiveness, another of the components of Antonovsky's (1996) SOC concept. Knowledge is closely related to environmental mastery and autonomy, which are also elements of psychological well-being (Keyes, 2005) and perceived control (Sparks, Zehr, & Painter, 2004). Psychological well-being and perceived control are important predictors of life satisfaction and perceived well-being later in life (Berg, Hassing, McClearn, & Johansson, 2006; Sparks et al., 2004). Autonomy and perceived control are two of the major sources of life strengths found to contribute to well-being and health later in life (Fry & Debats, 2010). The health-promotive potential in supporting older people's ability to manage daily life is thus evident.

In the third main category, to live well, we observed a great variety of participants' preferences and priorities regarding the meaning of living well and in visitors' approaches and personalized support. Such variety correlates with Baltes and Carstensen's (1996) "personal goals—whatever they must be" (p. 414), which constitute criteria for successful aging. This category included social relationships and participation in meaningful, enjoyable activities and reflects indicators of emotional well-being: positive affect and avowed quality of life and social well-being understood as social acceptance, social actualization, social contribution, social coherence, and social integration (Keyes, 2005).

Good social relationships are the most important aspect in defining whether older adults view themselves as having positive functioning and well-being (Ryff, 1989). In addition to a direct effect on well-being, being part of a quality social network and participating in leisure activities reduce the probability of all-cause mortality for men and women of all ages (Keyes & Simoes, 2012). Research shows the importance of the quality of a person's social network in relation to life satisfaction (Berg et al., 2006; Golden et al., 2009; Sparks et al., 2004), well-being and mood (Golden et al., 2009), onset of dementia (Paillard-Borg, Fratiglioni, Xu, Winblad, & Wang, 2012), and longevity, even among the oldest old or for people with chronic conditions (Rizzuto, Orsini, Qiu, Wang, & Fratiglioni, 2012). Supporting and improving older people's social relationships and participation in favorite activities can thus promote important aspects of health.

The fourth main category, to be somebody, included how visitors helped participants sustain a role and uphold

a preferred self-image, and confirmation of the intrinsic value of the participants, which relates to human beings' existential need for connectedness, personal meaning in life, self-acceptance, and self-worth. These are all elements in emotional, psychological, or social well-being, operationalized in Keyes' (2005) model of mental health. Confirmation of value is especially important when a person experiences physical/mental decline, loss, vulnerability, and/or dependency. The roles and identity that a person has and that contribute to self-esteem develop throughout the person's life, in social interaction and close relationships with other human beings. Social support—whether from family, social networks, or visitors—can enhance a person's sense of identity or feeling of value, and thereby reinforce his or her coping ability (Fry & Debats, 2010).

The use of life-history interviews by visitors has the potential to strengthen older people's SOC and stable self (Thorsen, 1998). Continuity in personal and sociocultural roles is a source of life strength (Fry & Debats, 2010). Supporting a person's authentic self is a fundamental part of person-centered nursing that results in user satisfaction with care, user well-being, and a therapeutic culture (McCormack, Roberts, Meyer, Morgan, & Boscart, 2012). It is therefore important to support older people's feelings of value if they are to experience well-being and zest for life.

The participants in this study reported long-term benefits of the PHV service that differed considerably from those outcomes most often measured in RCTs. One explanation for this finding might lie in the discrepancy between what older people and professionals define as healthy, successful, or good aging (Depp & Jeste, 2006). Other researchers have also confirmed our findings that older people have a limited focus on disease: Dapp and colleagues (2011) found that older people more commonly focused on social engagement and a positive outlook on life rather than on physical health. Also, other research shows that functional decline influences well-being less for the oldest old than for younger people (Nygren et al., 2005); emotional and existential domains tend to become relatively more important later in life (Fry & Debats, 2010; Tornstam, 1997).

Still, the small amount of data reported on disease-preventive strategies might reflect a limited focus on such strategies during the visits. This lack of data is an important finding that reflects a possible weakness of this PHV intervention. The prevention of several diseases and functional decline is possible even at an advanced age (Mor, 2005), and PHV interventions offer a unique opportunity for health personnel to regularly and systematically assess and detect the early signs of disease or decline. Our findings therefore helped us reveal a potential way whereby the PHV service can be improved, which is to

further enhance the focus on disease prevention, even for very old PHV users.

The PHV visitors applied a multitude of personalized strategies to support users' health, well-being, and independent living as their lives changed over time. Our comprehensive interpretation of the two latent themes, "living with an underlying, realistic concern about an uncertain future" and "striving to maintain oneself as a person," highlights the importance of the use of a personalized, longitudinal, and continuous approach in PHV and the importance of support that emanates from each user's current needs, problems, resources, values, and beliefs. Doing so realizes the essence of person-centered nursing: the delivery of care through a range of activities, including holistic care, working with beliefs and values, engagement, having a sympathetic presence, sharing decision making, and providing for physical needs (McCormack, Karlsson, Dewing, & Lerdal, 2010; McCormack et al., 2012).

Such a course of action is also comparable to Baltes and Carstensen's (1996) suggested criteria for successful aging: the achievement of personal goals—whatever they must be. The realization of self-defined and valued goals contributes to meaning in life and a positive self-image, and "adds meaning to the striving" (Daatland & Solem, 2011, p. 276). According to Antonovsky (1996), meaningfulness is the most important component of SOC because it is a motivational force that energizes older people to continuously strive for what is important in life. These interpretations of health and successful or good aging are, consequently, relevant as outcomes of PHVs.

Methodological Considerations

In this study, we investigated the long-term benefits of PHV, based on the experiences of older people who elected to avail themselves of this service for many years. All of the participants were very pleased with the service and seldom mentioned, even when urged to do so, any weaknesses of the PHV service. We assume that this omission of weaknesses was because only those individuals who perceived PHV to be relevant, beneficial, or valuable continued with the service, which is noncompulsory, for such an extended period of time. This article, therefore, should be read while taking this perspective into account. We based this study on information from 10 relatively old PHV users living in a Norwegian municipality; caution must therefore be applied when generalizing the findings to other populations. Even though we judged data saturation to be adequate, more participants could have strengthened the study. Nevertheless, the experiences the participants gained from many years of PHVs and the variation in the participants' characteristics have contributed to rich data and resulted in findings of a

generalized nature that cut across the variation. The findings might therefore be relevant to older people in other settings.

Conclusions

In our study, we observed that PHV provided a stable, safe support for aging citizens on their journey from who they once were to who they now strove to be, and onward toward an unknown future situation. PHV visitors added to older people's feelings of safety and helped older people preserve their independence, their sense of worth, and a good life through personally tailored support and follow up. These perceived benefits differed considerably from the outcome measures commonly used in RCT evaluations of PHVs. In this sample of relatively old people, the health-promotive aspects of the PHV service dominated the findings, but we also discerned disease-preventive aspects of the service. The participants valued the service highly.

Implications for Practice

To enable older people to live good and independent lives in old age, PHV interventions should include a longitudinal and continuous approach and support older people's personal, self-valued goals. The services should exploit the full potential of combining health-promotive and disease-preventive strategies. A comprehensive definition of health that includes positive health aspects as well as disease prevention should comprise the basis for evaluations of PHV, and evaluations should include outcome measures that reflect users' personal achievement of goals and the benefits they value. The knowledge gained in this study might additionally be relevant in international contexts when designing health-promotive strategies to improve caring for older people.

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Notes

1. Medline, Cinahl, and Embase.
2. Participants' spouses participated in two interviews.

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