Implementing a broad quality of life tool for determining care wishes and needs of older adults living at home

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ABSTRACT
The aim was to investigate the views of stakeholders on the practical relevance of a broad quality of life (QoL) outcome tool for care in older adults: the Extended Quality of Life Tool (EQLT). We conducted individual interviews and focus groups with a variety of stakeholders involved in the care for older adults which were analyzed using a framework analysis. Stakeholders considered relevant: focus on the client perspective; perspective on QoL broader than health; the possibility to take diversity into account; and the possibility to determine a minimum level of QoL. Three facilitators for implementation of the tool were mentioned as well as four barriers. The EQLT can support conversations with clients about their needs and wishes, thus enabling decisions about care services based on a broad set of domains of QoL. Implementation of the tool should take into account the facilitators and barriers identified in the current study.

KEYWORDS
Older adults at home; care services; quality of life assessment; implementation

Introduction
In the past decade, the number of older adults living and receiving care at home has increased dramatically (Sonnega, Robinson, & Levy, 2017; Tang & Lee, 2010). Governments provide home care services to improve overall quality of life (QoL) (Celani, Ponce, Quintero, & Vargas-Bonilla, 2018), to help maintain a basic standard of living for older adults, and to decrease medical costs (Ryburn, Wells, & Foreman, 2009). Currently, benefits of care are often measured using health-related QoL measures (Herdman et al., 2011). The EuroQol questionnaire (EQ-5D)(The EuroQol Group, 1990), for instance, is exclusively focused on health-related aspects of QoL (Al-Janabi, Flynn, & Coast, 2012; Coast, Smith, & Lorgelly, 2008). However, in older adults, these health aspects of QoL often cannot be (substantially) improved since increasing age often is accompanied with deteriorating health and chronic illness.
Other aspects of QoL, such as being able to manage one’s situation and feeling supported by others, or living independently (Lömås et al., 2020) are therefore important to be included as relevant outcomes of care. These QoL aspects might be improved through care services (author information removed, submitted, Lömås et al., 2020). In short, a broader perspective on QoL seems required in determining quality of care in this context.

The ASCOT (Adult Social Care Outcomes Toolkit) was developed in the United Kingdom to measure outcomes of social care in terms of QoL from a broader perspective than health alone (Netten et al., 2012). The ASCOT-SCT4 consists of eight domains; control over daily life; personal cleanliness and comfort, food and drink; personal safety; social participation and involvement; occupation; accommodation cleanliness and comfort, and dignity. This offers the opportunity to measure and compare the outcomes of different types of care and services that do not primarily aim to improve health. Specifically, the ASCOT focuses on outcomes which are related to the goals of social care.

In a systematic review on older people’s views on and experiences of QoL, we found that, next to the ASCOT domains, there are additional domains that older people living at home deem important (Van Leeuwen et al., 2019). In addition, a qualitative study was performed to explore in more in-depth what domains were important to older adults receiving services (Van Loon et al., submitted). Using an iterative consensus procedure based on these findings, 6 additional domains were defined: accessibility and age-friendliness of the neighborhood; connectedness; financial security; perceived health; resilience and emotional comfort. In order to assess outcomes of care in a way that also takes into account these additional domains, we have developed a tool consisting 6 additional QoL domains: the Extended Quality of Life Tool (EQLT). This tool thus consists of 8 ASCOT domains and 6 additional domains, each domain is covered by a specific question. The EQLT can be used in older adults living at home to map what is relevant for their QoL, to enable a conversation about QoL and to monitor QoL.

However, the question remains whether implementation of the EQLT is feasible in practice. The hypothesis is, on the basis of the systematic review and the qualitative study, that adding domains of QoL to those of the ASCOT is relevant. Do stakeholders, i.e. care providers, client representatives or others who are well-acquainted with the practical context in which the EQLT is envisioned to be used, confirm this relevance? Furthermore, do they think this extended tool can be implemented? What could be possible facilitators or barriers according to stakeholders?

The purpose of this study was to explore how stakeholders view the relevance of the EQLT for making decisions about provision of care services, and what, in their perception, might be possible facilitators or barriers, i.e. promoting and limiting factors, for the implementation of the tool.
Methods

To address the research questions, we organized interviews and focus groups with different stakeholders in the Netherlands. Stakeholders included professionals involved in providing care to older people living at home, client representatives, managers and policy officers of care institutions and policy officers of healthcare purchasing organizations. Given the explorative nature of this study, purposive sampling was used to reach a broad range of diverse stakeholders. Ethics approval was obtained from the METC VUMC Amsterdam.

