Impact of person-centered and integrated care for community-living older adults on quality of care and service use and costs
Uittenbroek, Ronald
Experiences of case managers in providing person-centered and integrated care based on the Chronic Care Model: a qualitative study on Embrace

Ronald J. Uittenbroek
Sijrike F. van der Mei
Karin Slotman
Sijmen A. Reijneveld
Klaske Wynia

Submitted
Abstract

Background
Due to the rise in the number of older adults within the population, healthcare demands are changing drastically whilst healthcare expenditures continue to grow. Person-centered and integrated-care models are used to support the redesigning the provision of care and support. Little is known, however, on how redesigning healthcare delivery affects the professionals involved.

Objectives
To explore how district nurses and social workers experience their new professional role as case manager in Embrace, a person-centered and integrated-care service for community-living older adults.

Methods
We performed a qualitative study consisting of in-depth interviews with case managers (district nurses, n=6; social workers, n=5), using a topic-based interview guide. Audiotaped interviews were transcribed verbatim and analyzed using qualitative content analysis.

Results
Experiences of case managers comprised four major themes: 1) changing relationship with older adults, 2) establishing the case manager role, 3) the case manager’s toolkit, and 4) benefits of case management. Subthemes addressed the shift to a person-centered approach; building a relationship of trust; the process of case management; knowledge and experience; competencies of and requirements for case managers; and differences in professional background.

Discussion
We found that the major role change was experienced as a learning process, providing opportunities for personal and professional growth. Case managers felt that they were able to make a difference and found their new role satisfying and challenging, although stressful at times as well. Ongoing training and support was found to be a perquisite to be able to shift the focus toward person-centered and integrated care.
Introduction

Modern societies are challenged by an increase in life expectancy and the consequent rise in the number of older adults within the population. Healthcare demands are changing drastically and healthcare expenditures continue to grow.\(^1\) Contemporary healthcare systems, once designed to solve single, acute, and short-term diseases, need to transform to be able to meet the changing demands while lowering cost. Person-centered and integrated-care models are used to support the redesigning the provision of care and support.\(^2-4\) New professional roles are introduced. However, little is known on how professionals experience these new roles.\(^5\)

Case management plays a central role in most person-centered and integrated care services. In case management, an individual or a small team, is responsible for navigating the patient through a complex process in the most efficient, effective, and acceptable way. There are many variants of case management, however, within patient-centered and integrated care services the patient advocacy or brokerage case management model is best suitable.\(^6,7\) The focus of this case management model is on a more comprehensive coordination of services across the continuum of care, viewed from the patient perspective.\(^8\) In this model, also referred to as the socioeconomic model, the care coordination is determined not only by the medical needs but also the financial, psychological, and social circumstances of the patient.\(^7,9\)

Embrace is an example of a person-centered and integrated care service for community living older adults in which case management based on the patient-advocacy model fulfills a central role.\(^10\) Embrace is based on the Chronic Care Model (CCM) and a population health management model, the Kaiser Permanente triangle. The CCM is a model that integrates community social care and healthcare services, and has four interdependent key elements: self-management support, delivery system design, decision support, and clinical information systems.\(^11\) The Kaiser Permanente triangle is used to segment the population of older adults based on the self-reported levels of case complexity and frailty. Care coordination is performed by the case managers who participate in a general practitioner led multidisciplinary Elderly Care Team in which also an elderly care physician participates. The ECT provides older adults
comprehensive, patient-centered, proactive, and preventive care and support.

Little is known on how redesigning healthcare delivery, especially case management affects healthcare professionals. We therefore explored how case managers experience their professional roles in a person-centered and integrated-care service for community-living older adults.

**Methods**

*Design*

We performed a qualitative study using a grounded theory approach\(^2\) to explore the experiences and personal perspectives of case managers. Data were collected by a trained interviewer (KS) through in-depth interviews, conducted 15 to 18 months after the start of Embrace in 2012. The methods were defined according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.\(^3\) We performed our study within the setting of a randomized controlled trial on the effectiveness of person-centered and integrated care, the Embrace study.\(^4\)

*Setting and intervention*

Embrace requires an Elderly Care Team (ECT) within each of the 15 participating GP practices that are located in the northern part of the Netherlands. The ECT provides comprehensive, proactive, preventive, patient-centered care and support and addresses as such, medical, psychological, social and environmental health related problems of older adults.

