Case Management for Community-Dwelling Seniors Living with Frailty: Perspectives of Case Managers

by

Declan F. Weir

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Submitted by: **Declan Weir**

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Examining Committee:

Chair of Examining Committee	Dr. JoAnne Arcand
Research Supervisor	Dr. Manon Lemonde
Examining Committee Member	Dr. Hilde Zitzelsberger
Examining Committee Member	Kelly Kay
Thesis Examiner	Leben Gebremikael

The above committee determined that the thesis is acceptable in form and content and that a satisfactory knowledge of the field covered by the thesis was demonstrated by the candidate during an oral examination. A signed copy of the Certificate of Approval is available from the School of Graduate and Postdoctoral Studies.

ABSTRACT

Frailty is a growing health concern in Canada's aging population. Community-dwelling seniors living with frailty are at an increased risk of adverse health and wellness outcomes. Case management has emerged as a promising approach to mitigate the burden of frailty. Case managers are responsible for the delivery of case management to community-dwelling seniors living with frailty. This phenomenological study explored case managers' experiences delivering case management to this population. The Senior Friendly Care Framework guided the core components of this study including the data collection, analysis, and discussion. Interpretative phenomenological analysis of the data resulted in the identification of 13 themes that affect case management. These results provide insight into the current barriers and facilitators of case management practices for community-dwelling seniors living with frailty. The implications of this study's results provide further evidence that can influence future practice, education, research and policy of case management for community-dwelling seniors living with frailty.

Keywords: frailty; community-dwelling seniors; case management; case managers

AUTHOR'S DECLARATION

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STATEMENT OF CONTRIBUTIONS

I hereby certify that I am the sole author of this thesis and that no part of this thesis has been published or submitted for publication. I have used standard referencing practices to acknowledge ideas, research techniques, or other materials that belong to others. Furthermore, I hereby certify that I am the sole source of the creative works and/or inventive knowledge described in this thesis.

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LIST OF ABBREVIATIONS AND SYMBOLS

LHIN	Local Health Integration Network
PRISMA	Program of Research to Integrate Services for Maintenance of Autonomy
sfCare	Senior Friendly Care
CDSR	Cochrane Database of Systematic Reviews
BMR	British Medical Research
CFN	Canadian Frailty Network
IPA	Interpretative Phenomenological Analysis
CCAC	Community Care Access Centre
NCMN	National Case Management Network
CIHI	Canadian Institute for Health Information
ACT	Assertive Community Treatment
GAIN	Geriatric Assessment and Intervention Network
PSW	Personal Support Worker
OT	Occupational Therapist
RNAO	Registered Nurses' Association of Ontario

Chapter 1. Introduction

1.1 Statement of the Problem

Frailty is a growing health concern in Canada's aging population (Statistics Canada, 2017). Frailty can be broadly described as a recognizable state of increased vulnerability resulting from a decline in physiological reserve and function across multiple organ systems (Xue, 2011). It is widely acknowledged that frailty is a multidimensional syndrome affecting the physical, emotional, and cognitive ability of the elderly (Khezrian, Myint, McNeil, & Murray, 2017). Currently over one million Canadians are considered frail and it is projected that in as little as ten years this number could reach as high as two million. Those living with frailty are at higher risk of adverse health outcomes than would be expected at their age (Canadian Frailty Network (CFN), 2020). Adverse health outcomes of frailty include: decreased activity and engagement, anorexia, weight loss, fatigue, sarcopenia, osteopenia, balance and gait abnormalities as well as cognitive impairment. These adverse outcomes are closely associated with a negative impact on health-related quality of life (Chang et al., 2012). Furthermore, studies have consistently demonstrated that frailty is a significant predictor of increased emergency department visits and hospital admission rates among community-dwelling older people (Kojima, 2016). Seniors living with frailty are also at a greater risk of receiving fragmented care with a limited focus only on physiological health (Boeckxstaens & De Graaf, 2011). As the Canadian population continues to age, strategies to improve health outcomes, maintain quality of life, and decrease hospitalization rates for seniors living with frailty have become exceedingly important.

Frailty poses a significant economic burden on the Canadian healthcare system. Older Canadians living with frailty are over-represented in all aspects of the healthcare system. As such, frailty is associated with an increased utilization of healthcare resources (Han, Clegg, Doran, & Fraser, 2019). It is estimated that half of Canada's healthcare budget, which amounts to approximately 110 billion dollars annually, is spent on seniors as a result of chronic disease and frailty (CFN, 2017). Mondor et al. (2019) found that frailty is associated with a greater one-year healthcare cost of up to 12,360 dollars per person due to a higher intensity of healthcare utilization among seniors living with frailty. Furthermore, it has been reported that those who are frail are also at greater risk for chronic illnesses (Onder et al., 2018). Bandeen-Roche et al. (2015) gave further credence to this notion as they demonstrated that chronic illness and disability prevalence increase sharply with frailty. The higher prevalence of frailty among the population will result in an increased need for in-home services, hospital-based care, and long-term care. Given the cost of treatment and the forthcoming demographic shift towards an even older population, maintaining the status quo in our healthcare system is not financially sustainable (McMaster Health Forum, 2016). Therefore, it is imperative we explore approaches that will allow us to better manage the economic and resource-based challenges posed by frailty.

1.2 Supporting Aging in Place

Despite complex and multifaceted health and social care needs due to frailty, older adults have expressed a desire for choices about where and how they age in place (Wiles, Leibing, Guberman, Reeve, & Allen, 2012). Aging in place is defined as seniors remaining living in the community, rather than in residential care (Fausset, Kelly, Rogers,

& Fisk, 2011). Having people remain in their homes and communities for as long as possible avoids the costly option of institutionalized care and is favoured by healthcare providers, policy makers, and seniors themselves (World Health Organization, 2007). The literature has elucidated a few of the reasons why seniors want to age in place and includes: having a strong attachment to their home, a sense of independence and feeling in control of their personal space (Ahn, Kwon, & Kang, 2017). Furthermore, aging in place can lower the risk of potential complications associated with institutionalized care for seniors living with frailty, such as the high mortality recently demonstrated in the COVID-19 pandemic (Hsu & Lane, 2020). Successful aging in place means seniors have access to health and social supports and services they need to live safely and independently in their homes (Government of Canada, 2016).

There are numerous stakeholders involved in delivering health and social supports to community-dwelling seniors including but not limited to: physicians, occupational therapists, physiotherapists, pharmacists, registered nurses, social workers, personal support workers, and family caregivers. These health care providers are increasingly faced with challenges posed by complex care needs that require the coordination of multiple services when supporting and managing care for this population (Moore et al., 2012). Traditional one-to-one approaches that exclude collaborative efforts from different healthcare professionals do not adequately meet the complex care needs of these individuals. Therefore, integrated and collaborative care has been recommended as the delivery method best suited to meet their needs (Oandasan & Closson, 2007). As Canada's demographic landscape continues to shift, it has become increasingly important

that we identify methods of integrated care that will facilitate successful aging in place for seniors living with frailty.

1.3 Case Management as a Model of Care for Seniors Living with Frailty

Navigating a complex healthcare system in order to get the appropriate care can be challenging for seniors living with frailty. They require approaches to care that are integrated and collaborative to help them negotiate the system and ensure health outcomes are optimal (Popejoy et al., 2015). Integrated care programs such as case management can meet the needs of this population, as the problems facing older adults living with frailty are multifaceted, requiring supports across different types of services and providers. Case management is defined as a collaborative process of assessment, planning, facilitation, care coordination, and advocacy for options and services to meet an individual's health needs (National Case Management Network of Canada (NCMN), 2009). The term "case management" may be referred to as "care management" or "care coordination" in the literature and may have the terms "interventions", "programs" or "plans" associated with it (Somme et al., 2012). Regardless of name, case management aims to enhance the quality of care and improve health-related outcomes for community-dwelling seniors living with frailty by helping them connect to the various services, treatments, and interventions they require. Case management interventions play a significant role in delivering integrated and continuous care to these seniors (Sandberg, Jakobsson, Midlöv, & Kristensson, 2014). Furthermore, case management interventions have demonstrated modest success in terms of improving cognitive function, physical health, psychological well-being, as well as medication management, addressing unmet needs, and decreasing hospital admission rates (Gowing, Dickinson, Gorman, Robinson,

& Duncan, 2016). Therefore, case management may offer the potential to aid seniors in successful aging in place and reduce the effects of frailty on the individual, their family, and the healthcare system.

In Ontario, there are various models of case management. These models can differ with respect to how services are delivered and by whom, the training provided to its staff, and the means of financing. One provincial model in Ontario for case management provides most home and community care related services under one administrative umbrella, the Local Health Integration Network (LHIN). The LHIN is divided into 14 branches that each encompass a geographic region of Ontario. The LHIN is responsible for integrating and funding local healthcare as well as delivering and coordinating care for community-dwelling seniors living with frailty (LHIN, 2017). As of 2019 there has been a shift to a more regionalized structure for many LHIN functions under a new agency called Ontario Health. However, the organization of home care services including care coordination, remains relatively unchanged at the time of writing. There are also community-based case management models in Ontario. Community-based models are smaller than provincial models and rely on cooperation across care providers while focusing on home and community care. They also play an active role in health and social care coordination (Beland & Hollander, 2011). A community-based model typically operates in a manner that may be referred to as the linkage model of case management. This occurs when privately funded independent health and social care organizations work in collaboration with government-funded health and social care organizations to provide services to community-dwelling seniors living with frailty (Vroomen-MacNeil et al., 2015). In this model, each organization has their own respective case managers with their

own individual clients, although it is also possible for client overlap. However, in Ontario, case managers from community-based models of case management must refer to the LHIN in order for their clients to receive services such as access to personal support workers, physiotherapy, or occupational therapy. This is the primary model of case management that will be explored in this study from the perspective of case managers.

Additionally, there are different intensities of case management models. These models include low, moderate, and high intensity, which is based on the frequency of contact from case managers to community-dwelling seniors living with frailty (Uittenbroek, Van Der Mei, Slotman, Reijneveld, & Wynia, 2018). There are some discrepancies on what constitutes a low, moderate, or high intensity model of case management in the literature. Generally speaking, a low intensity model may be one in which a client is relatively stable and requires minimal home visits and whereby communication by telephone is more suitable (Uittenbroek et al., 2018). Patients who require low intensity case management may only need a follow-up every three to six months with annual re-assessments (Community Care Access Centre (CCAC), 2012). A moderate intensity of case management may be described as one in which direct care needs are still stable and predictable, but the client requires an in-person follow-up monthly. They also require re-assessment roughly every six months as they are at higher risk of deterioration of their condition (CCAC, 2012). In high intensity case management, a case manager will have frequent contact with the patient, with more than 50 percent of the interventions happening face-to-face (Hudon et al., 2019). Patients that need high intensity case management are typically identified as having complex care needs based on the case manager's initial assessment (Hudon et al., 2019). Patients that require high

intensity case management may need a weekly follow-up and require re-assessment every three months (CCAC, 2012). The impact of the various models of case management from the perspective of case managers will be further discussed in this study.

1.4 Case Managers' Roles in Case Management

Case managers are responsible for delivering case management to community-dwelling seniors living with frailty. In the case of care for community-dwelling seniors living with frailty, the overarching goal of case managers is to aid them navigate the complexities of the healthcare system effectively and efficiently to acquire the care they need (Carter et al., 2018). Case managers support clients' achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment (NCMN, 2009). Collaboration with patients and family caregivers as well as implementation and evaluation of the effectiveness of services in achieving goals of care are also responsibilities of case managers (LHIN, 2017). In Ontario, case managers typically come from professional backgrounds, both regulated and unregulated. These backgrounds may include nursing, physiotherapy, occupational therapy, certified social worker, speech language pathology, personal support worker, or addiction counsellor (NCMN, 2012). Case managers may be known in their working environment under different titles such as care manager or care coordinator. Despite varying titles, the scope of practice for case management providers does not change, as there are common roles that must be performed in order to maximize client outcomes.