Procedure

In this study, we used qualitative methods to explore the perspectives of various stakeholders. The goal of such qualitative research is to understand the world from the perspective of these stakeholders, assuming that multiple meanings and understandings of a phenomenon are likely to co-exist (Green & Thorogood, 2018, p. 16), and that knowing them may help to create usable services or instruments (Batalden et al., 2016).

Qualitative methods, especially individual interviews and focus groups, are valuable in implementation research because they can help understand how implementation can be successful or what can be barriers (Hamilton & Finley, 2019). Our analysis approach combined deductive and inductive elements; the transcripts were summarized and grouped into themes, based on the topics from the research question and topic guide, which was based on previous research. We distinguished between (1) perceived value of the tool; (2) facilitators for implementation; and (3) barriers for implementation. The framework developed from previous research was used to identify factors influencing implementation (Hamilton & Finley, 2019; Hamilton et al., 2018).

Stakeholders were first approached through affiliated partners of the research project. Secondly, other organizations were approached by e-mail, explaining the goal and procedure of the study. At the beginning of the interview, respondents were verbally asked for consent to record the interview and it was explained that the content of the interview was confidential and reported data would be presented anonymously.

Data collection

Interviews were semi-structured, i.e. open, but guided by a topic list. The topic list was based on the EQLT domains ([author information removed]et al., submitted), complemented with questions about goals of care services for older adults and possible facilitators and barriers in implementing an instrument such as the EQLT. The topic list aimed to achieve coverage of the topics throughout the different conversations. Interviews lasted between 50 and 80 minutes.
In addition, we conducted three focus group interviews. The first focus group was conducted during a training for general practitioners. The second focus group was organized with client representatives, representing the voice of specific patient groups in care. During these focus group interviews we used a topic list similar to the interview topic guide. The focus groups lasted between 65–150 minutes. The third focus group was organized during a seminar discussing outcomes of a related project. This focus group lasted 75 minutes. The first two focus groups were recorded and transcribed, the last meeting was not recorded. During this meeting, three of the authors were present and summarized the results.

**Analysis**

Transcripts of the interviews and the first two focus groups, and the summary of the third focus group, were reviewed using framework analysis (Srivastava & Thomson, 2009). Three researchers (ML, GW, RO) analyzed the transcripts independently and discussed their findings. Through an inductive, iterative process, discussing disagreements until agreement was reached, themes were identified.

**Results**

**Sample/respondents**

27 respondents were included in this study (Table 1). All respondents had experience in their field, some working in large care organizations, and other in small care organizations such as a general practice. Also, respondents from health care purchasing organizations were included, as well as client representatives from an organization representing older adults. The organizations were located in urban area’s in the Netherlands.

The sample consisted of seven respondents for interviews (five female, two male). Three respondents (R1-R3) worked for care organizations providing services at home for older adults, and four respondents (R4-R7) worked for healthcare purchasing organizations. The first focus group had five participants (R8-R12) working in general practice (four female, one male). The second focus group had five participants (R13-R17) who were client representatives (three female, two male). The third focus group had nine participants (R18-R27) working for care organizations providing services for older adults. More detailed information about the respondents can be found in Appendix.
Findings

Guided by the research questions we identified several themes regarding the relevance of the tool (1), and facilitators and barriers for implementation (2).

Relevance

Concerning the relevance of the EQLT, we identified four themes on the basis of both interviews and focus groups: (1) a focus on client perspective; (2) looking broader than health; (3) the possibility to take diversity into account; (4) the possibility to determine a minimum standard.

A focus on client perspective. Respondents said it is important that clients can determine themselves what QoL means to them:

- “I cannot speak for someone else or say what another person understands as good care or good life. I mean, I have visited many people in their house and sometimes I think: ‘Gosh, I wouldn’t want to live in that way’, but for some people certain things can provide comfort or be important [...] everyone has their own standards of living” (R5)

Correspondingly, ideally, the client him- or herself can use the instrument to determine care needs. If necessary, informal care givers can be involved when completing the instrument, for instance by reading out the questions or filling in the instrument together.

- ‘The informal carer could read [the domains and ask] “dad, is this important for you?”’ (R3)

Looking broader than health. According to respondents, goals of care should not be too narrowly focused on health outcomes.