All ECT members completed a training program that focused on their new professional roles. The GPs followed a (3 days in total) training related to, amongst other things, team- and population management. The social workers (SW) and district nurses (DN) were trained to provide case management according to the principles of patient advocacy case management model.\(^5\) Furthermore, case managers were trained in proactive teamwork, preventive care, to apply self-management support methods, and to use the Electronic Elderly Record System (EERS). The
EERS enables registration of care delivery, and contains care and support plans that are reviewed during structured home-visits (approximately once a month). All ECT-members received monthly on-the-job coaching during their team meetings.

Within Embrace, community-living older adults were segmented in risk profiles: 1) older adults without complex care needs and with a relatively low frailty level (“Robust”); 2) frail older adults at risk for complex care needs (“Frail”); and 3) older adults with complex care needs at risk for institutionalization (“Complex care needs”). Older adults with the frail profile receive case management from the social worker and older adults with complex care needs receive case management from the district nurse (for detailed descriptions, see Spoorenberg et al.).

**Study sample and data collection**

All case managers were invited by one of the researchers (KS). Face-to-face in-depth interviews (average duration 107 minutes) were held at the case managers’ offices or another place of their choice. Interviews were performed by KS using a topic-based interview guide, consisting of open-ended questions related to the key-elements of the CCM, and case management in general. After the first interview, researchers (KS and SFM) evaluated the topic-based interview guide; only minor revisions were necessary. All interviews were audio recorded and transcribed verbatim. Transcriptions were reviewed for completeness and accuracy by KS.

**Data handling and analysis**

We analyzed data using a grounded theory approach and in line with current guidelines for qualitative data analysis. We used Kwalitan 5.0 to support data analysis.

Analyses started with open coding of the first interview by two coders independently (KS and SFM). After the assigned codes were compared and discussed, an initial code list was set. The next three interviews, the two coders independently coded the interviews and compared and discussed their findings. During this process, initial codes were preserved or revised, definitions modified, and new codes added. This resulted in a preliminary codebook. The two coders further revised
this codebook during the process of analysis by extending existing codes, shortening or eliminating redundant codes, or adding new codes.

After all interviews were analyzed, the codes found were clustered into categories. Major themes and subthemes were deduced and discussed by the researchers (KS, SFM, RU, KW) until consensus was reached. Next, illustrative quotes were selected and returned to the participants for member checking and study findings were presented during a meeting with all interviewees in order to facilitate feedback. The quotes and study findings were recognized and acknowledged by the all interviewees; only minor revisions were necessary.

The analysis procedure was performed in the source language (Dutch). An external, bilingual, certified translator translated the categories, themes, and quotations into English. The translations were reviewed by the researchers to ensure adequacy (see Supplementary Table S1 for the original quotations in Dutch and their English translation).

**Ethical considerations**

The Medical Ethical Committee of the University Medical Center Groningen assessed the Embrace study and concluded that their approval was not required (Reference METc2011.108). Informed consent from the case managers was obtained prior to the interviews, and transcripts were analyzed anonymously.

**Results**

All eleven case managers (all female) participated in this study. Nine of them combined their case manager roles with their regular jobs as district nurse (DN) or social worker (SW) (see Table 1). We identified four major themes within the data with a total of ten subthemes (see Table 2). The major themes were: 1) the changing relationship with older adults, 2) establishing the case manager role, 3) the case manager’s toolkit, and 4) benefits of case management.
Table 1 Demographic and job characteristics of the case managers (n=11)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Nurse case managers</th>
<th>Social worker case managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Age, year (mean, range)</td>
<td>43.3, 28.4-28.1</td>
<td>57.1, 49.2-61.7</td>
</tr>
<tr>
<td>Educational level (n, %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate vocational</td>
<td>6 (100)</td>
<td>1 (20)</td>
</tr>
<tr>
<td>Higher vocational</td>
<td>-</td>
<td>4 (80)</td>
</tr>
<tr>
<td>Job appointment (n, %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embrace only</td>
<td>2 (33)</td>
<td>-</td>
</tr>
<tr>
<td>Combination with regular job</td>
<td>4 (67)</td>
<td>5 (100)</td>
</tr>
<tr>
<td>Municipality (n, %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stadskanaal</td>
<td>3 (50)</td>
<td>2 (40)</td>
</tr>
<tr>
<td>Veendam</td>
<td>2 (33)</td>
<td>2 (40)</td>
</tr>
<tr>
<td>Pekela</td>
<td>1 (17)</td>
<td>1 (20)</td>
</tr>
</tbody>
</table>

