

Designing Outcome-Based Nursing Interventions for Multimorbid Populations: A Framework Grounded in Core Health Domains

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ABSTRACT: Multimorbidity poses a growing challenge to health systems worldwide, necessitating patient-centered, outcome-based approaches in nursing. This article introduces an innovative nursing framework designed to align care interventions with measurable outcomes reflecting both clinical priorities and patient needs. The framework draws from COSmm (Core Outcome Set for Multimorbidity), incorporating nine core domains relevant to chronic care, including HRQoL, treatment burden, and patient activation, operationalized using validated instruments such as EQ-5D, PHQ-9, and PAM. Nursing challenges commonly observed in multimorbid patients were mapped to SMART goals and matched with evidence-based strategies to form a structured intervention matrix, presented through two tables: one summarizing the nine COSmm outcome domains with definitions and instruments, and another linking six common nursing challenges (e.g., polypharmacy, frailty, poor coordination) to specific goals and interventions—for example, reducing treatment burden through deprescribing strategies monitored via the MTBQ. The framework enhances care clarity, evaluation, and personalization by integrating nursing roles into broader outcome monitoring systems, offering benefits such as improved accountability and collaboration, alongside challenges related to data integration and workforce readiness. This structured, adaptable model supports outcome-based nursing care in complex chronic conditions, with future research needed to empirically test it across diverse clinical environments.

Keywords: Multimorbidity, Outcome-Based Nursing, Care Coordination, Patient Activation, SMART Goals, Nursing Framework.



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INTRODUCTION

Multimorbidity, defined as the co-occurrence of multiple chronic conditions within an individual, presents a significant global public health challenge. The rising prevalence of multimorbidity, particularly among older adults, necessitates adaptive healthcare responses. Nurses, positioned at the frontline of healthcare delivery, play a critical role in managing the complex needs of this population (Rimmelzwaan et al., 2020; Whitehead et al., 2021). Their responsibilities demand not

only clinical expertise but also the ability to implement comprehensive, patient-centered care strategies.

The need for such strategies stems in part from the fragmented nature of current care models. Disjointed communication among healthcare providers frequently leads to uncoordinated care, which, in turn, results in increased emergency visits, hospitalizations, and patient dissatisfaction (Davis et al., 2019; Hackel & Roberts, 2019). In the context of multimorbidity, this fragmentation impairs care continuity and weakens the effectiveness of interventions. Integrated care models have therefore emerged as vital for improving health outcomes, emphasizing continuity, coordination, and comprehensive patient support (Moreno-Chico et al., 2021).

To address this challenge, outcome-based frameworks have gained prominence in chronic disease management. These frameworks center care delivery around measurable outcomes, such as symptom control, quality of life, and adherence. By doing so, they enable providers to tailor interventions that reflect both clinical priorities and individual patient needs (Ng et al., 2020; O'Connor et al., 2018). For example, nurse-led coordination models have proven effective in promoting engagement and continuity in complex care settings (Pugh et al., 2021).

A pivotal component of these frameworks is the integration of patient-reported outcomes (PROs). Collecting data directly from patients regarding their experiences, health status, and treatment responses allows for a more precise understanding of individual priorities and challenges. PROs contribute significantly to the personalization of care and are linked to better treatment adherence and satisfaction (Doyle et al., 2022; Grundberg et al., 2016). Their use supports a shift toward models that are not only effective but also responsive to patient values.

Despite these advancements, gaps remain in the nursing care of multimorbid patients. Many existing care models remain disease-centered, overlooking the broader implications of living with multiple chronic conditions. Furthermore, a lack of interdisciplinary collaboration and deficiencies in nurse training contribute to the persistence of fragmented care delivery (Leiva-Fernández et al., 2021; Whitehead et al., 2023). Addressing these shortcomings is essential to ensure high-quality, patient-centered care that is both comprehensive and adaptable.