- “If someone has limitations, in providing care you should focus on which adaptations you can make to account for these limitations. [...] To maintain the quality in people’s life”. (R12)

A tool addressing more than health, such as the EQLT, can help to understand the needs of a client from a broad perspective on QoL.

- “If someone visits the GP, well the GP has 10 minutes, I have a headache – let’s prescribe a pill [...] Maybe the headache will disappear, but if the headache springs from the fact that someone is stressed out because he has no financial security [...] In that case you could continue to prescribe pills, but the problem will not be solved” (R5)
**Taking into account diversity.** A further aspect of the EQLT that according to respondents contributes to its relevance is that it takes into account the fact that people are different. Respondents said the meaning of QoL can vary greatly from person to person.

- "Diversity in older adults is immense [...] what is required to enable them to participate in society just like everyone else? That is very much tailor-made, depending on someone’s strength, depending on the need for support” (R3)

This implies that certain domains are more important for one person than for another, or that the desired level of functioning in a specific domain may differ from person to person. A person’s life story can influence their preferences for specific aspects of QoL.

- “If someone was very active in the past, had a big and rich friend groups, and now is at home alone, the question might be: is this person really happy?” (R5)

**Providing a minimum standard.** Although respondents emphasize that people are different, they also believe there are certain basic domains of QoL that are important to everyone. In these domains, a minimal standard should be determined, to set a minimum outcome threshold of care.

- ‘Control over daily life and food and drink are really important, if that’s not in order, a person literally crashes.’ (R2)

- “[personal care] is a basic condition [...] It should be present minimally” (R5)

Having a tool that helps identifying a minimum standard of living can support interventions to maintain a basic level of QoL in certain domains.

- “There are things you wouldn’t want to impose upon people. But being in control and food and drink, those [domains] can provide reasons for intervention: we have to interfere here if it’s not going well” (R11)

**Facilitators and barriers for implementation**

**Facilitators.** Regarding facilitators for implementation of the EQLT, three themes were identified: (1) the attractiveness of the tool as guidance for conversation; (2) its flexibility; (3) fostering a joint learning process.

**Guidance for conversation.** Several respondents noted that there is a need for an instrument that can serve as a guidance to structure and inspire a conversation between client and caregiver, as well as a dialogue between (teams of)
caregivers. A list with QoL domains can help to clarify what is important for older persons and a dialogue between a caregiver and an older adult can shed light on how he or she perceives and values these domains in the context of QoL, while also taking into account the responses on the specific questions (domains).

- “Often people cannot assess properly [what kind of help they need]. After a good conversation, we can give advice to someone which domain could be supported and how.”(R3)

Another aspect that respondents mention is that a conversation about QoL is needed to fully understand what the client means by a score on a specific domain; simply going over the domains as identified in the EQLT and asking a care receiver to “tick the boxes” would not work.

[The tool is] a guidance for a conversation, you cannot really use it as a fixed standard’ (R5)

Flexibility. Respondents explained that they need an instrument that allows them to be flexible. This helps them in providing personalized care, i.e. care that is tailored according to the wishes and needs of an individual client. By taking into account the various domains of the EQLT, a personal care plan can be designed for each client.

- “The home nurse may look a little further [than the client’s health status]. Make a personal plan, be it care or welfare” (R5)

A tool that supports flexibility in establishing care goals can also enable clients and caregivers to make decisions together throughout care trajectories, in which different types of care are received, depending on the situation and condition of the client. This may start with home care and end with institutional care, for instance.

- “an instrument that moves with the client throughout the chain” (R7).

Fostering a joint learning process. According to respondents, the EQLT can be used to learn from other care institutions. Within a care institution, outcomes of the tool may give insight into aspects of care that can be improved.

- “What can be done to improve, what is going well, what isn’t, and how can we learn?”(R6).

Respondents from healthcare purchasing organizations emphasized the importance of fostering learning between care organizations.

- “We bring organizations in contact with each other, in order for them to learn. Enabling them to become better.”(R4)
Using the EQLT, both as a conversation and monitoring tool, may support this joint learning process.

**Barriers.** Next to facilitators, four barriers, i.e. limiting factors, in implementing the EQLT were identified: (1) the tool may distract attention from core activities; (2) there may be a lack of time; (3) professionals may have resistance to the evaluation of care outcomes; (4) results may not be useful because of an absence of adequate funding.