Table 2 Themes and subthemes identified

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The changing relationship with older adults</td>
<td>Shift to person-centered approach</td>
</tr>
<tr>
<td></td>
<td>Building a relationship of trust</td>
</tr>
<tr>
<td>2. Establishing the case manager role</td>
<td>Case management</td>
</tr>
<tr>
<td></td>
<td>Care and support plan</td>
</tr>
<tr>
<td>3. The case manager’s toolkit</td>
<td>Knowledge and experience</td>
</tr>
<tr>
<td></td>
<td>Competencies of case managers</td>
</tr>
<tr>
<td></td>
<td>Preconditions for case managers</td>
</tr>
<tr>
<td></td>
<td>Differences in professional background</td>
</tr>
<tr>
<td>4. Benefits of case management</td>
<td></td>
</tr>
</tbody>
</table>

The changing relationship with older adults

The first theme relates to the change in focus that district nurses and social workers experienced in their new role as case manager, ‘the shift to person-centered approach,’ and the changes in their relationship with older adults related to this new role, ‘building a relationship of trust.’

Shift to person-centered approach

Case managers reported that their focus shifted from being a traditionally task-oriented focus to one with a person-centered focus. This was based on a long-term relationship with the older adult that enabled a case manager to gain an in-depth and broad view of the older adult’s needs and preferences, and to provide individualized and person-centered care and support.
Since I adopted the perspective of the older adults themselves, I’ve been doing things their way, consistent with their own lifestyles and according to their own standards. (DN2)

I try to clarify what their concerns are, what is really bothering them or find out what’s on their minds. [...] Furthermore, you really take a look around, how their house is furnished [...] I often walk with them around the house […], and if someone is 85 and can barely walk and has a huge garden, you’ll ask, ‘Gosh, how do you manage the garden? Yes, it is all inclusive […]. (SW2)

Building a relationship of trust
All case managers mentioned the importance of establishing a relationship of trust with the older adult. Case managers invested in this relationship by taking sufficient time, being attentive, and being true to their promises. A critical ingredient in this was creating a sociable atmosphere, which was not a goal per se but rather a means to enhance feelings of connectedness and to build a partnership.

[...] it is important because it’s also a part of building a relationship of trust. Clients apparently like the social aspect, having a nice time. Well, I do think that this is an important component, but it’s certainly not my main reason for coming. (SW5)

Establishing the case manager role
This theme relates to the experiences of district nurses and social workers who provide case management in a person-centered and integrated-care service, and to the differences between district nurses and social workers as case manager.

Case management
Reflections of case managers on providing case management relate to central elements of person-centered and integrated care like proactive and preventive care delivery including monitoring, self-management support, care coordination, and network collaboration. Case managers
stressed the need for a thorough knowledge of an older adult’s situation in order to make early detection of problems feasible and to provide proactive and preventive care.

[...] even if there aren’t any immediately obvious hazardous situations that could be expected. Keeping in contact could have a preventive effect. (SW5)

Monitoring and reviewing the care situation of older adults, by means of regular home-visits and follow-up by telephone, were regarded as essential and were figuratively described as “taking an older adults’ pulse.”