In this context, models such as COSmm (Core Outcome Set for multimorbidity) and ICOPE (Integrated Care for Older People) offer structured approaches to care integration. COSmm identifies critical domains for outcome evaluation in multimorbidity care, including mental health, treatment burden, and care coordination (Carrasco-Ribelles et al., 2023). ICOPE complements this by promoting holistic care strategies tailored to older adults, encouraging coordinated and individualized care plans (Iglesias et al., 2018). These frameworks inform the development of comprehensive nursing strategies grounded in real-world patient complexity (Davis et al., 2019).

This article proposes an outcome-based nursing framework that aligns nursing interventions with core outcome domains identified in multimorbidity literature. The framework aims to operationalize outcome planning using SMART goals and validated indicators, thus enhancing evaluation, personalization, and care integration. By providing a replicable matrix that links patient-prioritized problems with evidence-based interventions, this study addresses key limitations in

current nursing practice and contributes to the advancement of outcome-focused care planning in multimorbid populations.

METHOD

In addressing the design of an outcome-based nursing framework for multimorbid patients, this study draws upon structured methodologies and established instruments that enhance patient care planning and outcome measurement. The methodology integrates validated measurement tools, the application of SMART goals, and existing care frameworks that connect nursing interventions to quantifiable outcomes in chronic care contexts.

Validated instruments form the foundation of outcome monitoring in chronic care. Among the most frequently used tools is the EuroQoL 5-Dimension (EQ-5D), which assesses mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. This instrument is widely adopted for its simplicity and applicability across various chronic disease populations (Iduye et al., 2021; Lung et al., 2017). Another prominent tool is the Health Utilities Index (HUI), which provides a multi-attribute utility score representing overall patient health status, proving effective in tracking quality of life over time (Hirdes et al., 2018).

In terms of self-management, the Chronic Disease Self-Efficacy Scale (CDSSES) and the Patient Activation Measure (PAM) are critical. CDSSES evaluates a patient's confidence in managing health challenges, while PAM measures an individual's activation level knowledge, skills, and confidence necessary for self-management. High activation is associated with improved adherence and clinical outcomes (Alahiane et al., 2023; Ghasemiardékani et al., 2024).

These instruments are selected not only for their clinical validity but also for their compatibility with nursing workflows, enabling nurses to systematically assess, document, and respond to patient-reported health data.

To translate assessment into action, the methodology applies SMART goal principles: Specific, Measurable, Achievable, Relevant, and Time-bound. These goals facilitate clear planning, progress tracking, and coordination among nursing teams. For example, replacing a general goal like "improve mobility" with "increase walking duration to 15 minutes, three times weekly, within 4 weeks" enables measurable evaluation and patient engagement (Poulin et al., 2018).

In interdisciplinary settings, SMART goals support shared decision-making and resource optimization, ensuring that all team members are aligned toward defined outcomes. Their incorporation into digital care plans further improves traceability and accountability in chronic care management (Fraze et al., 2020).

This methodology also aligns with three key frameworks. First, the Chronic Care Model (CCM) promotes proactive, coordinated care and emphasizes patient self-management and use of evidence-based practices. Nursing interventions mapped to CCM principles show increased patient activation and reduced hospitalizations. Second, the Interprofessional Collaborative Practice (IPCP) model enhances care planning through shared expertise, especially vital in complex multimorbidity cases (Fraze et al., 2020).

Third, Quality Improvement (QI) initiatives offer a process-driven foundation to evaluate the effectiveness of interventions. QI strategies often measure outcomes such as readmission rates, functional gains, and patient satisfaction, linking performance indicators directly to care planning (Garrison et al., 2017).

In summary, the proposed methodology relies on a structured combination of validated outcome tools, SMART planning strategies, and integrative care models. These elements work synergistically to inform the development of the article's outcome-based nursing matrix, ensuring that nursing interventions are both evidence-based and responsive to patient priorities in the management of multimorbidity.