The NCMN (2012) defined seven roles that are necessary duties for case managers. These seven roles include: case management expertise, communicator, collaborator, navigator, manager, advocate, and professional. There are key competencies

associated with these roles. As case management experts, case managers must be able to screen clients for eligibility, perform comprehensive assessments, develop care plans, and evaluate outcomes. As communicators and collaborators, case managers must develop rapport, utilize effective means of communication, and work closely with stakeholders such as the client, the client's social network, and any organization involved in providing health and social supports to the client. Furthermore, in relation to their roles as navigators, managers, advocates, and professionals, case managers must identify and remove barriers to care. They also must make decisions about care plans while promoting autonomy of their client in a professional manner. It is of great significance that case managers enable competencies of patients and family caregivers. This includes educating patients and family caregivers on availability of services, self-advocacy, and self-navigation of health and social systems. Fulfilling these roles ensures case managers adequately support community-dwelling seniors living with frailty.

1.5 Research Purpose, Question, Objective, and Outline

The purpose of this research study is to inform future policies and practices related to case management for community-dwelling seniors living with frailty. The Canadian demographic continues to undergo a shift towards older ages and case management has emerged as a strategy for improving health and social care integration to meet the holistic needs of seniors living with frailty (Althaus et al., 2011). Case management has demonstrated the ability to reduce the fragmentation of health and social care services that can result in higher quality and more cost-effective service outcomes for seniors living with frailty (Sadler et al., 2018). Case management has also been associated with reduced long-term care admissions compared to usual care and improved

family caregiver outcomes (Reilly et al., 2015) As such, case management has become a key aspect of support for community-dwelling seniors living with frailty (Warrick, Prorok, & Seitz, 2018). Therefore, it is crucial that the implementation and delivery of case management is guided by evidence-informed practices.

Case managers play a pivotal role in providing case management to community-dwelling seniors living with frailty. They provide a single point of contact for care, support, and advice for this population (Hudon et al., 2019). However, as case management often organizes components that may act independently and interdependently, it is difficult to assess and evaluate the efficacy of case management interventions (Sandberg et al., 2014). Furthermore, limited evidence exists that specifically evaluates components of case management in the Ontario healthcare system. Examining case managers' experiences can provide a window into the processes of case management that hold the greatest potential for helping older adults with frailty remain in the community. Therefore, the research question of this study was developed with a focus on exploring case managers' experiences:

- What are case managers' experiences delivering case management to community-dwelling seniors living with frailty?

A qualitative approach to research is needed to explore this research question and increase our understanding of the components of case management for community-dwelling seniors living with frailty from the perspective of case managers. This leads us to the objective of this study, which is to identify the barriers and facilitators of case management for community-dwelling seniors living with frailty from the perspective of case managers.

The introductory chapter covers the impact of frailty on the population and the strategies utilized by case managers to mitigate the issues associated with frailty currently facing older adults in Canada. Furthermore, it provides a rationale to undertake a qualitative study that explores case managers' experiences delivering case management to community-dwelling seniors living with frailty. The literature review is the second chapter and accomplishes several purposes. A key purpose of it is to share with the reader the results of other studies that are closely related to my study as well as provide the reader of my study a relation to the larger, ongoing dialogue on the topic and identify significant gaps in the literature. It also introduces the theoretical framework that guides data collection and analysis. The third chapter is the methodology, that covers the study's sampling strategy, data collection and analysis techniques, and perspectives on validity. The fourth chapter presents the findings of the participant interviews. The fifth chapter is the discussion of the results, where they are linked to relevant evidence. The sixth chapter is the conclusion of the study. This chapter offers a brief summary of the study as well as highlights the study's strengths, limitations, and the implications of this study on future case management practices, education, research, and policy.

Chapter 2. Literature Review

2.1 Central Themes of the Literature Review

As mentioned in the introduction in Chapter 1, there is evidence that case management can be delivered to community-dwelling seniors living with frailty to improve adverse health outcomes, reduce economic burden on the healthcare system, and support aging in place. However, further research is needed as there is limited literature that explores the barriers and facilitators of case management for this population from the perspective of case managers. Elucidating this information will allow the informing and optimizing of future case management for community-dwelling seniors living with frailty. Furthermore, the selection of a conceptual framework to support and structure the study is one of the most important aspects of the research process. The framework provides the foundation from which all knowledge will be constructed in this study. Most importantly, it serves as a grounding base for the methods and analysis of this study (Grant & Osanloo, 2014). Therefore, the literature review aims are two-fold. Firstly, to gather a deeper understanding of case managers' roles in case management for community-dwelling seniors living with frailty. Secondly, to identify a specific framework to guide the research process.

Upon undertaking this literature review, three main stakeholders were identified in case management. These three stakeholders include case managers, community-dwelling seniors living with frailty, and family caregivers. Due to the significance of their roles and the interpersonal relationships between these stakeholders, they each have the ability to greatly impact the outcomes of case management. Furthermore, the effectiveness of different models and intensity of case management as well as the

relationship between case managers and the organization in which they work are recurring topics within the literature. Therefore, the central themes that are covered in this literature review include: case managers' perspectives of their role, case managers' relationship with community-dwelling seniors with frailty, case managers' relationship with caregivers, effectiveness of different models of case management, intensity of case management, and organizational goals and constraints.

This literature review also explores the gap in relevant Canadian literature on case management for community-dwelling seniors living with frailty. Due to the uniqueness of the Canadian healthcare system, exploring literature on case management for community-dwelling seniors living with frailty in Canada is important. Furthermore, examining research that focuses on case management in Ontario is also important as provincial differences exist in the delivery of health and social care services (Government of Canada, 2019). Lastly, the conceptual framework known as The Senior Friendly Care (sfCare) Framework was identified in the review of the grey literature. This framework serves as the guide for the entire research process and is integral in developing the key components of this study.

2.2 Search Strategy and Selection Criteria

Criteria based on the two literature review aims were devised and refined during the selection retrieval process from November 2018 to January 2020. Due to the rapidly evolving field of case management, the search reviewed studies that were published within the last ten years, covering the period of January 2010 to April 2020. The databases that were searched included Google Scholar, PubMed, and Cochrane Database of Systematic Reviews (CDSR). Grey literature was also reviewed to provide further

insight on case management. Grey literature sources that contributed to the literature review included publications by government and health and social care organizations. A keyword search was established based on the prominent terminology surrounding the topic. The keywords, “case management”, “care management”, “chronic disease”, “frailty”, “aged”, “geriatric”, “senior”, and “frailty” combined with Boolean search words and free text keywords were utilized in the search. A total of 721 studies were identified and screened. Study selection was done by screening titles and abstracts for eligibility and relevance. Studies were then included if they were written in the English language, published within the last ten years, and focused on case management interventions for community-dwelling seniors living with frailty. Studies were excluded if they included case management interventions for younger adults, were aimed towards seniors who live in long-term care facilities, or used additional healthcare approaches outside of case management to achieve their outcomes. A snowballing strategy was also implemented, whereby reference lists of eligible studies and other previous relevant literature reviews were examined to locate additional studies not found in the initial search strategy. Table 2.1 outlines the inclusion and exclusion criteria applied to potential studies to ensure that all relevant studies were included in the literature review.

Table 2.1: Inclusion and exclusion criteria when screening for eligible articles in literature review

Item	Inclusion	Exclusion
Population	• Seniors aged 65 and older • Living in the community with frailty	• Adults living with frailty • Seniors living with frailty in long-term care facilities

Intervention	• Case management or any words synonymous with case management (care management, care coordination)	• Any additional methods of care outside the scope of case management
Outcomes	• Cost-effectiveness • Health outcomes • Ability to support seniors age in place	• Studies without reported outcomes
Publications	• Published in English • Published after 2010	• Duplicate articles • Published before 2010
Article Type and Study Design	• Qualitative studies • Quantitative studies including randomized controlled trials, cohort studies and cross-sectional studies • Mixed-methods studies • Systematic reviews and scoping reviews • Reviews and summaries from grey literature including clinical practice protocols, guidelines and consensus	• Trials without participant data including newsletters, commentaries, opinion pieces and editorials

After applying the inclusion and exclusion criteria to the identified studies, a total of 26 articles were retained for the literature review. Table 2.2 displays the number of articles retrieved from each database and the number of studies deemed relevant to

include in the literature review. In the literature search, there were duplicate articles between the databases and the numerical count in this table does not exclude duplicates.

Table 2.2: Number of articles retrieved from the databases

Database	Number of articles retrieved	Number of relevant articles
PubMed	377	16
Google Scholar	294	7
CDSR	50	3

The breakdown of the studies selected are ten qualitative studies, seven systematic reviews, five quantitative studies, three mixed-methods, and one scoping review.

2.3 Case Managers' Perspectives of their Role

As mentioned in the key themes of the literature review case managers are integral stakeholders in case management for community-dwelling seniors living with frailty. Studies by Balard, Nargeot, Corvol, Saint Jean, and Somme (2016), You, Dunt, and Doyle (2016), and Sandberg et al. (2014) explored some of the representations and expectations of the role of case managers from their perspective. A similar conclusion was drawn between these studies that case managers view themselves as healthcare navigators, problem-solvers, and as health and social supports for community-dwelling seniors living with frailty. Furthermore, these studies found that case managers function as those who can assist seniors living with frailty connect to required services and supports in the community. However, none of the studies came to a consensus on specific case management activities that are required components of case management

interventions. This suggests that there may be inconsistencies in how case managers perceive their role and how they deliver case management to community-dwelling seniors with frailty.

This literature review also identified collaboration as a core competency necessary for case managers to deliver case management to community-dwelling seniors living with frailty. Case managers act as collaborators by facilitating the achievement of optimal client and system outcomes by working with broad health and social networks (National Case Management Network (NCMN), 2012). Lawless, Archibald, Ambagtsheer, and Kitson (2020) cautioned that special attention needs to be given to the dynamics of establishing contact and collaboration between case managers and specialists within integrated care models. This was echoed by de Stampa et al. (2014) who emphasized the importance of effective interprofessional collaboration between case managers and healthcare providers. To date there is a paucity of evidence that explores case managers' roles as collaborators within a larger healthcare team on behalf of community-dwelling seniors living with frailty. Therefore, it is evident that examining case managers' perspectives of how they view their role and how they collaborate with other healthcare providers is becoming increasingly important to case management.

Questions surrounding case managers' experience and previous background that may impact delivery of case management interventions were raised in the literature. The study by You et al. (2016) used surveys to examine components of case management interventions with which case managers are primarily concerned. The information in the surveys demonstrated that case managers who have at least five years of work experience focus more on needs assessment or health-related outcomes as opposed to other aspects

like coordination of care. Likewise, case managers with differing professional backgrounds also reported a difference in the focus of specific components of case management interventions. Case managers with a nursing background reported to be more comfortable in educating patients on health-related issues compared to those with a social worker background. Similarly, the study by Gustafsson, Kristensson, Holst, Willman, and Bohman (2013) stated that case managers may utilize their pre-understanding from their professional background to govern how they should or should not perform certain tasks. It was also reported by Van Durme et al. (2015) that there is a need for future research that investigates the training received by case managers as well as the experiences and specific functions they perform. Therefore, it is essential to further explore how case managers view their own role, what impacts the focus of their care, and how it affects their overall delivery of case management interventions.

Lastly, only a few of the aforementioned studies that investigated case managers' perspectives utilized frameworks to guide their data collection and analysis. The study by Balard et al. (2016) utilized a framework, known as the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA). The PRISMA framework developed by Hébert, Durand, Dubuc, and Tourigny (2003) measures the implementation of case management interventions, observes modifications of the professional practice, and explores the users' and case managers' experiences. Similarly, the study by Sandberg et al. (2014) used a research framework developed by the British Medical Research (BMR) Council for measuring the complexity of case management interventions. However, these studies fail to elaborate on how the framework guided their research methodology. As the importance of utilizing a framework must not be understated in a

research study, there is a need to determine a specific framework that can be utilized that will serve as the structure and support for examining case managers' perspectives of their role.