You’re right there with the patients and following the processes. You start something up and then you monitor. If it’s not okay, you intervene. (DN1)

Case managers indicated that they were able to adjust the intensity of monitoring, based on the situation of the older adult. Some needed more frequent visits, while for other older adults a lower frequency of home-visits, combined with contacts by telephone, was more suitable. Case managers also indicated that they experienced incompatibility between pro-active preventive care and Embrace guidelines regarding intensities of care and support provision. Embrace guidelines stated that when goals had been attained and the situation had improved, older adults could be transferred to a less intensive care profile. Some case managers found this more difficult, since they felt personally involved and responsible. In some situations they continued case management after consultation with the Elderly Care Team.

Regarding self-management support, case managers’ aim was to increase older adults’ feeling of responsibility for their situation, to give them insight into their own abilities, to foster their sense of power, to motivate them to take steps themselves, and ultimately to take control of their own lives.

A case manager is someone who maintains a critical overview of everything taking place with regard to the older person. They get things going, and they keep track, checking to see if things have actually been done, and whether they’ve been done properly. They really take a load off others’ shoulders, in my opinion. On the other hand, they are also able to encourage older adults to
start doing things themselves. Just helping: “Yes, that's right,” “You can do it yourself, like this,” and because people often have no idea how things work. And then they can do it themselves. It works both ways: being there for them and encouraging them to start doing things themselves. (DN1)

Case managers felt responsible for care coordination but explicitly stated they were not responsible for care provision. They emphasized the importance of this independent position. Their activities were aimed at achieving continuity of care and enhancing the independent living of older adults.

If I already do not know [where to find relevant information], imagine how hard that is for our clients. It's quite complicated to find your way...That I have learned this past year.(DN4)

Within the Elderly Care Team, case managers viewed themselves as representatives (“messengers”) of the older adults. The collaboration between the Elderly Care Team members was perceived as satisfactory. Sharing medical information and discussing physical functioning led to a broader perspective on older adults’ situation. Case managers experienced appreciation on the part of the GP; the GP had confidence in them. Furthermore, case managers experienced better access to the GP when it came to discussing the needs of the older adults.

Care and support plan
Case managers agreed that, although time-consuming, the computer-based individual care and support plan (part of the EERS) was a suitable method for gaining a complete overview of the situation of the older adult. Some case managers, however, experienced the use of a computer as a barrier in their communication with older adults.

After a while, I would often decide not to bring the laptop along. Instead, I'd just take a look at the EERS in advance and update it afterwards. I think it interferes with the conversation. If you’re sitting there with a laptop while you’re having a conversation, I think it gets in the way somehow.(DN4)

The comprehensive assessment of an older adults’ situation, mostly completed by the second or third home-visit, provided a case manager with in-depth insight and helped to establish a basis for continuation of
the care process. Case managers indicated, however, that older adults had difficulty judging the severity of their problems and had even more difficulty judging the feasibility of solving those problems. The same difficulties were experienced during the annual review of the care plan, in which older adults evaluated the past year’s achievements and set new goals.

The case manager’s toolkit

Case management within a person-centered integrated care service requires, according to the interviewees, knowledge and experience, and competencies. Furthermore, several preconditions were found to be essential and case managers acknowledged differences in professional backgrounds.

Knowledge and experience

All case managers agreed that higher vocational education (college-level education) was needed as well as basic medical knowledge regarding ageing and the consequences of ageing to provide case management. In addition, work experience in the care and support of older adults, and knowledge of local healthcare organizations and community services was deemed essential.

I think the most important thing is to have a good knowledge of the network - knowing where you can turn for things and what the possibilities in your district are. At any rate, that I (...) know where I can find information. If even I don’t know that, you can just imagine how difficult it would be for clients. (DN4)

Competencies of case managers

Case managers listed various competencies necessary in performing the case manager role such as the ability to separate the essentials from the non-essentials, and to establish productive interactions with the older adults, the members of the Elderly Care Team, and other professionals.

Essential communication and collaboration skills were: listening and asking the right questions, understanding implicit messages, and giving
feedback. Skills to motivate and stimulate older adults to improve their self-management abilities and independence are also just as important. *Observational skills* were deemed essential in order to detect existing problems and to anticipate future ones, for example, the condition of the housing and living situation, as well as the physical appearance, personal hygiene, and the mobility of older adults. Furthermore, the case manager indicated that it was essential to be flexible and creative regarding planning activities so that they were attuned to older adults’ daily schedule and the varying number of clients throughout the year.