RESULT AND DISCUSSION

Core Outcome Domains: Definitions, Tools, and Integration

Table 1. COSmm Core Outcome Domains, Definitions, and Tools

Core Domain	Definition	Measurement Tools	Relevance to Chronic Care
Mortality	All-cause death as a primary health outcome	Registry data, mortality rate	Indicates life-saving potential of interventions
Physical Health	Functional capacity and ability to perform daily tasks	ADL/IADL, mobility scores	Reflects general physical functioning
Mental Health	Psychological wellbeing including anxiety, depression	PHQ-9, GAD-7	Affects self-management and treatment adherence
HRQoL	Impact of health on quality of life across domains	EQ-5D, SF-36	Central to person-centered care
Disability	Physical impairments limiting activities	Functional scales, clinician assessments	Reflects long-term burden of disease
Symptoms	Frequency and severity of condition-specific symptoms	Symptom diaries, pain/fatigue scales	Directly impacts daily well-being
Healthcare Utilization	Frequency of care use (ED, hospitalization, outpatient)	EHR, claims data	Indicates care efficiency and burden
Patient Activation	Knowledge, skills, and confidence in self-care	PAM, CDSSES	Predicts adherence, engagement, outcomes
Treatment Burden	Workload imposed by care and its effect on functioning	MTBQ	Crucial for planning simplified, manageable regimens

The nine COSmm domains cover the full spectrum of health impacts faced by patients with multimorbidity. Each domain reflects an important facet ranging from mortality to patient activation and is measurable with validated tools. Their integration into chronic care models promotes unified language across disciplines and enhances performance benchmarking. By

embedding these domains into assessment routines, clinicians can ensure care is both comprehensive and targeted.

Outcome-Based Nursing Intervention Matrix

Table 2. Nursing Challenges, SMART Goals, and Strategies for Multimorbid Patients

Nursing Challenge	Core Domain	SMART Goal Example	Evidence-Based Strategy
Polypharmacy	Treatment Burden	Reduce medications from 9 to 6 over 3 months without ADEs	Medication reconciliation; deprescribing reviews; patient education
Frailty	Physical Function	Improve mobility score by 15% within 6 weeks	Mobility exercises, nutrition support, fall prevention programs
Poor Care Coordination	Healthcare Utilization	Reduce ED visits by 30% in 3 months	Care navigator assignment; integrated visit planning; interdisciplinary meetings
Low Patient Engagement	Patient Activation	Increase PAM score by 10 points in 8 weeks	Goal-setting sessions; self-management coaching; teach-back
Mental Health Distress	Mental Health	Reduce PHQ-9 from 14 to <10 in 6 weeks	Psychosocial support; referral to mental health professionals
Treatment Overload	HRQoL	Improve EQ-5D index from 0.6 to 0.8 in 2 months	Tailored care plans; schedule simplification; burden-reducing interventions

This matrix translates nursing challenges into specific outcomes using SMART goals. For example, reducing polypharmacy involves a quantifiable medication target, paired with strategies like deprescribing and patient counseling. Similarly, interventions for frailty prioritize functional gains through structured mobility programs. These examples illustrate how outcome-based planning enhances the precision and effectiveness of nursing care for complex chronic patients.

The implementation of outcome-based nursing frameworks has emerged as a promising strategy to improve care delivery, especially in populations with chronic multimorbidity. These frameworks bring multiple advantages improving patient outcomes, enhancing accountability, and encouraging holistic, patient-centered care. The integration of validated outcomes and SMART-aligned nursing goals allows for structured care planning, performance tracking, and data-driven decision-making (Harrison et al., 2022; Reinke et al., 2018).

One of the foremost benefits is the potential to significantly improve physical, mental, and psychosocial outcomes in chronic care. By focusing on measurable endpoints, nurses and care teams can monitor progress and adjust interventions dynamically. Furthermore, such frameworks reinforce accountability by enabling practitioners to link clinical actions to quantifiable results, justifying care choices and resource allocations (Love et al., 2021). Their holistic nature also aligns

with the multidimensional realities of multimorbidity, ensuring interventions consider physical function, emotional wellbeing, social context, and health literacy (Hammond et al., 2020).