2.4 Case Managers' Relationship with Community-Dwelling Seniors Living with Frailty

The relationship between case managers and community-dwelling seniors living with frailty was highlighted as significant to the effectiveness of case management. The studies by Balard et al. (2016) and Sandberg et al. (2014) explored perspectives of community-dwelling seniors living with frailty about case managers. It was noted that community-dwelling seniors living with frailty viewed case managers as a helping hand and one who can provide information to them about their health status, the healthcare system, social activities, nutrition, and medication. Among these studies there was agreement that contact by case managers is generally well appreciated by many seniors living with frailty. This was echoed by Berner, Anderberg, Rennemark, and Berglund (2016) who found that regular contact between case managers and seniors living with frailty, approximately two to three times a week, is important to perform and implement case management. Furthermore, Gridley, Brooks, and Glendinning (2014) found that seniors with complex needs want patient-centred care where time is taken to get to know them. Experiencing trust in case managers has also been identified as an important facilitator of case management for community-dwelling seniors living with frailty to share their situations with case managers and enable them to voice their concerns (Gustafsson et al., 2013). However, the researchers noted that there is a limited understanding of the role of case managers, especially by seniors living with cognitive

impairments. This leads to a lack of clarity of case managers' duties which can lead to many people having expectations that do not fall within the usual scope of assistance and care provided by case managers. This was exemplified by Hjelm, Holst, Willman, Bohman, and Kristensson (2015) who found that in some instances, seniors living with frailty did not know what case managers could do for them. It is evident that issues and discrepancies exist in the literature on case managers' relationships with community-dwelling seniors living with frailty. Gaining a deeper understanding of this significant relationship could be used to inform future case management practices.

Contrary to the largely reported positive attitudes that community-dwelling seniors living with frailty have towards case managers, the study by Roland et al. (2012) found that a significant portion of English-based patients had less than positive experiences with case management. Patients in their study appeared to experience a reduction in continuity of care as they found it more difficult to see a doctor or nurse of their choice. Therefore, they sometimes felt they weren't included in decision-making by case managers. These authors speculated that this was due to the process of care planning and management which may have led to the 'professionalising' of care rather than engaging patients more personally in their care. The significance of engaging in personalized care for community-dwelling seniors with frailty has been well documented in the literature. Bergenstal et al. (2020) demonstrated that patients with personalized integrated care plans had decreased hospital admissions and reduced healthcare costs, which are two key case management goals. Furthermore, Balard et al. (2016) noted that some patients may refuse care from case managers. The factors that led to refusal of care and issues surrounding the inclusion of patients in decision-making were not elucidated

in their study. Therefore, there is a growing need to further explore the relationship between case managers and community-dwelling seniors, especially concepts related to decision-making in case management.

All of the aforementioned studies that explored case managers' relationships with community-dwelling seniors with frailty took place outside of Canada. As the studies occurred in Europe, comparisons on the dynamic of the relationship between case managers and community-dwelling seniors with frailty are difficult to make in Canada or its provinces. The relationship between case managers and community-dwelling seniors with frailty will be significantly influenced by the context of the current case management model operating uniquely in Ontario. Therefore, a study that explores the relationship between community-dwelling seniors living with frailty and Canadian case managers has become increasingly important to case management outcomes.

2.5 Case Managers' Relationship with Family Caregivers

The relationship between case managers and family caregivers is also significant to the efficacy of case management. Family caregivers are deeply involved in the case management process and are essential figures for maintaining seniors with frailty at home (Willemse et al., 2016). For brevity, the term "family caregivers" refers to anyone involved in coordination or delivery of care without any financial compensation (Cameron, Naglie, Silver, & Gignac, 2013). Typically, this includes family members, neighbours, friends or other social supports and connections (Canadian Institute for Health Information (CIHI), 2018). The rising demand and lengthy wait times for long-term care services has transferred a significant portion of the burden of care for seniors living with frailty to family caregivers. Therefore, effective support intervention

strategies to enhance the coping and health of family caregivers of seniors living with frailty is becoming crucial (Yu, 2016). Khanassov and Vedel (2016) reported that the effects of case management on family caregivers are positive. Increased confidence in caregiving, improved decision-making capacity, satisfaction with social supports, and involvement in care plan development were listed as the positive effects. However, Lopez-Hartmann, Wens, Verhoeven, and Remmen (2012) found that the effect of case management related to supporting caregivers of seniors living with frailty is small and inconsistent between studies. As caregiving is a dynamic process, and despite many common experiences, family caregiver roles are highly variable between individuals who provide them. Furthermore, the aforementioned studies were not qualitative in nature and did not expand on the specific components of case management involving family caregivers that have an impact on the health outcomes of seniors with frailty. They also did not expand on the role that case managers have in supporting family caregivers to facilitate the case management process for seniors with frailty. Due to the growing importance of family caregivers, further investigation is warranted to understand how their roles are viewed by case managers.

Although literature exploring the relationship between case managers and family caregivers is limited, the study by Balard et al. (2016) briefly examined a component of this relationship. Balard et al. (2016) specifically investigated the perceptions that family caregivers have on case managers. It was found that family caregivers ultimately view case managers as isolation breakers, solution finders, and partners in care for community-dwelling seniors living with frailty. These authors also highlighted that the representation of case managers by family caregivers is not fixed and evolved during the

implementation phase of case management. Furthermore, they noted that expectations of family caregivers about case management and the roles of case managers vary widely. Although this evidence assesses family caregivers' perceptions of case managers, it is useful as it demonstrates the uncertainties in the role and function of caregivers in case management for community-dwelling seniors living with frailty. In addition, the systematic review by Berthelsen and Kristensson (2015) reported that family caregivers play an important role in case management due to the practical and emotional support they provide. However, the researchers stated that health professionals can be reluctant to include them in the care of seniors living with frailty. This further suggests that in some instances the role of family caregivers in case management may be misunderstood and misused. To date, no study has explored case managers' perceptions of family caregivers in case management interventions. As family caregivers are important frontline stakeholders in case management interventions it is imperative to explore how case managers' view their role.

2.6 Effectiveness of Different Models of Case Management

The delivery of integrated care to community-dwelling seniors with frailty can be achieved in a variety of different models. All case management models have the same goal of providing effective coordinated care across different types of services to ensure continuity of care for seniors with frailty (Beland & Hollander, 2011). The provincial case management model currently in Ontario is operationalized through the LHINs. This model is a large-scale model that has a single administrative authority and single budget spread across 14 regional LHINs. This provincial wide model is also supported by smaller community-based models sometimes known in the literature as linkage models

(Van Mierlo, Meiland, Van Hout, & Dröes, 2014). The studies by Vroomen-MacNeil et al. (2015) and Vroomen-MacNeil et al. (2016) compared a larger-scale model to the linkage model of case management. Results were objectively measured through health outcomes, quality of life, hospitalization rates, and cost-effectiveness. The larger-scale model was found to be slightly more cost-effective compared to the linkage model but the differences in clinical outcomes were insignificant. Noted also was that the results should be interpreted with caution. Furthermore, the study by Van Mierlo et al. (2014) investigated the barriers of the linkage model of case management. It was found that the presence of multiple competing case managers may impede implementation of case management. However, this study was performed in the Netherlands where the linkage model of case management operates differently, as it is not connected to the same provincial model that operates in Ontario. Furthermore, no study considered case managers' perceptions of working in a community-based linkage model or larger-scale model. It is evident there is a need to develop a deeper understanding of how case managers function in the different models of case management in the Canadian healthcare system.

2.7 Intensity of Case Management

The next recurring theme in the literature relates to intensity of the model of case management implemented. It is likely that individuals with different degrees of frailty will require different formulations and levels of intensity of case management. This variation in intensity will likely have different impacts on seniors living with frailty, case managers and services, with implications for health and social care utilization and costs (Sadler et al., 2018). As such, Uittenbroek et al. (2018) stated that case managers must be

able to adjust the intensity of their monitoring based on the needs of the senior living with frailty. Furthermore, the systematic reviews by Somme et al. (2012) and Hudon et al. (2019) examined the impact of different intensities of case management for community-dwelling seniors with frailty. These researchers found that high and moderate intensity case management positively impacted clinical effects such as health outcomes, hospitalization rates, and resource use. These studies also demonstrated that low intensity models had only slight effects on these outcomes. Despite these findings, Somme et al. (2012) noted that the evidence is still weak and further research is needed. There is also no clear definition on what constitutes a high, moderate, or low intensity case management intervention. Hudon et al. (2019) defined high intensity case management as frequent case manager contact with their patient, with greater than 50 percent of the interventions happening face-to-face. In contrast, Somme et al. (2012) utilized an 18-item scale developed by Pacala et al. (1995) that incorporates case managers' caseload size to measure the intensity of case management. The inconsistencies surrounding what constitutes the level of intensity of case management means there is a need to further explore this gap in the literature.

The relationship between case management intensity and the improvement of quality of life indicators and health outcomes has become exceedingly important. Granbom, Kristensson, and Sandberg (2017), Taube, Kristensson, Midlöv, and Jakobsson (2017), and You, Dunt, Doyle, and Hsueh (2012) compared high intensity case management interventions with low or no case management intervention. Intervention intensity was objectively measured through participation in physical activity, social participation, quality of life score, hospitalization rates, emergency department visits, and

unmet service needs. It was determined that case management interventions intensity correlated with health outcomes. However, improvements in some of the measurable outcomes such as hospitalization rates and quality of life were not statistically significant. Likewise, Hudon et al. (2019) noted the results of some studies regarding the effects of high intensity case management for older patients with complex care needs remains unclear. Furthermore, these studies did not take into account case managers' perspectives in the delivery of various intensities of case management. There is a need to explore case managers' perspectives on case management intensity, as this may give us additional insight into the demands of case management and how that impacts care of community-dwelling seniors with frailty.

2.8 Organizational Goals and Constraints

The next theme evident in the literature and a contributor to the efficacy of a model of case management interventions was the relationship between governing organizations and case managers. Case managers and models of case management interventions need to achieve the desired goals of their respective employing organization (You et al., 2016). Case managers are expected to achieve the goals of all their patients while managing budgets wisely. You et al. (2016) noted that organizational goals were sometimes in conflict with case managers' goals. The reasons given for this included tight timeframes, limited resources, administrative requirements, and bureaucracy. This was supported by Sandberg et al. (2014) who reported that in various instances healthcare agencies did not adequately support case managers in their job. In some instances, case managers' felt that they were not acknowledged by healthcare agencies and that they did not get timely responses or help from the organization. Van Mierlo et al. (2014) had

noted that an essential facilitating factor for the implementation of case management is the organizational structure and collaboration between partners in the care network. Therefore, exploring the relationship between case managers and employing organizations may elucidate invaluable information on barriers and facilitators to case management.

As mentioned, a key goal of case management is to reduce the economic burden on the healthcare system, making it a key organizational goal. The study performed by Vroomen-MacNeil et al. (2016) explored if case management models were cost-effective for the governing organization. It was demonstrated in their study that some models, such as provincial and linkage models of case management are slightly more cost-effective when compared to not utilizing case management. In contrast, Uittenbroek et al. (2018) found that these models of case management are not cost-effective after 12 months of monitoring. However, Uittenbroek et al. (2018) stated that case management could still be worthwhile as it is associated with decreased hospital admission rates and emergency department visits for older adults with complex care needs if society is willing to invest substantially. These mixed findings based on quantitative studies demonstrate a need for further investigation into the cost-effectiveness of case management and its impact on organizational goals. Specifically, examining case managers' perspectives may allow us to identify inefficiencies in case management and mitigate them where possible.