(...) you’re constantly having to adapt. You have to set aside your own values and beliefs and just observe how others live. This is very important. (...) you have to be open, avoid being judgmental. People live their own lives in their own way: coffee gets reheated; they’ve been doing that their whole life. (...) I accept people for who they are; that’s something you have to learn.(DN1)

**Preconditions for case managers**

Case managers listed several preconditions that enabled them to fulfill their role, such as autonomy, a quiet workplace, training, and support of the Embrace project leaders. Most case managers reported a lack of support from the manager of their own organization. They also expressed the need to swap experiences and to harmonize with fellow case managers because of the experimental nature of their role and uncertainty about how to fulfill it.

It’s still in the development stage, and you need feedback. Now and then, you need to be able to talk it out with colleagues to see if you’re on the right track.(DN1)

**Differences in professional background**

Case managers with a SW background felt that they focused more on the psychosocial aspects, for example, disturbed interpersonal relationships and loneliness as compared to DN case managers. In contrast, DN case managers felt that they focused more on solving healthcare and medical problems than SW case managers. In their opinion, some SWs had insufficient medical knowledge and were therefore unable to detect older adults’ physical problems, possibly interfering with providing
Experiences of case managers in providing integrated elderly care

preventive care. Nevertheless, this difference in expertise also benefitted care delivery:

*I once was visiting a couple and (...) they were having trouble filling in a questionnaire. I thought that the questions were too difficult for them, and I just couldn’t understand. And they were having some problems with their house, and they weren’t getting anywhere with them. So I told [name of the social worker], “I just don’t know what I should do.” [Name of the social worker] went over there for an hour. Neither of these people could read and write properly, and they were having a real hassle with the housing corporation. No wonder – they couldn’t read the housing corporation’s forms. [Name of the social worker] was able to get this out in the open with her approach and manner of questioning. (DN1)*

Case management closely follows the framework of the nursing process and was therefore a new method of working for case managers with a SW background. In addition, SW case managers felt less experienced when participating in “medical meetings” and in verbalizing problems concisely. During Elderly Care Team meetings, they at first felt restricted in introducing topics that were related to well-being.

Benefits of case management

For most case managers, their new role was truly satisfying and transformed their career perspective. The older adult’s satisfaction was regarded as highly rewarding. One case manager stated she had felt less satisfied at first, since it seemed to her she was not able to “actually do” anything, but later she realized that attentive listening, for example, was also “doing something.” The role of case manager provided the case managers with a new outlook on their regular job as SW or DN.

Case managers felt that older adults perceived them as confidants and gladly shared personal information with them. They had the feeling that older adults appreciated this personal attention, which gave the older adults a sense of strength and support.
Chapter 5

(...) after I’d been there as a case manager, he felt stronger. With the tips he received, he was able to start enjoying life again and doing some things on his own.\(\text{DN2}\)

Case managers, acting as “brokers,” felt that they were truly able to make a difference by organizing care and support in collaboration with other organizations or professionals.

She [an older woman with physical and psychological symptoms] was receiving home care, and all kinds of organizations dropped by, but it didn’t seem as if anyone really had a proper understanding of what was going on.\(\text{DN6}\)

The case managers were modest about their contribution to older adults and often labeled their activities as “small acts,” while at the same time stressing the importance of those seemingly small acts for older adults:

When I started with Embrace, I knew that small things can make a world of difference to older adults. Having a good wheelchair or not having a good one makes a huge difference.\(\text{DN1}\)

**Discussion**

The aim of this study was to explore how case managers experience their professional role in a person-centered and integrated care service for community-living older adults. We found that the major role change was experienced as a learning process, providing opportunities for personal and professional growth. Case managers felt that they were able to make a difference, and found their new role truly satisfying and challenging, although stressful at times as well. Ongoing training and support was found to be a perquisite to be able to shift focus toward person-centered and integrated care.