**Distraction from focus on core activities.** A potential barrier for implementation of a tool like the EQLT is that it contains many domains. Some domains might be more relevant for a specific care organization than others. Respondents saw difficulties in deciding who determines which domains should be targeted by which care service. Also, the question was raised whether it was within the span of control – or the responsibility – of a specific care service to deal with certain domains.

- “Dignity, control, those are very important. But some other [domains] have less significance for us. […] Finances can determine how you feel, but a care organization cannot fix [finances] directly.” (R5)

**Lack of time.** As a second barrier, respondents mention lack of time. There is (often) not enough time allocated to have a lengthy conversation about QoL with clients, and to adequately address all domains that are included in the EQLT.

- “In practice, […] there is lack of time to fully understand social issues” (R3)
- “Time is limited because caregivers have to produce, they have to do things as fast as possible” (R3)

**Resistance to evaluating outcomes of care.** Another barrier is resistance to evaluating outcomes of care. Respondents question whether tools which measure outcomes are really helpful in getting insight in what people need. Although the questions in the EQLT are quite concrete, it is not always clear what the answers mean.

- [If the neighborhood is not experienced as accessible enough] “what does that mean? There is no bus stop in front of someone’s house? There is no public space? There is a lack of green areas?” (R5)

Respondents also mention that many instruments are used already. Adding a new tool might be redundant, or even complicate evaluation processes.

- “There are also other instruments to assess the outcomes of elderly care […]so there is an incredible mass of measurements” (R11)
No adequate funding. A final barrier that was mentioned is the lack of adequate funding to provide the care needed. Respondents indicated the current system of funding is not suitable to meet or anticipate on caring needs, both because of a lack of money and because of allocation decisions.

- “Very often there is also no basis for payment to do anything in an early phase. So you often also see that people think about the money instead of what is needed in terms of content.” (R3)
- “If you do an intervention, you get paid for it. Knee surgery costs so much. Whereas, for example, if you were use value-driven purchasing, you would assess whether someone can walk well without pain. And then you manage that outcome, both with physio in advance in the process, and with GP and rehabilitation later. And then you should give a bag of money which they can divide among themselves.” (R2)

Discussion

This study investigated the relevance of a broad instrument for monitoring care for older adults living at home, specifically the EQLT, as well as limiting and promoting factors concerning the implementation of this tool.

Concerning the relevance, we identified four themes; (1) the tool provides a focus on the perspective of the client; (2) it enables to assess aspects of QoL broader than health; (3) it helps taking into account diversity; (4) it can be used to define a minimum standard of QoL. Three facilitators for implementation of the tool were described by respondents: (1) the attractiveness of the tool as guidance for conversation; (2) the flexibility of a tool; (3) fostering of a joint learning process. Also, four barriers or obstacles were identified: (1) the tool may distract attention from core activities; (2) there may be a lack of time; (3) professionals may have resistance to evaluating care outcomes; (4) results may not be useful because of an absence of adequate funding.

The relevance of the EQLT as identified by the respondents is in line with the central ideas behind the tool. Its two constitutive elements, i.e. the ASCOT and the extra domains of QoL (based on the systematic review (Van Leeuwen et al., 2019) and the qualitative study ([author information removed]et al., submitted)), both depart from the views of older people themselves on QoL. The Capability Approach can be used as framework to put the values and diversity of people at the center and move away from a health focused view (Gopinath, 2018; Meijering, van Hoven, & Yousefzadeh, 2019). In this way, the CA can help to understand what really matters to older adults who receive care. A previous study showed that the ASCOT can be regarded as an operationalization of the CA (Van Loon, Van Leeuwen, Ostelo, Bosmans, & Widdershoven, 2018). The answer options in the additional domains of the EQLT are also in line with the CA, as they are operationalized as functionings.
The results of this empirical study confirm the importance of putting the perspective of the client central, and that health is not the only important issue in life. Furthermore, the results also emphasized the importance of recognizing diversity, and defining a minimum standard of QoL.

The facilitators mentioned by our respondents are in line with the aspects that make the tool relevant according to the respondents. Since the tool focuses on what clients deem important, it can be used in a dialogue between clients and caregivers about what matters in life, and which care is needed. Shared decision making has been shown to provide many benefits for the patient, such as respect for values, preferences and needs of the patient (Barry & Edgman-Levitan, 2012; Elwyn et al., 2012). The flexibility of the tool is directly related to the client perspective. What is important for one client, may be less so for another client.