2.9 Gaps in Relevant Canadian Literature

Currently there exists a lack of studies performed on case management for community-dwelling seniors with frailty and the role of case managers within the Canadian healthcare system. Issues such as differences in case managers' professional backgrounds,

the uniqueness of the Canadian healthcare system, and a reflection of Canadian values arise when evaluating and applying the results of international studies to a Canadian context. The breakdown of the location of the studies reviewed is displayed in Table 2.3

Table 2.3: Breakdown of the location of studies reviewed

Country	Number of Studies
Sweden	6
Netherlands	4
United Kingdom	2
France	1
Australia	1
Belgium	1
Hong Kong	1
United States of America	1
Canada	1

There are differences surrounding the qualifications required for occupation as a case manager in different countries. In the Canadian system, case managers are held to a high standard and must come from a recognized professional background such as nursing, physiotherapy, or occupational therapy. As highlighted in the studies by You et al. (2015), Gustafsson et al. (2013), and Van Durme et al. (2015) case managers professional backgrounds, training, and previous work experience may affect delivery of case management. Therefore, it is plausible to say that case management may be impacted by the professional experience, education, and licensure of a case manager in the international studies reviewed.

The Canadian healthcare system also operates in a unique manner compared to the majority of countries where the studies have been performed (Government of Canada, 2018). For example, Ontario operates a provincial case management model that is supported by smaller community-based models. Comparing this to a model based in the United States of America, such as the Program of All-Inclusive Care of the Elderly model, highlights pronounced differences, from the funding mechanisms to the level of involvement of additional healthcare professionals (Beland & Hollander, 2011). Therefore, a study that represents case managers perceptions of the current Canadian case management model is necessary.

Lastly, health and wellness indicators such as quality of life may be influenced by cultural, ethical, and religious values (Molzahn, Kalfoss, Makaroff, & Skevington, 2011). As Canada has a unique cultural background in comparison to the locations of the studies reviewed have been performed, it is difficult to make cross-case generalizations on the case management process. This may be demonstrated in the studies by Vroomen-MacNeil et al. (2016) and Balard et al. (2016) where health and wellness indicators or relationships between different stakeholders may report results that would not be similarly found if based on Canadians. It is evident a gap in relevant Canadian literature surrounding models of case management interventions needs to be addressed.

2.10 Frameworks

Frameworks are a significant component in a qualitative research study for multiple reasons and may be considered one of the most important aspects of the research process (Grant & Osanloo, 2013). A framework limits the scope of the relevant data by defining the viewpoint that the researcher will take in analyzing and interpreting the data.

It also facilitates the understanding of concepts according to given definitions and builds new knowledge by validating or challenging theoretical assumptions (Labaree, 2009). In the literature reviewed there was a limited utilization of frameworks. Only the studies by Balard et al. (2016) and Sandberg et al. (2014) mentioned the use of the PRISMA and BMR council frameworks to guide their study. However, through reviewing the grey literature, a framework developed by The Regional Geriatric Program of Toronto (2017) known as the Senior Friendly Care (sfCare) Framework was identified. The goal of the sfCare Framework is to provide a foundation for achieving a level of care that will facilitate the best possible health outcomes for older adults.

The sfCare Framework is a blueprint for what senior friendly care should look like across the healthcare system and is targeted towards seniors with frailty. Therefore, I selected it as the framework to guide the research methodology of this study. The sfCare Framework has not been used to guide a research study before, thus making this a novel use of the framework in the literature. The sfCare Framework is comprised of seven guiding principles applied across five domains. These five domains are comprised of 31 defining statements, as outlined by Table 2.4.

Table 2.4: The sfCare Framework domains and defining statements

Domain	Defining Statements
Organizational Support	• Senior friendly care is an organizational priority • The values and principles of senior friendly care are evident in all policies and procedures • The organization collaborates with system partners to meet needs of older adults and implements

	standard/monitors indicators relevant to care of older adults
Processes of Care	• An interprofessional model of care is followed and care is integrated and provides continuity during transitions • Older adults are partners with the care team and care is aligned with an individual's preferences • Communications are adapted to meet the needs of older adults and information is provided in a way that makes it easy to understand
Emotional and Behavioural Environment	• The care of older adults is planned and delivered in alignment with personal goals • Care providers respect each individuals' breadth of lived experience, relationships, unique values, preferences and capabilities • Family and caregivers are valued and supported as care partners and social connections are recognized as an important contributor to the health and well-being of older adults
Ethics in Clinical Care and Research	• Autonomy, choice and dignity of older adults are protected in care processes • An older adult will not be denied access to care
Physical Environment	• The structures, spaces and equipment provide an environment that minimizes the vulnerabilities of older adults and promotes safety, functional independence and well-being

The sfCare Framework aligns with the themes present in the literature review. An example of this alignment is demonstrated through the theme of organizational support, which was a significant topic arising from this literature review and is a domain of the sfCare Framework. The defining statements of organizational support in the sfCare Framework includes senior friendly care being an organization priority, the values and principles of senior friendly care being evident in all policies and procedures, and organizational collaboration to meet the needs of older adults. As mentioned in the literature review, there were questions raised by You et al. (2016) and Sandberg et al. (2014) about the constraints and supports case managers' governing organizations provide them. Therefore, the principles of the sfCare Framework can be used to guide this study and help to explicate the current gaps that exist in the literature surrounding the organizational support domain as well as the remaining four domains.

2.11 Summary of Literature Review

This literature review accomplishes several purposes. These purposes include sharing the results of other studies that are closely related to my study, relating this study to the larger, ongoing dialogue in the literature and identifying gaps currently surrounding case managers' roles in case management for community-dwelling seniors with frailty. This literature review has provided a framework for establishing the importance of the study and a benchmark to which this study's results relate. This literature review has identified the current central themes pertinent to case management and includes insights about case managers' perspectives of their role, relationship with community-dwelling seniors with frailty, and relationship with family caregivers as well as effectiveness of different models of case management, intensity of case management, organizational goals

and constraints, and the lack of studies originating in Canada. Furthermore, this literature review identified the sfCare framework which will guide the methodology, and discussion of this study.

Chapter 3. Methodology

3.1 Overview of Methodology

The purpose of this research study was to inform future policy and practices related to case management for community-dwelling seniors living with frailty. The objective of this qualitative research study was to identify the barriers and facilitators of case management for community-dwelling seniors living with frailty. This research took place in a large urban city at a community-based organization and recruited their actively employed case managers. The name of the organization is withheld in order to protect the identity and confidentiality of the case managers in this study.

The qualitative approach to research used in this study is phenomenology. The phenomenological approach involves the researcher producing an account of the lived experiences of individuals about a phenomenon as described by participants. This description culminates in the essence of the experiences for several individuals who have all experienced the phenomenon (Creswell, 2013). In this study, I used the phenomenological approach to explore how case managers perceive case management for community-dwelling seniors living with frailty. As the researcher, I have an active role in exploring and building the essence of case managers' experiences delivering case management to this population (Smith, Flowers, & Larkin, 2009). Therefore, this study includes a two-stage interpretation process: through collaborative semi-structured interviews case managers described their experiences, which I then identified and articulated the essence of their experiences (Smith & Osborn, 2014). The theoretical framework selected to guide the methodology of the study was the sfCare Framework. This framework has not been utilized to guide a research study to date, as such this was a

novel use of the framework in the literature. Applying the framework to the research question allowed for the guidance of the methodology of this study. This chapter covers the following topics, the researcher's role, ethical considerations, sampling practices, recruitment strategy, data collection, data analysis, and the evaluative criteria.

3.2 The Researcher's Role

As a researcher, it is imperative that I declare all potential biases in order to position myself in relation to the study. Creswell (2013) noted that in qualitative research, the role of the researcher as the primary data collection instrument necessitates the identification of personal values, assumptions, and biases before conducting the study. This allows my contribution to the study to be positive and useful as opposed to detrimental. My perceptions of the barriers and facilitators of case management for community-dwelling seniors living with frailty are shaped by my personal experiences. I had two grandparents who lived independently in the community with frailty between the years of 2010 to 2018. During this time, they were both supported by case managers that assisted them to remain in the community. Since 2018, they have both been moved to a long-term care facility. I witnessed the difficulties and challenges associated with being a senior living with frailty, experienced by their caregiver, and supported by their case manager. I have also witnessed the dynamics of the relationships between each stakeholder involved in case management. I believe this understanding of case management for community-dwelling seniors living with frailty has enhanced my awareness, knowledge, and sensitivity to the complexity of delivering case management to community-dwelling seniors living with frailty. As a graduate student, I have completed two specialized advanced topics courses, where I was able to further

investigate and articulate the role of case managers and case management in supporting seniors living with frailty to remain in the community. Therefore, I bring a breadth of theoretical and practical knowledge about the goals of case management and how case managers facilitate this process.

Due to my experiences of observing and studying the role of case managers in case management for community-dwelling seniors with frailty, I bring inherent biases to this study. Therefore, every effort will be made to ensure trustworthiness of my study. I elaborate on how I ensure trustworthiness of this study in section 3.8 (**Evaluative Criteria**). However, it is important to note that these biases shape the way the data is viewed, understood, collected, and how I interpret participants' responses to the interview questions. I commenced this study with the belief that the role of a case manager is complex and challenging as well as often misunderstood by the general population.

3.3 Ethical Considerations

As the researcher, I have an obligation to respect the rights, needs, values, and desires of the participants in this study. I employed various safeguards as discussed by Creswell (2013) in this study to ensure that participants rights, needs, values, and desires were respected. The initial safeguard that I used ensured that the research purpose was articulated verbally and in writing so that it was clearly understood by each participant. I achieved this through the Consent Form (**Appendix A**) which participants had access to before voluntarily participating in the study as well as it being read to them before their signing of the form and the commencement of the interview. Furthermore, participants were made aware of all data collection devices and activities, which included the use of audio recorders and written notes during the interview. Finally, I ensured verbatim

transcriptions, written interpretations, and reports were made available to participants during the study. Ensuring that these safeguards were closely followed allowed this study to be conducted in an ethically sensitive manner.

3.4 Sampling Practices

I utilized a four-point approach to sampling for qualitative interview-based research in this study. As discussed by Robinson (2014), the four-point approach to sampling includes: defining a sample universe, deciding upon a sample size, selecting a sample strategy, and sample sourcing.

The initial step in the four-point approach was to delineate a sample universe, otherwise known as the target population, through a set of inclusion criteria or exclusion criteria, or a combination of both (Robinson, 2014). The inclusion criteria for this study was actively employed case managers with a minimum of one-year experience working in the profession. The exclusion criteria for this study was case managers who do not primarily work with community-dwelling seniors with frailty. Applying these inclusion and exclusion criteria allowed the study to remain contextualized within a defined setting (Robinson, 2014).

The second step in the four-point approach was to decide upon the sample size. Creswell (2013) recommended a sample size of three to ten participants for a phenomenological study. A sample size in this range provides a scope for developing cross-case generalities without impeding the study by having excessive data to analyze (Robinson & Smith, 2010). A sample size that is sufficiently small also allows each individual participant to have a locatable voice within the study, and my in-depth analysis

of each interview (Smith, Flowers, & Larkin, 2009). Ultimately, the study sample size was guided and refined by the concept of data saturation while keeping the scope of study, sampling strategy, quality of data, and study resources in mind (Mason, 2010). Data saturation is considered the gold standard of determining sample size, and is defined as the point in which no new data, themes or codes emerge from participant interviews (Vasileiou, Barnett, Thorpe, & Young, 2018). This sampling strategy is supported by other phenomenological studies that have been conducted on healthcare providers (Kelly, Svrcek, King, Scherpbier, & Dornan, 2020).

The next step in the four-point approach was selecting a sample strategy. The sample strategy selected was purposive sampling. Purposive sampling strategies group participants according to preselected criteria relevant to the research question, which is to explore case managers' experiences delivering case management to community-dwelling seniors living with frailty (Robinson, 2014). In my study, it was necessary to purposefully sample case managers who have current experience in delivering case management to community-dwelling seniors living with frailty. The use of purposive sampling is supported by other studies that examine perspectives of healthcare providers (Van Damme, Neiterman, Oremus, Lemmon, & Stolee, 2020). One of the most significant guiding principles of purposive sampling is to ensure maximum variation of the target population. Maximum variation in relation to my study meant seeking to include the widest variety of perspectives possible within the case manager profession to ensure the sample is diverse enough to represent the natural variation known within the population (Palinkas et al., 2015). Therefore, I sought to ensure participants from diverse

professional backgrounds, ages, and years of experience working with community-dwelling seniors with frailty.