Case managers indicated that the relationship with older adults changed. Trust was found to be essential to be able to establish the case manager role, confirming findings of the few previous qualitative studies on case management for older adults.\(^{17,18}\) We also found that the boundaries of the traditional patient-professional relationship were often crossed, transforming the relationship into a so called hybrid form of informal and formal service-oriented relationship.\(^{19}\) Such a
relationship aims to empower and help older adults to remain in control of their lives, and to improve patient outcomes. A relationship that is built on trust should therefore be seen as a perquisite to become an older adults’ representative or “voice” while organizing and coordinating care and support.

We found that case managers established the case manager role and also convincingly adopted the patient advocacy model. The regular house-visits enabled the case managers to take an older adults’ pulse and enabled them to coordinate care with the aim to enhance the independent living of older adults, without providing care themselves. This is in line with findings of similar qualitative studies in which case managers of frail older adults described themselves as “coaching guards,” alluding to their underlying roles as problem solvers, supporters, sentinels, and navigators. Case managers were able to focus on the financial, psychological, and social circumstances of the older adult as well, essential to be able to provide person-centered and integrated care.

Regarding the case managers’ toolkit we found that for case manager’s knowledge and experience, combined with specific competencies, were essential to fulfill their role. This is in line with our findings from a longitudinal study on the levels of implementation of integrated care. Furthermore, we found similar differences between the two types of case managers as Park et al. did. Nurses tended to focus on health conditions, while social workers addressed psychosocial and financial problems. However, during the Elderly Care Team meetings and home visits, case managers were able to exchange information and knowledge. Such a difference in professional expertise benefitted not only the delivery of care, but also their professional development.

We found that not all preconditions needed for case management were met. Challenges in daily work, such as a high caseload, combining the case manager role with a regular job, and case closures led in some occasions to stress and role conflict, also referred to as a challenge to the professional identity. This could also interfere with job satisfaction. In addition, case managers expressed feelings of isolation and uncertainty about their functioning. It is therefore important to provide continuous training and support, including peer to peer coaching and involve the managers of their own organization.
Strengths of this study were researcher triangulation (two coders), using a code book, constant comparison, keeping field notes (memos), and intercoder discussion, which increased validity and reliability. Regarding validity of data interpretation, feedback on study findings was obtained from project leaders and researchers from the Embrace study. Some limitations should be mentioned as well. The small sample size could be seen as a potential limitation in terms of data saturation. Although all Embrace case managers participated in this qualitative study, further research is needed to confirm the results found.

Conclusion

We found that providing person-centered and integrated care was found to be very rewarding and required a major role change for case managers, which they experienced as a learning process that provided opportunities for personal and professional growth.
Experiences of case managers in providing integrated elderly care

References


15. Evers J. Qualitative analysis: Art and skills [in Dutch]. Amsterdam: Boom Lemma; 2015.

16. Peters VAM. Kwalitatiew 5.0: An users guide [in Dutch]. Nijmegen, the Netherlands: Department of Methodology, Radboud University; 2000.