The tool can also provide a basis for learning between care institutions. Using the same broad set of domains of QoL enables comparison between care services. In this respect, the ASCOT can be regarded as providing the basic domains which should be addressed by all care services (Van Loon et al., submitted). In the EQOLT, domains can be selected based on the relevance of domains for older adults in a specific situation (Van Loonen et al., submitted).

Barriers for implementation, however, are also mentioned by respondents. For successful implementation, outcome measures should be “tailored by identifying and addressing potential barriers according to the setting” (Antunes, Harding, & Higginson, 2014). The first barrier, distraction from core activities, might be addressed by explicitly raising the question what should count as core activities. What care organizations define as core activities may not be most relevant from the perspective of older people themselves. The development of the EQOLT as an extension of the ASCOT recognizes this contrast. Whereas the domains of the ASCOT are based on the (explicit) goals of social care, the EQOLT contains also other domains, which go beyond these official goals. From the perspective of older people themselves, the relevance of care services may sometimes be different from what organizations themselves define as goals. As person-centered care is increasingly implemented, and policy-makers increasingly adapt systems to enhance person-centered care (Moore et al., 2017), we should take their perspective seriously.

An example from another study shows that older adults living at home appreciate informal contact with their caregivers, as this contributes to their QoL in the domains of relationships and emotional comfort ([author information removed]et al, submitted). The second barrier for implementation, lack of time to use a tool like the EQOLT, was also found in other implementation studies (Dunckley, Aspinal, Addington-Hall, Hughes, & Higginson, 2005; Ellen et al., 2014). One way of addressing this might be to make professionals aware that tailoring care to the needs and wishes of the care receiver in the end may save time (Blumenthal et al., 2016; Hibbard, Greene, & Tusler, 2009). The
third barrier, a resistance against measurements, refers to skeptical attitudes from professionals and traditional structures which are found also in other studies as barriers for implementation (Moore et al., 2017). One way to deal with this, might be to look critical at existing tools and remove those that are not effective. The fourth barrier, no adequate funding for early intervention, is related to the current payment system in health care and social care. This is not easily solved.

A strength of this study is that data were collected through interviews and focus groups. Combining these methods, and including a variety of stakeholders, enabled us to study the topic from different perspectives. A weakness is that one focus group was not recorded. This could influence the accuracy of the data analysis. However, the non-recorded focus group was attended by multiple researchers and findings were meticulously reported afterward. The attending researchers discussed the report and agreed on the content. Furthermore, although data saturation was obtained to a large extent, the number of respondents included in this study was still relatively small (27 in total). Therefore, these results are not generalizable nor exclusive. This qualitative study sought to explore the implementation of the EQLT in a local population in order to come to first insights in the value of the EQLT and facilitators and barriers for implementation. Generalizability of the results will require further research in other contexts and with other populations, as well as the synthesis of various (qualitative) data (Leung, 2015). This study focused on the perspective of professionals and client representatives. A next step is to explore the usability and the validity of the EQLT, including the perspective of older adults.

Conclusions

Given the growing need for providing care to older people living at home, it is important to determine how care services can contribute to their QoL. The results of this study highlight the relevance of the EQLT, mainly as it has the potential to support dialogues between caregivers and clients about their needs and wishes based on a broad set of domains of QoL. This provides a basis for personalized care, i.e. care in which people have choice and control over the way their care is planned and delivered. It also promotes the recognition that, for many people, their needs go beyond purely medical issues. The EQLT may help older adults living at home who deal with physical and/or mental health conditions to make decisions about the care that is needed, so they can live the life they want to live, based on what matters to them. A next step could be to structurally implement this tool in one or multiple organizations, investigating the process and effects on changes in actual care.
Data availability statement

The data that support the findings of this study are available on request from the corresponding author, GW. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethical approval

Reviewed by The Medical Ethics Review Committee of VU University Medical Center, no 2016.007

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References

Al-Janabi, H. N., Flynn, T., & Coast, J. (2012). Development of a self-report measure of capability wellbeing for adults: The ICECAP-A. Quality of Life Research, 21(1), 167–176. doi:10.1007/s11136-011-9927-2