The final step of the four-point approach to sampling was the sample source. This step involved the sourcing of case managers from the real world. The key aspects of the sourcing sample are to ensure that case managers are informed of the study's purpose, what participation entails, its voluntary nature, how anonymity is protected, and the necessary information that will help participants reach an informed and consensual decision to participate in this study. As mentioned in section 3.3 (**Ethical Considerations**), I achieved the goal of ensuring participants were adequately informed about the research study through various safeguards. Due to the voluntary nature of sample sourcing it was also important to note that case managers who consent to be involved in the interview process are different than those who do not, in ways that are unrelated to the sampling criteria. This phenomenon is known as self-selection bias (Robinson, 2014). As it is not possible to circumvent self-selection bias in interview-based research, it is my responsibility to be aware of the possibility for bias and its possible impact on results.

3.5 Recruitment Strategy

After Ontario Tech University REB approval (#15456) and the sampling methods were finalized, I sought approval to undertake the research study in conjunction with local agencies that employ case managers that work with community-dwelling seniors living with frailty. The Central East LHIN and a community-based organization were contacted with a Request for Permission to Conduct Research email (**Appendix B**) to undertake a research study recruiting their case managers. The Central East LHIN did not

respond to the invite. However, the study was granted approval by the board at the community-based organization. Upon approval of the study at the community-based organization, I met with an administrative manager to finalize recruitment details and the interview settings. After this meeting, I was invited to deliver a ten-minute presentation during a regularly scheduled employee meeting. During this presentation, I explained the study outline, purpose, and objective of the research as well as what would be required of case managers if they were to participate. Case managers were asked to express their interest at the end of the presentation or to get into contact with me at their convenience. I then sent case managers the Recruitment Script Email (**Appendix C**) which reiterated the key aspects of the presentation. It also highlighted the key ethical issues surrounding the study and ensured that participants were aware of the voluntary nature of the study as well as their ability to drop out at any time. This resulted in a homogenous sample of six case managers who work with community-dwelling seniors living with frailty (n=6) becoming participants in the research study. I then contacted participants by phone to select an interview date.

3.6 Data Collection

The sfCare Framework and research question guided the process for data collection. The phenomenological approach of the study was ideal to answer the research question that focused on case managers' experiences delivering case management to community-dwelling seniors living with frailty. Data was collected through face-to-face, semi-structured interviews, as this type of interviewing allows the researcher to engage in a dialogue where probes can be utilized to clarify any responses or elicit elaboration if further detail is required (Smith & Osborn, 2007). McGrath, Palmgren, and Liljedahl

(2018) recommend five to 15 interview questions be formulated for a qualitative research study. Therefore, seven open-ended central interview questions devised from the sfCare Framework formed the Interview Guide (**Appendix D**) to collect data from participants. These seven questions were supplemented by prompts in order to fully explore the feelings, attitudes, and beliefs of participants on case management interventions for community-dwelling seniors with frailty.

Data was collected between the period of October 30, 2019 to November 20, 2019. The interviews were conducted at the participants' place of work. Smith and Osborn (2007) state that it is important to conduct interviews in an atmosphere where the participant feels safe to freely discuss their experiences. Therefore, the interviews took place in a private office where participants regularly conduct their work. When I met with the participant during the assigned interview time, I briefed them for approximately five to ten-minutes. During this briefing, I reiterated the purpose of this study as well as the Consent Form. I then provided any necessary clarifications to participants as per their request. Participants were also made aware that the study was completely voluntary and they could withdraw at any time, and can refuse to answer any questions during the interview. They were also made aware that the transcript would be made available to them within seven days of the interview for them to approve the accuracy. I then briefed participants on the Socio-Demographic Form (**Appendix E**). The Socio-Demographic Form collected data on age, gender, professional background, employment status, and years-experience working with community-dwelling seniors with frailty. Participants then signed the Consent Form and completed the Socio-Demographic Form.

After participants signed the Consent Form and completed the Socio-Demographic Form, the interviews commenced. I asked the participants to discuss each question on the Interview Guide. Each interview lasted approximately 45 minutes. During this time two audio recorders were used simultaneously to record the entirety of the interview. Notes about important statements and phrases were taken during the interview. As the researcher, I ensured that I remained a facilitator and guide for the interview process instead of dictating exactly what happened (Smith & Osborn, 2007). Upon completion of the interview, I followed up with a short debrief with the participant. During this debrief, I gave participants a final thank-you statement to acknowledge the time they spent during the interview. Lastly, I informed participants on how to express interest in accessing the final results of the study and reminded them about confirming the accuracy of their interview transcript.

3.7 Data Analysis

The data analysis occurred simultaneously with data collection. This process allowed emerging data to be at the forefront of the direction of the study (Ritchie, Lewis, Nicholls, & Ormston, 2013). This may be contrasted with the quantitative proclivity to proceed stepwise; where data collection and analysis are undertaken sequentially. As Flick (2013) noted that when qualitative research is guided purely by procedural rules, sequential or not, it misses the point, which is to provide understanding of an experience. Therefore, I transcribed the audiotapes of the interviews verbatim on the same day they concluded. The transcriptions include all false starts, significant pauses, laughs, and other features deemed worthy of recording. Non-verbal behaviour was excluded from the transcription and notes taken in this study (Smith & Osborn, 2014). Each case manager

transcript was assigned a digital identification number in order to keep the data anonymous. Upon completion of the interview transcription, analysis of the data commenced immediately.

I utilized an interpretative phenomenological analysis (IPA) approach to data analysis in this study. In an IPA, I am concerned with case managers' experiences delivering case management to community-dwelling seniors living with frailty. The purpose is to understand the content and complexity of the experiences rather than measure their frequency (Smith & Osborn, 2007). Therefore, I had a sustained engagement with the interview text and utilized a process of interpretation to capture the meanings of participants' experiences. I utilized a step-by-step approach as discussed by Smith and Osborn (2007) in this study. These steps include, identifying codes and themes in the first interview, connecting the themes, continuing the analysis with other interviews, and the final write up.

In the initial step, I read the first participant's interview transcript a number of times, with the margin used to annotate what was interesting about what the participant said. I used the sfCare Framework domains (organizational support, processes of care, emotional and behavioural environment, ethics in clinical care and research, and physical environment) as a guide for commenting on any significant text, phrases, or sentences from the interview. I used the domains as a guide for initial comments as no qualitative study should begin from pure observation, and prior conceptual structure composed of theory and methods should provide the starting point for all observations (Creswell, 2013). However, I ensured the inductive nature of an IPA study by building the essence of experience from participants. This meant there was no restrictions on the content of

initial comments on the data. I wrote about my interpretations of the text in a descriptive or conceptual manner. After the initial comments, I returned to the beginning of the transcript and I documented the emerging theme titles.

In the second step, I listed all of the original comments and emergent themes in a new document and compared them for connections. All emergent theme titles were then clustered together. This process resulted in the creation of a preliminary table of themes that emerged from the first interview. In the third step, I followed this exact iterative process with every other interview, where I developed a final superordinate table of themes.

Lastly, in the write-up, I moved final themes generated into final statements outlining the meaning inherent in participants' experiences delivering case management to community-dwelling seniors living with frailty. In this section of the analysis care was taken to distinguish between the participant's words and my interpretation of it. The table of themes provided the foundation for the account of the participants' responses, interspersed with verbatim extracts from the transcripts to support the findings of the study.

3.8 Evaluative Criteria

The general consensus surrounding the evaluative criteria of a qualitative approach to research is that researchers need to demonstrate that their study is trustworthy (Creswell & Miller, 2000). As discussed by Lincoln and Guba (1985) there are four criteria that must be met in a study to establish trustworthiness. These criteria include credibility (internal validity), transferability (external validity), dependability (reliability),

and confirmability (objectivity). In order to satisfy these criteria, Lincoln and Guba (1985) created a list of techniques that the researcher can employ in their study. The techniques I employed in this study to establish trustworthiness includes member checking, utilizing a rich description to communicate findings, peer debriefing, external auditing, an audit trail, and clarification of the researcher's position in relation to the research question.

The initial technique that I utilized to ensure trustworthiness of the study was member checking. Member checking has been described as the most crucial technique for establishing credibility (Lincoln & Guba, 1985). All participants of this study were asked to review the transcripts of their interviews and asked to comment on their accuracy. At the conclusion of the study, participants should be able to see their experiences within the final results, as without this the findings could not be viewed as evidence (Birt, Scott, Cavers, Campbell, & Walter, 2016).

Peer debriefing was also drawn upon to increase the credibility of the study. The supervisory committee members were selected to provide peer debriefing, as they were familiar with the study. The role of the committee members is to support, play devil's advocate, challenge assumptions, and ask difficult questions about the methods and interpretations in order to push the study to the next step methodologically (Lincoln & Guba, 1985). The peer debriefing provided by the committee members enhances the credibility of the study as they help uncover my taken for granted biases, perspectives, and assumptions.

The next validation technique I utilized to ensure transferability of the study was the use of a rich and thick description to communicate the study's findings. Deep,

detailed accounts of the feelings surrounding the participants' perceptions of the barriers and facilitators of case management for community-dwelling seniors is reported in the findings of the study to increase verisimilitude. This allows anyone interested in transferability of my study a solid framework for comparison (Korstjens & Moser, 2018).

I also utilized an external auditor to ensure dependability of the study. The external auditor was not familiar with this study. The external auditor reviewed all documentation of the research decisions and activities. The external auditor asked the following questions of the study: Are the findings grounded in the data? Are the inferences logical? Can the research be justified? What strategies were used for increasing credibility? (Creswell & Miller, 2000). Furthermore, as Lincoln and Guba (1985) discussed the external auditor provided important feedback that can lead to the development of stronger and better articulated findings. This is particularly important to an IPA study that is committed to the depth of analysis.

To ensure confirmability of the study an audit trail was created. As discussed by Lincoln and Guba (1985) an audit trail is a transparent description of the research steps taken from the start of a research project to the development and report of findings. I maintained all raw data from the research proposal, interview notes, transcripts, analytic notes on emerging concepts, methodological notes, and notes from meetings with committee members in order to achieve trustworthiness through confirmability in the study.

Lastly, the final technique I used to establish trustworthiness of the study was reflexivity. In order to achieve reflexivity, I underwent a process of critical self-reflection about any bias, preferences, and preconceptions in my field of study (Korstjens & Moser,

2018). At the outset of this study, my potential bias was articulated under the section 3.2 (**The Researcher's Role**). It is extremely important to identify potential bias in order to position myself in relation to the research process. Smith and Osborn (2014) emphasized that interpretative phenomenological analysis is complicated by the researcher's own conceptions; as these are required in order to make sense of the participants' experiences through a process of interpretative activity. Therefore, ensuring that I provide the reader of the study greater transparency into the process of the interpretation and analysis of the findings then reflexivity is achieved.

Chapter 4. Results

This chapter presents the results based on the data collected from the participant interviews. First, a description of the participants will be highlighted. This will be followed by the results of the interviews. These results are structured according to each domain of the Senior Friendly Care (sfCare) Framework that they correspond with. The five domains of the sfCare Framework are: organizational support, processes of care, emotional and behavioural environment, ethics in clinical care and research, and physical environment. This chapter concludes with a summary of the results.

4.1 Socio-Demographics of Participants

Socio-demographic information was collected from participants for the purpose of describing the sample population (Connolly, 2013). Participants were briefed on the socio-demographic form and completed it prior to commencement of the interview questions. The form consisted of five different questions that covered age group, gender, professional background, employment status, and length of time delivering case management to community-dwelling seniors living with frailty. Table 4.1 outlines the socio-demographic information of the participants.