### Supplementary Table S1 Original quotations in Dutch with English translation

<table>
<thead>
<tr>
<th>Dutch</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Je staat echt naast die patiënten en je volgt processen. Je zet iets in gang en je volgt het. Als het niet goed is, grijp je in.&quot; (DN1)</td>
<td>&quot;You’re right there with the patients and following the processes. You start something up and then you monitor. If it’s not okay, you intervene.&quot; (DN1)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;[…] ook al is er niet echt heel duidelijk een calamiteit te verwachten. Juist dan kan het preventief werken om wel contact te houden.&quot; (SW5)</td>
<td>&quot;[…] even if there aren’t any immediately obvious hazardous situations that could be expected. Keeping in contact could have a preventive effect.&quot; (SW5)</td>
</tr>
<tr>
<td>&quot;Een casemanager is iemand die alles rondom de oudere volgt en ook kritisch volgt. Die dingen in werking zet en het blijft volgen. Die gaat kijken of dingen echt zijn gebeurd of dingen goed zijn gebeurd. Die anderen echt een zorg van de schouders neemt vind ik. En aan de andere kant ook wel weer iemand die ook de oudere kan prikkelen om weer dingen zelf te ondernemen. Even weer helpen ‘oh ja zo was het’, ‘U kan het zelf, het werkt zo.’, want vaak hebben mensen ook geen idee hoe dingen moeten. Dan kunnen ze het zelf. Dus het is twee kanten, én er naast staan, maar ook prikkelen om dingen weer zelf te ondernemen.&quot; (DN1)</td>
<td>&quot;A case manager is someone who maintains a critical overview of everything taking place with regard to the older person. They get things going, and they keep track, checking to see if things have actually been done, and whether they’ve been done properly. They really take a load off others’ shoulders, in my opinion. On the other hand, they are also able to encourage older adults to start doing things themselves. Just helping, “Yes, that’s right,” “You can do it yourself, like this,” and because people often have no idea how things work. And then they can do it themselves. It works both ways: being there for them and encouraging them to start doing things themselves.” (DN1)</td>
</tr>
<tr>
<td>&quot;Heb ik toch op een gegeven moment ook vaak voor gekozen om niet de laptop mee te nemen en gewoon vooraf in het EOD te kijken en ook achteraf in het EOD weer bij te werken. Ik vind ‘m wel belemmerend in een gesprek. Ik vind als jij een laptop op schoot hebt en je zit, je bent in gesprek met iemand, ik vind ‘m toch een soort van belemmering.&quot; (DN4)</td>
<td>&quot;After a while, I would often decide not to bring the laptop along. Instead, I’d just take a look at the EERS in advance and update it afterwards. I think it interferes with the conversation. If you’re sitting there with a laptop while you’re having a conversation, I think it gets in the way somehow.&quot; (DN4)</td>
</tr>
<tr>
<td>&quot;Ik was bij een echtpaar en […] die hadden moeite een vragenlijst in te vullen. En toen dacht ik dat die vragen te moeilijk waren, en ik begreep het gewoon niet. En er waren wat problemen met hun woning en dat schoot maar niet op. Dus toen zei ik tegen [naam ouderenadviseur], ik zeg: ‘Nou [naam ouderenadviseur] ik weet gewoon niet wat [ik hier mee moet]…’. [naam ouderenadviseur], was er een uur geweest. Die mensen konden dus alle twee niet goed lezen en schrijven, hadden een heel gedoe met de woningbouw. Ook geen wonder want ze konden de formulieren van de woningbouw dus ook niet lezen. Dus [naam ouderenadviseur] had door haar manier van vragen en benaderen dat boven tafel.&quot; (DN1)</td>
<td>&quot;I once was visiting a couple and (...) they were having trouble filling in a questionnaire. I thought that the questions were too difficult for them, and I just couldn’t understand. And they were having some problems with their house, and they weren’t getting anywhere with them. So I told [name of the social worker], ‘I just don’t know what I should do’…’ [Name of the social worker] went over there for an hour. Neither of these people could read and write properly, and they were having a real hassle with the housing corporation. No wonder – they couldn’t read the housing corporation’s forms. [Name of the social worker] was able to get this out in the open with her approach and manner of questioning.” (DN1)</td>
</tr>
</tbody>
</table>
Chapter 5