Antunes, B., Harding, R., & Higginson, I. J.; Euroimpact. (2014). Implementing patient-reported outcome measures in palliative care clinical practice: A systematic review of facilitators and barriers. Palliative Medicine, 28(2), 158–175. doi:10.1177/0269216313491619

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making—The pinnacle of patient-centered care. New England Journal of Medicine, 366(9), 780–781. doi:10.1056/NEJMp1109283

Batalden, M., Batalden, P., Margolis, P., Seid, M., Armstrong, G., Opipari-Arrigan, L., & Hartung, H. (2016). Coproduction of healthcare service. BMJ Quality & Safety, 25(7), 509–517. doi:10.1136/bmjqs-2015-004315

Blumenthal, D., Anderson, G., Burke, S., Fulmer, T., Jha, A. K., & Long, P. (2016). Tailoring complex-care management, coordination, and integration for high-need, high-cost patients: A vital direction for health and health care. NAM Perspectives, 6(9). doi:10.31478/201609q

Celani, N. L., Ponce, S., Quintero, O. L., & Vargas-Bonilla, F. (2018). Improving quality of life: home care for chronically ill and elderly people. Caregiving and Home Care, 161 Coast, J., Smith, R., & Lorgelly, P. (2008). Should the capability approach be applied in health economics? Health Economics, 17(6), 667–670. doi:10.1002/hec.1359
Dunckley, M., Aspinal, F., Addington-Hall, J. M., Hughes, R., & Higginson, I. J. (2005). A research study to identify facilitators and barriers to outcome measure implementation. *International Journal of Palliative Nursing, 11*(5), 218–225. doi:10.12968/ijpn.2005.11.5.218

Ellen, M. E., Léon, G., Bouchard, G., Ouimet, M., Grimshaw, J. M., & Lavis, J. N. (2014). Barriers, facilitators and views about next steps to implementing supports for evidence-informed decision-making in health systems: A qualitative study. *Implementation Science, 9*(1), 1–12. doi:10.1186/s13021-014-0179-8

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., . . . Edwards, A. (2012). Shared decision making: A model for clinical practice. *Journal of General Internal Medicine, 27*(10), 1361–1367. doi:10.1007/s11606-012-2077-6

Gopinath, M. (2018). ‘Thinking about later life: Insights from the capability approach.’ *Ageing International, 43*(2), 254–264. doi:10.1007/s12126-018-9323-0

Green, J., & Thorogood, N. (2018). Qualitative methods for health research. London: Sage. UK (London)

Hamilton, A. B., & Finley, E. P. (2019). Qualitative methods in implementation research: An introduction. *Psychiatry Research, 280*, 112516. doi:10.1016/j.psychres.2019.112516

Hamilton, A. B., Mittman, B. S., Campbell, D., Hutchinson, C., Liu, H., Moss, N. J., & Wyatt, G. E. (2018). Understanding the impact of external context on community-based implementation of an evidence-based HIV risk reduction intervention. *BMC Health Services Research, 18*(1), 1–10. doi:10.1186/s12913-017-2791-1

Herdenman, M., Gudex, C., Lloyd, A., Janssen, M. F., Kind, P., Parkin, D., . . . Badia, X. (2011). Development and preliminary testing of the new five-level version of EQ-5D (EQ-5D-5L). *Quality of Life Research, 20*(10), 1727–1736. doi:10.1007/s11136-011-9903-x

Hibbard, J. H., Greene, J., & Tusler, M. (2009, June). Improving the outcomes of disease management by tailoring care to the patient’s level of activation. *The American Journal of Managed Care, 15*(6), 353–360.

Låmås, K., Bölenius, K., Sandman, P. O., Bergland, Å., Lindkvist, M., & Edvardsson, D. (2020). Thriving among older people living at home with home care services—A cross-sectional study. *Journal of Advanced Nursing, 76*(4), 999–1008. doi:10.1111/jan.14307

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care, 4*(3), 324–327. doi:10.4103/2249-4863.161306

Meijering, L., van Hoven, B., & Yousefzadeh, S. (2019). “I think I’m better at it myself”: The capability approach and being independent in later life. *Research on Ageing and Social Policy, 7*(1), 229–259. doi:10.17583/rasp.2019.3678

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences, 31*(4), 662–673. doi:10.1111/scs.12376

Netten, A., Burge, P., Malley, J., Potoglou, D., Towers, A. M., Brazier, J., . . . Forder, J. (2012). Outcomes of social care for adults: Developing a preference-weighted measure. *Health Technology Assessment, 16*(16), 1–166. doi:10.3310/hta16160