Table 4.1: Participant socio-demographic information

Age Group	**Number of Participants**
- 25-34	2
- 35-44	1
- 45-54	1
- 55+	2
Gender	**Number of Participants**
- Male	0
- Female	6
Professional Background	**Number of Participants**

- Registered Nurse - Occupational Therapist - Certified Social Worker - Other	1 1 1 3
Employment Status - Full-Time - Part-Time	**Number of Participants** 6 0
Years as Case Manager - Less than 5 - 5-10 - 10+	**Number of Participants** 3 1 2

4.2 Results of Participant Interviews

The results of the participant interviews are identified in this section. Participants were assigned a participant identifier number from one to six. These appear at the end of each quote and help to give each participant a locatable voice in this study.

4.2.1 Organizational Support

The organizational support domain of the sfCare Framework is defined by an organizational commitment to implementing policies and procedures that prioritize senior friendly care. Organizations that employ case managers should adhere to the sfCare Framework principles to ensure senior friendly care is evident in case management for community-dwelling seniors living with frailty. Three themes were identified from participant interviews that aligned with the organizational support domain of the sfCare Framework. These themes are significant factors that affect case managers' delivery of case management for community-dwelling seniors living with frailty and includes intra-professional collaboration, organizational commitment to supporting case managers' well-being, and caseload size.

4.2.1.1 Intra-Professional Collaboration.

Participants identified implementation of intra-professional collaboration in the workplace as an important aspect of the organizational support they receive. Intra-professional collaboration is defined as multiple members of the same profession working collaboratively to deliver quality care (College of Nurses of Ontario, 2018). During the interviews, participants spoke about the impact of intra-professional collaboration on breaking down barriers of case management for community-dwelling seniors living with frailty. At the community-based organization, weekly huddles have been utilized to support intra-professional collaboration amongst case managers. Participants highlighted how weekly huddles have contributed to problem solving complex cases of case management for community-dwelling seniors living with frailty.

> "We just recently incorporated weekly huddles, where if any case you are stuck on or need extra attention or extra brainstorming with we will help each other. We have different specialities for people right we have addiction and mental health, we have people specialized in senior abuse, cancer support groups, and stuff. We do ask each other when we need it" (P4).

Furthermore, weekly huddles were identified as important for knowledge and resource sharing between case managers. Every participant interviewed spoke about the importance of being able to share experiences and resources to overcome difficulties in case management.

> "We will sit together and then we will maybe share about an experience or share the resources. Or we have a case where we don't know how to move forward and

> we will talk about it without mentioning clients name or whatever and we will share the resources" (P1).

Despite intra-professional collaboration being practiced, some participants noted that it was not always easy to share cases with colleagues. Although participants acknowledged the importance of intra-professional collaboration, they were cognizant that they are sometimes alone in dealing with barriers to case management for community-dwelling seniors living with frailty.

> "We are very individual. We only really talk about issues if it comes up and we are at a monthly meeting. Or recently we have little weekly 20 minute ones. We will say does anybody have an issue. A lot of the time we are all just like no we are okay. Even though in the back of our mind we are like oh there is a lot. Sometimes we might say, OK this is the client, this is the history, this is what I am struggling with and we might all throw out ideas which is good, but it doesn't really happen that often. Sometimes my clients are like these are the issues and the other care managers are like addiction? I don't really know what to say" (P3).

Even in circumstances where participants may feel a lack of direct support with a client, they reiterated the significance of team meetings, weekly huddles, and informal conversations with each other. As one participant stated, every case manager possesses different experiences and professional backgrounds, which can be used to gather different perspectives and insight for clients that are challenging.

> "It is important. Sometimes it may not be helping you out with the work but as a listening ear. Through the conversation you might get some insight. Because we

> are all different personalities, we are all different experience, background all these. So, obviously talking to co-worker, the team member is very important. That is why I love my team. I think we are pretty diversified in terms of cultural background and professional training background. I love it." (P6).

It is apparent that participants value intra-professional collaboration in the workplace. As participants indicated, when intra-professional collaboration is effectively utilized, it may be a facilitator of optimal care for community-dwelling seniors living with frailty.

4.2.1.2 Organizational Commitment to Supporting Case Managers' Well-Being.

Organizational commitment to supporting case managers' well-being was identified from the interviews as an emerging theme. Participants feel they are exposed to a higher degree of occupational stress due to the nature of working with community-dwelling seniors living with frailty. At times, participants feel they may be subjected to a rapidly increasing expansion of their roles and responsibilities in order to adequately support their clients. This rising level of involvement may increase the burden of work-related stress on a case manager, ultimately leading to burnout. One participant detailed their desire to support the client while also managing their perceived feelings of burnout.

> "Sometimes in case management your involvement ends up being a lot more than your actual job. And then that kind of adds to your burnout in a sense right. At the same time, I think everybody that is in this field is here to help, but you also have to take care of yourself essentially right." (P4).

Furthermore, participants that deal primarily with complex needs clients, requiring high intensity case management indicated that the increased responsibilities for their patient's

care can increase the feeling of clinical burnout. One participant that has experience delivering high and low intensity case management for community-dwelling seniors reflected on the unique challenges supporting complex clients.

> "I find with more complex clients it was...it was draining. I found it more draining for me and I can see why burnouts occur, because it was just…clients seeing you daily, daily because they are so isolated and you are the only point of contact. You tend to hold on to a lot of responsibility almost for their care, when you are supposed to facilitate the care rather than you know, than like be the primary." (P4).

Similarly, other participants spoke about how the job description does not always accurately reflect the work they undertake. Due to this, the participant indicated that they experienced higher occupational related stress. This participant described a situation where they were required to leave an intervention in order to pick up adult incontinence pads as it was not safe for their client to do so. When asked if this was something that was a normal part of case management for seniors living with frailty they responded:

> "Yes and no. For me it is such a norm in my role and with my population. But I do know my other care manager team members they have told me things they have done and I'll be like wow that seems intense but I could also see myself being in that position, it happens." (P3).

Through the interviews, it became apparent that case management for community-dwelling seniors living with frailty is demanding. Therefore, as one participant stated, the

importance of implementing strategies or support mechanisms to ensure the well-being of case managers is paramount to the success of case management.

> "I think the barrier might be that if we don't receive the proper support in-house, the barrier is the burn out rates. This is a high burnout field right." (P4)

Another participant highlighted how she developed her own strategies to reduce the burden of burnout. This participant recounted a time they were asked how they ensured their well-being after many years of delivering case management to community-dwelling seniors living with frailty. In this circumstance, they utilized a strategy that a previous mentor had taught them about setting boundaries and ensuring their own wellness before meeting with a client. This strategy allowed the participant to deliver case management to their clients while maintaining their well-being.

> "Even my friends ask me after all the years your job is very demanding. Seniors are not easy and this and that. They said how do you manage yourself not being burned out. I said how? They said 17 years you haven't burned out yet. I said not yet. I haven't thought of quitting yet. The trick is what she taught me. I need to set up a boundary and the next key is when I go back into see the client I am totally present with that person. In order for me to be totally present I need to have that boundary." (P6).

It is evident through participant's experiences that delivering case management to community-dwelling seniors is a challenging role that may increase the risk of work-related burnout. Therefore, as the participants suggest, they may require additional organizational support to facilitate optimal case management delivery.

4.2.1.3 Caseload Size.

Caseload size is a theme that emerged from the interviews that impacted case management for community-dwelling seniors living with frailty. Caseload size refers to the quantity of community-dwelling seniors living with frailty that fall under the care of each case manager. Participants ranged from having caseloads of 14 to 100, based on the complexity of their clients. Despite the wide range of caseload sizes, each participant felt they were at the upper limit of how many community-dwelling seniors living with frailty they could adequately support. One exchange between the interviewer and participant highlighted how they felt about taking on additional cases.

> "Interviewer: Could you take on a couple more, if today they said you are taking on 5 more?
>
> Participant: No of course no.
>
> Interviewer: You don't want more.
>
> Participant: Yeah too much." (P1).

Participants noted caseload size is not always indicative of intensity of cases. As many clients in larger caseloads have supports in the form of family caregivers or an additional case manager from the Local Health Integration Network (LHIN). Participants further noted that clients in larger caseloads are typically stable and require less of their time. One participant expanded on how additional human care resources helps share the burden of their 100-client caseload. However, this participant reiterated that they were at their maximum capacity of how many clients they could handle.

> "I think 100 is enough. They don't have crisis all at the same time [laughter]… Plus, all of them most likely have case manager from Central East LHIN already and a lot of them are living with caregivers. Not many are alone." (P2).

Participants who deliver high intensity case management and had smaller caseload sizes still reported they were at their capacity of clients. They felt a significant burden of care even with a comparatively low caseload size. One participant who had delivered both high and moderate intensity case management reflected on how having double the caseload size in moderate intensity caseload still felt lighter than the higher intensity caseload.

> "The case manager for addiction, that case-load is like 15 people. The work load while I was doing that, and I am doing over double that now, was way harder for the addiction clients even with a lighter case load because the complexity was so severe. Where here, I am like almost double that and it is still lighter because I deal with complex mental health clients." (P4).

Furthermore, participants who deliver high intensity case management felt it may be easier on them to share the caseload amongst a team of staff. The manner in which Assertive Community Treatment (ACT) and Geriatric Assessment and Intervention Network (GAIN) teams operate in Ontario was an idea put forth by one participant that might help with easing the burden of high intensity case management.

> "I think it would be nice if we actually shared client load. To me I would rather have 100 clients but share… You could also be like oh this client is kind of burning me out could you take over for another week or two." (P3).

It is evident that participants feel their caseload size impacts the delivery of case management for community-dwelling seniors living with frailty. Regardless of caseload size, all participants reported needing additional support to adequately manage their clients.

4.2.2 Processes of Care

The processes of care domain of the sfCare Framework is defined by the models of care utilized to address the needs and optimize the health outcomes of seniors. For case managers, this means providing community-dwelling seniors living with frailty evidence informed and patient-centred care throughout the case management process. Three themes were identified from participant interviews that aligned with the processes of care domain of the sfCare Framework. These themes are significant factors that affect case manager's delivery of case management for community-dwelling seniors living with frailty and includes the linkage model of care, creativeness and adaptability of approach to case management, and continuity of care.

4.2.2.1 The Linkage Model of Care.

The linkage model of care refers to the relationship between the community-based and provincial-based organizations that offer case management. In order for community-dwelling seniors living with frailty to have their care needs met, the relationship between these two organizations requires open communication and cooperation. Case managers at the community-based organization must refer to the LHIN for resources such as personal support workers, physiotherapists, or occupational therapists. Participants indicated that case managers from the LHIN are not always receptive to communication. Participants

stated that the level of communication may be based on the individual case manager you are working with from the LHIN.

> "All depends on the individual… individual case manager. I would say that 80% of them are not so… open to communication with community staff." (P1).

Due to a lack of communication at times, participants feel left out of the circle of care for their clients by case managers from the LHIN. One participant elaborated on the frustration this posed her.

> "No, this is pretty frustrating. For me that is why if I know who is the coordinator I try to connect with the coordinator as well. I would call them and tell them. I would also encourage the client and the caregiver if anything happens report to the LHIN coordinator as well. I always make myself visible to them. If you think I can help out and play a part let's work together." (P6).

Participants recognized the importance of making themselves visible in the circle of care to the LHIN, client, and family caregiver. However, one participant stated, making themselves visible in the circle of care does not always result in them being included.

> "Depends on the case coordinator who gets the call to refer. So, when I call the LHIN and I am like oh, I would like to make a referral for OT for this client. They will take down my details oh why is it needed, where are they living, OK great. I have to emphasize could you call me back and let me know if you are seeing this client. Most of the times they are like yeah sure we can do that. Other times I have been told no, once we speak to the client it is confidential unless a client says you can call my case worker." (P3).