Despite their advantages, implementation challenges persist. Resource limitations technological, financial, and personnel-related pose major barriers, especially in under-resourced settings (Sanon et al., 2019). Equally, cultural resistance to change within care teams can slow the adoption of new methodologies. Nurses unfamiliar with outcome-tracking systems may perceive them as overly complex or burdensome (McKay et al., 2024). Moreover, the technological backbone required for effective outcome monitoring (e.g., integrated EHR systems) is not always available or interoperable across platforms, complicating data sharing and longitudinal tracking (Schubert et al., 2016).

Outcome monitoring systems are instrumental in enhancing care coordination. Through real-time data sharing, interdisciplinary teams gain access to shared insights, enabling better decision-making and synchronized interventions (Bennett et al., 2019). These systems support longitudinal tracking, which is vital in multimorbid care as patients' conditions evolve over time. Additionally, standardizing outcome reporting enhances communication among providers, fostering collaboration across care disciplines (Betz et al., 2016).

The successful adoption of outcome-based frameworks requires strategic system adaptations. Training is essential to ensure that nursing staff are competent in outcome assessment and interpretation. Tailored education programs help staff align their clinical activities with performance metrics, while fostering engagement in team-based care (Sierra et al., 2023). On the technical side, institutions must invest in user-friendly, interoperable systems that facilitate the integration of outcome monitoring into daily workflows (Ellenbecker & Edward, 2016). Promoting a culture of collaboration and mutual accountability further supports the sustainability of these frameworks (Masood et al., 2024).

Finally, there is growing evidence linking patient-reported outcomes (PROs) to nursing performance metrics. PROs have predictive value for key indicators such as readmission risk, treatment adherence, and patient satisfaction (Perera et al., 2023). Nurses who leverage PROs in their decision-making processes contribute to better patient engagement and health outcomes. Embedding PROs into performance evaluations also promotes reflective practice and enhances accountability, reinforcing the value of person-centered care (Kwon et al., 2021).

In summary, outcome-based nursing frameworks have the potential to transform care for patients with multimorbidity by fostering measurable, accountable, and collaborative practices. However, their success hinges on adequate training, system readiness, and cultural alignment. As healthcare evolves toward more personalized and data-informed models, these frameworks offer a pathway to integrate nursing actions more tightly with patient-centered outcomes.

CONCLUSION

This study presents an outcome-based nursing framework specifically designed to enhance care for patients with multimorbidity. By systematically linking prevalent nursing challenges to

standardized outcome domains, measurable indicators, and evidence-based interventions, the framework advances the integration of nursing practices into patient-centered care strategies. The nine COSmm core outcome domains ranging from mortality and functional ability to patient activation and treatment burden provide a robust foundation for evaluating and optimizing care in complex clinical scenarios.

One of the primary contributions of this framework is its capacity to transform abstract patient priorities into structured, SMART-aligned goals that can be actively tracked and managed by nursing teams. Through the use of validated tools like EQ-5D, PAM, and PHQ-9, the model ensures that care planning is grounded in measurable, clinically relevant data. This not only fosters accountability but also enhances interdisciplinary collaboration, as different providers can align their roles around shared, outcome-driven objectives.

The implications for clinical practice are substantial. Nurses can employ this matrix to design tailored interventions that reflect both systemic care goals and the lived experiences of patients. Furthermore, the framework's integration potential into electronic health records enables longitudinal monitoring, real-time updates, and performance evaluations all essential in managing chronic, multifaceted conditions.

Importantly, this article underscores the role of training, infrastructure investment, and organizational culture in enabling the successful adoption of such frameworks. Without supportive systems and collaborative practices, even the most robust designs may falter.

In conclusion, the outcome-based nursing framework introduced in this article offers a structured, actionable, and patient-centered approach to care planning for individuals with multimorbidity. Its scientific contribution lies in operationalizing nursing care within outcome domains that matter most to patients and providers alike, paving the way for more coordinated, effective, and accountable chronic care systems. Future research should focus on testing the framework's implementation in real-world settings, exploring its impact on both process and patient-level outcomes.

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