Nussbaum, M. (2003). Capabilities as fundamental entitlements: Sen and social justice. *Feminist Economics, 9*(2–3), 33–59. doi:10.1080/1354570022000077926

Ryburn, B., Wells, Y., & Foreman, P. (2009). Enabling independence: Restorative approaches to home care provision for frail older adults. *Health & Social Care in the Community, 17*(3), 225–234. doi:10.1111/j.1365-2524.2008.00809.x

Sonnega, A., Robinson, K., & Levy, H. (2017). Home and community-based service and other senior service use: Prevalence and characteristics in a national sample. *Home Health Care Services Quarterly, 36*(1), 16–28. doi:10.1080/01621424.2016.1268552

Srivastava, A., & Thomson, S. B. (2009). Framework analysis: A qualitative methodology for applied policy research. *Journal of Administration and Governance, 4*(2), 72–79
Tang, F., & Lee, Y. (2010). Home-and community-based services utilization and aging in place. *Home Health Care Services Quarterly, 29*(3), 138–154. doi:10.1080/01621424.2010.511518

The EuroQol Group. (1990). EuroQol-a new facility for the measurement of health-related quality of life. *Health Policy, 16*(3), 199–208. doi:10.1016/0168-8510(90)90421-9

Van Leeuwen, K. M., Van Loon, M. S., Van Nes, F. A., Bosmans, J. E., De Vet, H. C., Ket, J. C., & Ostelo, R. W. (2019). What does quality of life mean to older adults? A thematic synthesis. *PloS One, 14*(3), e0213263. doi:10.1371/journal.pone.0213263

Van Loon, M. S., Van Leeuwen, K. M., Ostelo, R. W. J. G., Bosmans, J. E., Metselaars, S., Widdershoven, G. A. M. (resubmitted) ‘How do care services contribute to quality of life? Views and experiences of Dutch older adults living at home’.  

Van Loon, M. S., Van Leeuwen, K. M., Ostelo, R. W. J. G., Bosmans, J. E., & Widdershoven, G. A. M. (2018). (resubmitted). How do care services contribute to quality of life? Views and experiences of Dutch older adults living at home. Quality of life in a broader perspective: Does ASCOT reflect the capability approach? *Quality of Life Research, 27*(5), 1181–1189. doi:10.1007/s11136-017-1756-5

### Appendix

| Group | Respondent | Organization | Function (professional) | Type of interview |
|-------|------------|--------------|-------------------------|-------------------|
| I1    | R1         | General practice | Geriatric nurse         | Interview         |
| D1    | R2         | Healthcare purchasing organization 1 | Policy officer | Interview         |
|       | R3         | Healthcare purchasing organization 1 | Policy officer | Interview         |
| D2    | R4         | Healthcare purchasing organization 2 | Policy officer | Interview         |
|       | R5         | Healthcare purchasing organization 2 | Policy officer | Interview         |
| D3    | R6         | Care organization | Policy officer         | Interview         |
|       | R7         | Care organization | Manager                | Interview         |
| F1    | R8         | General practice | General practitioner   | Focus group       |
|       | R9         | General practice | General practitioner   | Focus group       |
|       | R10        | General practice | General practitioner   | Focus group       |
|       | R11        | General practice | Nurse                  | Focus group       |
|       | R12        | General practice | Nurse                  | Focus group       |
| F2    | R13        | Client organization  | Client representative | Focus group       |
|       | R14        | Client organization  | Client representative | Focus group       |
|       | R15        | Client organization  | Client representative | Focus group       |
|       | R16        | Client organization  | Client representative | Focus group       |
|       | R17        | Client organization  | Client representative | Focus group       |
| F3    | R18        | Care organization | Senior researcher       | Focus group       |
|       | R19        | Care organization | Team manager            | Focus group       |
|       | R20        | Care organization | Client manager          | Focus group       |
|       | R21        | Care organization | Policy officer          | Focus group       |
|       | R22        | Care organization | Manager                 | Focus group       |
|       | R23        | Care organization | Manager                 | Focus group       |
|       | R24        | Care organization | Project manager         | Focus group       |
|       | R25        | Care organization | Therapist (activities)  | Focus group       |
|       | R26        | Care organization | Manager                 | Focus group       |
|       | R27        | Care organization | Therapist (group activities) | Focus group |