Participants further identified that there is the possibility of a difference of opinion between themselves and the case manager from the LHIN on service needs for clients. Participants acknowledged that they understand the LHIN has their own budgetary constraints but still felt sometimes their client's needs were not adequately met.

> "But in terms of what we think is needed and how much they are able to provide then that's a huge gap. We understand their own policy and eligibility, you know every program has an eligibility and sometimes what we see is quite different from how they see. So that is kind of a big barrier." (P5).

Participants are cognizant of the barriers in advocating for their client to receive additional services in the form of personal support worker (PSW) hours from the LHIN. Participants directly mentioned that budgetary constraints have impacted the LHIN's ability to give out PSW hours.

> "Oh, lot of barriers. Yes, because home care they have their own limitations because…what happens is they have a budget to watch out for, so they can't give out too many PSW hours." (P1).

Another participant highlighted the challenges associated with differing opinions when determining service needs for community-dwelling seniors living with frailty. This participant felt the LHIN had a higher degree of focus on the functional level of seniors living with frailty, thereby, not taking into account key aspects of their client's health needs.

> "We are kind of thinking OK you know what this individual needs a lot more daily PSW assistance not only for personal care but also for safety, medication reminding, or whatever. So, we make the request to the home and community care but when they assess the patient they tend to focus on like more a functional kind of level. Oh, he walks and he still does bathing… he doesn't need a PSW." (P5).

Participants that have been successful in advocating for clients to receive a service found it difficult to intervene if they notice their client's situation deteriorating. One participant spoke about how the difficulties in increasing the number of services for their clients.

> "But after they have PSW hours… if you think they need more you have to bargain with them, that would be very challenging." (P1).

Participants reiterated the difficulties associated with advocating for additional services. This participant then described how their client could not get ready in the morning without additional PSW hours to assist them. Therefore, they were not able to attend a program that was beneficial to their health and well-being.

> "In the morning, they could not get themselves ready to get picked up by our bus. Then we try to call LHIN, oh do you think you can give her additional hours just to get ready in the morning. The door is shut. OK." (P1).

It is evident that the linkage model of care between case managers from the community agency and the LHIN has produced barriers to case management for community-dwelling seniors living with frailty. As participants have described, issues such as lack of communication and feeling left out of the circle of care has affected the level of care provided to community-dwelling seniors living with frailty.

4.2.2.2 Creativity and Adaptability of Approach to Case Management.

The ability of case managers to be creative and adaptable was identified as significant to the outcomes of case management for community-dwelling seniors living with frailty. Participants indicated that seniors living with frailty may be reluctant to receive interventions. Reluctance to receive specific interventions has meant that case managers need to be creative in order to deliver case management. One participant elaborated on how important creativity is in order to overcome barriers in case management.

> "You have to be very creative in this field with different strategies and different approaches. Like especially, we had a client that was like a hoarder for example and would not let go of anything and I think one of the strategies was we went to his house and said, it's like garbage clean up you pick what you want to throw away. We are doing community environment things. It has to be almost… like a lot of enthusiasm and a lot of creativity." (P4).

A key objective of case management is for case managers to set goals based on discussion with their client. However, participants reported they may have differing views than their client's goals of care. This has created circumstances where case managers are balancing the autonomy of their clients with their health and safety. Due to this, participants identified that they must be creative and adaptable in their approaches to deliver case management.

> "That is why we have to be really creative sometimes, we can't cookie cutter every situation. If the person is capable we have no problem. Like everybody has

> their own entitlement we try to support the individual the way they want to. But when we are dealing with incapable or we think they are incapable but we haven't done any assessment, then how can we balance things out between their autonomy and independence and their safety risks?" (P5).

Seniors living with frailty may not understand their capacity, and may deny services or interventions when offered to them. Participants identified that this is extremely challenging when offering services specifically to seniors living with dementia. To ensure seniors living with dementia were receiving necessary support, participants have adapted their communication strategies. One participant expanded on how they adapt communication strategies to promote their client's enrollment in a program beneficial to their wellness.

> "But they don't feel that, they have dementia. They don't see themselves as a frail senior, they don't want to be in the senior's program so when we talk about certain programs we don't necessarily directly use the terminology we kind of make it sound that it is a little bit more applicable to the individual. So, he or she might be a little more open." (P5).

Participant's experiences of delivering case management to community-dwelling seniors living with frailty has demonstrated the importance of being creative and adaptable. Creativity and adaptability can break down barriers associated with delivering case management to community-dwelling seniors living with frailty.

4.2.2.3 Continuity of Care.

Community-dwelling seniors living with frailty may receive fragmented care that lacks continuity. Continuity of care is how one patient experiences care over time as coherent and linked (Waibel, Henao, Aller, Vargas, & Vazquez, 2011). Participants identified that continuity of care is an area of concern for their clients. In one instance, a participant reflected on an experience where their client was promised services to support their discharge from hospital.

> "The issue is let's say before discharge sometimes hospital will have team meeting. Team meeting will have dietitian, doctor, nurse, OT, PT together to make sure client is safe to discharge home. Sometimes they will invite us to attend those meetings. So, to make sure that we are on the same page. But the issue is they promise… I have one case recently, so they promise client will have this, this, and this service when they are discharged home. Nothing happened. So, there is a gap like maybe she will get some but not the day she was discharged home." (P2).

Similarly, another participant described the service gaps that impact their clients. This participant spoke about how the implementation of transitional care to support seniors living with frailty who are discharged from the hospital to go home still face barriers in receiving optimal care.

> "Even though now they have one thing called transitional care. That means they want the client to go home but actually the client is not safe. They will have a transitional centre to provide care but sometimes it is not enough." (P2).

It was stressed that the care seniors living with frailty are receiving after discharge from hospital is not enough to support their transition back into the community. In one situation, a participant voiced their dissatisfaction with the discharge process when they were asked to do an assessment of their client while they were in a rehabilitation clinic. They felt the rehabilitation clinic should have the proper in-house tools and supports to do the assessment themselves and determine if their client was ready for safe discharge.

> "Example when a client is going to be discharged from rehab to back here. We were asked to go do an assessment and I thought to myself why would I have to do the assessment. They are already in the rehab is it not you who is in the profession to tell me whether that person is ready to come home and what type of support they should have before they come home. Why did you ask me to go do an assessment?" (P6).

Due to the gaps in services after discharge, participants have found themselves in precarious situations at times. One participant described how they have expanded their role to fill gaps that should be provided to the client after discharge. Despite this participant acknowledging that this is not normal or regular practice they had to intervene beyond the usual scope of duty.

> "Sometimes what we do is we know there will be some kind of wait time. Let's say it could be a few weeks or a month. We see immediate needs for the time being so we might actually be doing something until the patient gets the service from the LHIN. Not as a regular practice but like you know if we see the needs we can't just let them wait until…" (P5).

Participants feel the current Ontario healthcare system approaches to ensure continuity of care to community-dwelling seniors living with frailty are not comprehensive. Due to this, seniors living with frailty encounter barriers in achieving optimal health and wellness outcomes.

4.2.3 Emotional and Behavioural Environment

The emotional and behavioural environment domain of the sfCare Framework is defined by the manner in which care is delivered to seniors. A focus for case managers related to this domain is the development of social connections between themselves, family caregivers, and seniors living with frailty. Three themes were identified from participant interviews that aligned with the emotional and behavioural environment domain of the sfCare Framework. These themes are significant factors that affect a case manager's delivery of case management for community-dwelling seniors living with frailty includes sensitivity of care, case manager – family caregiver dyad, and empowering seniors and family caregivers while building rapport.

4.2.3.1 Sensitivity of Care.

Sensitivity of care may be described as care that reflects the ability of case managers to be appropriately responsive to the attitudes, feelings, or circumstances of seniors living with frailty. Participants felt that providing care that is sensitive to the needs, beliefs, values, and diversity of seniors living with frailty is crucial to the success of case management. One participant reflected on how barriers to case management arise if care is delivered in a manner that is not sensitive and respectful to seniors living with frailty. In this situation, their client's family had experienced a recent traumatic car

accident. The relationship between the participant and their client became strained as they did not have prior knowledge about the accident during their first meeting.

> "I go into this client's home and I asked one question about I think family involvement, like do you have any kids or relatives here. And this client got so upset, how do I not know his background. Mind you this is a new referral and this is my first time meeting him. But he felt that I should have read his file a little bit more and right there that was a strain in the therapeutic alliance." (P4).

Furthermore, participants spoke about the importance of offering services and resources that are culturally specific to support seniors living with frailty. One participant expanded on the importance of offering culturally diverse day programs to help seniors living with frailty feel comfortable about enrolling.

> "That is why we have four day programs here. Chinese speaking, Chinese including Cantonese and Mandarin and Greek. The day program is for English speaking, so it is kind of cultural specific. So, for Chinese day program we will celebrate Chinese festivals. So, they feel at home." (P2).

It is apparent that participants recognize the importance of culturally sensitive resources for community-dwelling seniors living with frailty. Despite this, participants have indicated that culturally sensitive supports are not always available to all of their clients. One participant expanded on how their client has benefitted from the introduction of a Filipino support group. Before the introduction of the Filipino support group their client was not comfortable enrolling in a day program.

> "Yes, it is very helpful but very often there is no cultural specific support. Very rare. For example, let's say if I have a Filipino. So, I want to maybe refer her to a support group for a Filipino support group. There is none. But now we have one here we just started for few months. They will feel more comfortable to come out" (P2).

Participants also spoke about the importance of recognizing the need for sensitivity of care when dealing with different cultures. One participant reflected on the need for an adaptable approach to case management that considers barriers surrounding cultural background that may affect their clients. As English is the predominant language in Canada, this participant explained how clients who come from countries where English is not the first language may have challenges in accessing resources or support.

> "Very much. Because I do have Mandarin speaker, Cantonese speaker and one that I have seen is an even more rare dialect. With knowing the culture is very important. My experience over the 17 years, take for example you need help to apply for old age pension. An English speaker and a Chinese speaker come into my office I need to have a different approach to work with them because of the level of knowledge. I have a client that is fairly new to this culture, even to make a phone call it can be a barrier." (P6).

Participants reported that when available their clients often utilize culturally specific supports. However, participants noted they avoid being presumptuous when recommending culturally specific programs. Participants indicated they only do so after discussion with the client and determining if they want to partake in a culturally specific program.

> "Right but that is with discussion with the client too. We wouldn't want to assume just because you are Tamil that you would like a Tamil group right. So, with discussion with the client like oh what kind of programs seem more suitable for you? Do you feel more comfortable speaking English or Tamil? What would you prefer?" (P3).

It is evident that participants feel sensitivity of care is an important aspect of case management for community-dwelling seniors living with frailty. Taking into account their client's backgrounds, needs, beliefs, and values provides case managers a foundation from which to provide appropriate and optimal care.

4.2.3.2 Case Manager – Family Caregiver Dyad

The relationship between case managers and family caregivers was identified by participants as significant to the delivery of case management to community-dwelling seniors living with frailty. Participants spoke about family caregivers being partners in care to help facilitate optimal outcomes of case management. Furthermore, participants indicated that the role family caregivers play in improving case management outcomes starts as soon as the case manager is assigned to their client. One participant emphasized the importance family caregivers have in identifying areas of concern that may not be elucidated from discussions with the client.

> "There is a lot of limits in terms of collecting data or getting the person's reactions or getting meaningful social history. So, in order for us to identify any meaningful intervention we need to have correct data, right? Then when we are dealing with people with either dementia or MCI, which means mild cognitive

> impairment, we need to have somebody who actually knows about the situation. So, that we can have a better kind of more accurate information." (P5).

Similarly, another participant expanded on the importance of engaging family caregivers at the commencement of case management. This participant emphasized the value of working together with family caregivers in case management to achieve positive health outcomes for seniors living with frailty.