Supplementary Table S1 continued

<table>
<thead>
<tr>
<th>Dutch</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinds ik vanuit de oudere kijk dan doe ik het op de manier zoals zij dat willen. Binnen hun levensstijl en maatstaven.” (DN2)</td>
<td>“Since I adopted the perspective of the older adults themselves, I’ve been doing things their way, consistent with their own lifestyles, and according to their own standards.” (DN2)</td>
</tr>
<tr>
<td>“[...] probeer ik verheldering te krijgen waar hun zorgen liggen, wat hun bezighoudt, wat hun dwars zit. [...] En daarnaast kijk je heel erg, hoe is het ingericht [...]. Gewoon praktisch, qua veiligheid, losse matjes, wc’s aanpassingen, douche aanpassingen. Vaak loop ik ook met de mensen [...] even door het huis [...]. Kijk, en als iemand een enorme tuin heeft en die is 85 en die kan amper lopen, ja, dan vraag je toch, ‘Goh, hoe doet u dat met de tuin?’ Ja, dat neem je allemaal mee [...].” (SW2)</td>
<td>I try to clarify what their concerns are, what is really bothering them or find out what’s on their minds.[...]Furthermore, you really take a look around, how their house is furnished [...]. I often walk with them around the house [...], and if someone is 85 and can barely walk and has a huge garden, you’ll ask, ‘Gosh, how do you manage the garden? Yes, it is ‘all inclusive’ [...]. (SW2)</td>
</tr>
<tr>
<td>“[...] het is belangrijk omdat ‘t ook een onderdeel is van het kweken van een vertrouwensband. Gezelligheid vinden de cliënten zelf kennelijk plezierig. Nou, ik vind het een belangrijk element, maar het is natuurlijk niet waarvoor ik echt kom.” (SW5)</td>
<td>“[…] it is important because it’s also a part of building a relationship of trust. Clients apparently like the social aspect, having a nice time. Well, I do think that this is an important component, but it’s certainly not my main reason for coming.” (SW5)</td>
</tr>
<tr>
<td>“Ik denk dat het belangrijkste is dat je het netwerk goed kent. Dat je heel goed weet waar je terecht kunt voor dingen en wat er dus allemaal in je wijk voor mogelijkheden zijn. Maar in ieder geval en dat ik [...] weet waar ik de informatie vandaan haal. Als ik dat al niet weet dan kun je wel nagaan dat het voor cliënten nog veel moeilijker is.” (DN4)</td>
<td>“I think the most important thing is to have a good knowledge of the network – knowing where you can turn for things and what the possibilities in your district are. At any rate, that I (…) know where I can find information. If even I don’t know that, you can just imagine how difficult it would be for clients.” (DN4)</td>
</tr>
<tr>
<td>“[...] dus je moet je overal aanpassen. Je eigen normen en waarden moet je wegdrukken en je moet gewoon kijken naar hoe anderen leven. En dat is dus gewoon heel belangrijk. [...] je moet open staan. Niet oordelen, niet veroordelen. Mensen leven hun eigen leven zoals ze leven, koffie wordt opgewarmd, dat zijn ze hun hele leven gewend. [...] Ik laat mensen in hun waarde, dat moet je leren.” (DN1)</td>
<td>“(...) you’re constantly having to adapt. You have to set aside your own values and beliefs, and just observe how others live. This is very important. (...) you have to be open, avoid being judgmental. People live their own lives in their own way: coffee gets reheated; they’ve been doing that their whole life. (...) I accept people for who they are; that’s something you have to learn.” (DN1)</td>
</tr>
<tr>
<td>Het is nog steeds in ontwikkeling en je hebt feedback nodig. Je moet af en toe kunnen sparren met collega’s om te zien of je goed bezig bent.” (DN1)</td>
<td>“It’s still in the development stage, and you need feedback. Now and then, you need to be able to talk it out with colleagues to see if you’re on the right track.” (DN1)</td>
</tr>
<tr>
<td>“[…] doordat ik nu geweest ben als casemanager daar, voelde die zich sterker. Hij had weer meer houvast in het leven omdat hij weer meer handvatten kreeg om weer zin het leven te krijgen en om dingen te ondernemen.” (DN2)</td>
<td>“(...) after I’d been there as a case manager, he felt stronger. With the tips he received, he was able to start enjoying life again and doing some things on his own.” (DN2)</td>
</tr>
</tbody>
</table>
Supplementary Table S1 continued

<table>
<thead>
<tr>
<th>Dutch</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Zij had wel thuiszorg en allerlei instanties kwamen er ook hoor, maar niemand pikte de dingen echt op leek het wel.” (DN6)</td>
<td>“She was receiving home care, and all kinds of organizations dropped by, but it didn’t seem as if anyone really had a proper understanding of what was going on.” (DN6)</td>
</tr>
<tr>
<td>“Ik wist dus toen ik begon in SamenOud, dat voor de ouderen kleine dingen een wereld van verschil maken, ja. Wél een goede rolstoel of geen goede rolstoel maakt een heleboel verschil.” (DN1)</td>
<td>“When I started with Embrace, I knew that small things could make a world of difference to older adults. Having a good wheelchair or not having a good one makes a huge difference.” (DN1)</td>
</tr>
</tbody>
</table>