> "I will always try to engage the caregiver if I could. Because the reality is that community resources are limited. I like to engage the caregiver if the dynamic to speak is OK. Because I think ahead. I don't want the caregiver to feel regret if they don't partake along. When situation becomes out of hand to bring them in it becomes difficult for them as well. So, if I engage them on work from day one so they will know all along and we work hand in hand. I find that is a win-win." (P6).

Participants further described the significance family caregivers have on improving outcomes for seniors living with frailty. In one participant's experiences, family caregivers also reduce case managers stress. This is due to the fact that they feel less of their time and resources are utilized on one patient, if the family caregiver is very supportive in the process.

> "If the family is very involved in the care, if they are very supportive, you just see less of our resources and our time, we will still do the linking, we will still do everything to support the family and we have caregiver supports separate from the client support. It's just the outcome is always better when the family is

> involved… Even in like in terms of stress wise for us, or at least from me I am going to say, is that when the family is very involved, it makes my job easier essentially." (P4).

When family caregivers are not present, participants feel the intensity of their involvement substantially increases. One participant reflected on how this is typical in complex high needs seniors living with frailty. In this instance, the participant had increased the scope of their duty due to the situation.

> "One out of 10 might have an involved family member. Everyone else is on their own. No friends, no family, so our role is very intensive. In the sense that we end up doing everything. I just took a client to a doctor's appointment yesterday myself." (P3).

Despite participants recognition of the importance of family caregivers in case management, situations do arise when they are barriers to care. Sometimes family caregivers can impede the case management process by disagreeing with case managers on the care plan. One participant expanded on how challenges arise when incorporating the family caregiver in the case management process. In this situation, the family caregiver neglected the input of the participant and the senior living with frailty, which hindered the implementation of the case management intervention.

> "The issue comes where let's say the client is saying, yes, I want to go to day program for example. And the caregiver is like well, I know my mom and I don't think she will like it and I don't think she will go. So, here you have the client telling you one thing and they are your primary and the caregiver completely

> disagreeing with that decision. Like I have had a case where, I had two daughters involved and the primary like the client, and each daughter wanted something different and the client wanted something different. And I was used as the middle person to communicate, which is not my job right." (P4).

Similarly, another participant recounted a time when the family caregivers were in denial about the ability and limitations of their sibling with dementia. In this situation, the family caregivers outright rejected the participant's recommendations. Much to the dismay of the participant, the family caregivers would not change their mind and this resulted in the client's health and safety being put at risk.

> "The situation is like this, she got lost in the community and don't remember how to come back because she lived in the end of the building. So, I tried my very best to explain to her family, her siblings especially two siblings that were primary caregiver just said no my sister is doing fine. So, what they did was draw a map for her to show her to cross the street to the mall. But end up every time she didn't know how to get back. She can't understand a map. They tried their very best to teach the client to cross the street. One time they mention to me it is her attention drawing technique. I said no, no, she is not." (P2).

However, it is overwhelmingly clear that participants still value the input and support of family caregivers in case management. As one participant stated, any amount of help will almost certainly result in better case management outcomes for community-dwelling seniors living with frailty.

> "Even if they are limited in how much they can do a little bit of help here and there does work. Whether it is OK I am coming by next month I will help them get groceries or I am willing to help take over their financial needs because they are no longer you know spending money the way they should spending like on things they need. So, if the family member can step in and the family member is willing for them to do it. It helps us a lot because that is one less thing we need to worry about." (P3).

It is evident that participants value the role of family caregivers in case management. As when family caregivers are supportive of the care process they can be instrumental in breaking down barriers of case management for community-dwelling seniors living with frailty.

4.2.3.3 Empowering Seniors and Family Caregivers while Building Rapport.

Empowering seniors and family caregivers while building rapport was identified as a key component of case management for community-dwelling seniors living with frailty. Participants indicated that enabling seniors and family caregivers to appropriately advocate for themselves in the healthcare system is key to achieving required services. One participant elaborated on how they empower family caregivers to advocate for themselves to receive more supports and services for their client when speaking with the LHIN. This participant found when family caregivers are educated on how to advocate for seniors living with frailty under their care, they may be successful in being allocated resources from the LHIN.

> "So, the best person is the caregiver to advocate for themselves and I will tell them what language to use in order to get the success. Like how frequent they fall and the caregiver stress they are faced with. So, you have to know what agendas they are looking for." (P1).

Similarly, another participant reported how educating clients will allow them to utilize the appropriate community resources when needed. In one situation, a participant described how their clients have encountered doctors that are unwilling to refer to geriatricians. As geriatricians are specialized in care for seniors living with frailty, they are integral resources for this population. This participant found that educating family caregivers on how to advocate for the senior to receive this support was an important step in getting a referral.

> "Yes. You know the referrals to family doctors for the form… some family doctors have their pride. OK, I can take care of client with dementia why do I have to refer it. So, then we will encourage the family member to advocate for their mom or dad that it is important to see a geriatrician because this person is specialized for this issue." (P2).

Participants also recognize how important their role is to supporting family caregivers and seniors emotionally. One participant reflected on how they do not always have all the solutions in case management. However, they can offer support by spending time and listening to family caregivers and seniors when challenges arise. This was viewed by participants as significant to building social connections with their clients.

> "Besides the knowledge part the emotional part is also very important. Because very often client has adult children they have their own family, their own job, and then they have to take care of their parents. So, they really burnout. I have clients they just want to talk just tell me how difficult they are facing their daily life. Actually, sometimes I can't provide any real solution. But after talked it out it is a kind of support just spending time listening." (P2).

Furthermore, participants reiterated the importance of building social connections and developing rapport with their clients as a key component of case management. As one participant stated, building rapport is the basis of success in case management as trust is developed between the case manager and client, thereby, increasing the likelihood of client acceptance of case management.

> "Building rapport is probably, I would say the basis of a lot of successes in case management because everybody knows what they need to do to get better. Whether it's me, you, our clients, you know what I mean. If you were trying to eat healthy and not eat junk food to lose weight, cut out junk food, go the gym, you'll get better. You know what to do. It is just hard for people to do it right. But some people just refuse to do it right. You have a little bit more leeway of suggesting things and promoting things and encouraging clients to get out of their comfort zone and try new things if you have a better relationship with them." (P4).

It is evident that developing social connections with family caregivers and community-dwelling seniors living with frailty is important to case management outcomes. As participants' experiences demonstrate, the development of social connections through

empowering family caregivers and seniors living with frailty while building rapport improves the probability of successful case management.

4.2.4 Ethics in Clinical Care and Research

The ethics in clinical care and research domain of the sfCare Framework is defined by care being delivered in a way that protects the rights of seniors and does not deny them access to care. For case managers, this involves ensuring community-dwelling seniors living with frailty are provided appropriate access to required resources in case management. Three themes were identified from participant interviews that aligned with the ethics in clinical care and research domain of the sfCare Framework. These themes are significant factors that affect case managers delivery of case management for community-dwelling seniors living with frailty and includes access to timely resources, affordability of resources, and knowledge of community-based resources.

4.2.4.1 Access to Timely Resources.

Access to timely resources was a significant theme identified by participants. Participants explained the barriers to accessing resources that community-dwelling seniors living with frailty must overcome in order to receive adequate care. Community-dwelling seniors living with frailty must often venture out of their homes to access beneficial resources. However, as one participant stated, some of their clients are not permitted to utilize transportation services due to their level of frailty.

> "I'll give you an example I have clients with dementia, recently they are not allowed to ride on their own in Wheel-Trans to get here because of their dementia behaviour – because of the behaviour issue. They need someone to be with them

to control the behaviour so that they won't have anything drastic happen inside the ride OK" (P1).

Furthermore, participants have expressed their frustration at the access of timely resources. It was mentioned that PSWs for seniors living with frailty are routinely late to their scheduled time. In one participant's experiences this has denied community-dwelling seniors living with frailty the necessary support to allow them to attend beneficial programs.

> "Yes. Yes. This morning there is one that I went and I asked for a joint visit with the coordinator because of the PSW schedule that the LHIN contract to… you know that right. The PSW agency out there and it is chaos. The schedule is like, if you are the user and you are expecting the person will show up at 9:30 and they didn't show up until 3:30 what would you do. You would be frustrated. This is only one example, it was like that for months with clients frustrated." (P6).

Wait times significantly impacted the ability of participants to ensure that their clients received required access to community resources. One participant elaborated on how wait times meant they had to perform social work interventions in the meantime to ensure the health and safety of their client.

> "So, we make all the right referrals but let's say you know when it comes to counselling or any type of professional counselling the community it is about a 5 month wait time. I know she is struggling which is affecting her function and with her cognition, I can't just let her wait until 5 months later. So, I might still do some social work interventions in the meantime." (P5).

Lastly, participants spoke about the impact a lack of human support has on providing adequate support for community-dwelling seniors living with frailty. One participant explained that case managers are supported in their role by colleagues known as client intervention workers, as they perform follow ups with their clients. However, as client intervention staff are limited in numbers, follow up appointments may not always occur even though they are required.

> "Human resources are a barrier. We have great difficulty to hire staff. OK, and suppose I have two assistants, I call them client intervention worker then after I did an assessment I have no time to follow I can assign my subordinate to help me out. Lack of human resources is a challenge. Not enough human support here." (P1).

It is apparent through participant's experiences that barriers to accessing care for community-dwelling seniors exist across the healthcare system. These barriers have contributed to the inability of community-dwelling seniors to utilize necessary supports and resources that ensure their health, well-being, and safety.

4.2.4.2 Affordability of Resources.

Affordability of resources emerged as an important theme that affects community-dwelling seniors living with frailty. Participants indicated that there are few affordable services for clients with lower socioeconomic standing. Due to the lack of affordable services, seniors who have limited financial means are denied access to supports that may ensure their health and safety. One participant recounted a situation where the hospital social worker contacted them in regard to community services to support the discharge of

their client. Unfortunately, the participant could not recommend any beneficial services due to the clients financial standing.

> "One of our responsibilities is to coordinate resources. What I mean is if a client lives alone and had a fall and sends to hospital, before my client is discharged home sometimes hospital social worker knows OK they have a care manager. They will call me to ask about services we can provide in the community. Basically none. I mean for free services" (P2).

Participants reiterated the issue of financial well-being as being a barrier for their clients to receive community supports. As one participant reported, many clients can't afford transportation to utilize the services they are linked with. One participant bluntly stated that the largest barrier impacting their clients was financial means.

> "The biggest barrier with clients going places is financial." (P3).

However, participants pointed out they are always seeking to ensure financially challenged patients have additional support. Their budget flexibility ensures the most financially vulnerable clients have their essential needs met.

> "So, let's say when we are dealing with a lot of financially challenged patients, I know our mandate is to not provide any food to them. But when I go see them, no food in the home, nothing in the fridge, we kind of got to… while we are initiating all the other resources we have to do something in the meanwhile. We use our financial asset to bring in what is needed for the moment. So, our budget kind of allows that a little bit in extreme cases." (P5).

It is apparent that financial constraints of community-dwelling seniors living with frailty impacts their ability to access affordable resources. As participants have stated, a lack of affordable resources has denied financially challenge seniors living with frailty the care they require to ensure their health and safety.

4.2.4.3 Knowledge of Community-Based Resources.

Knowledge of community-based resources was identified as having a significant impact on case management for community-dwelling seniors living with frailty. Participants indicated that having a strong knowledge of available resources in the community ensures they can link their clients to the appropriate supports. However, as one participant stated, case managers can still improve their knowledge base of available community-based resources.

> "There are a lot of resources and I don't think everybody knows about them. Like yeah, I know some resources but I think there are a lot more resources that I don't know about right so, the more resources the better it is. So definitely I think knowledge of resources that's a lack in general for everyone." (P4).

Similarly, another participant reported that it is impossible for case managers to know every single available community-based resource. Although they noted that they are provided a book that lists an extensive amount of the resources, it still does not seem feasible for them to have knowledge of all resources.

> "But sometimes there is so many resources in the community it is impossible to know them all. Yeah. Even though we have a book we won't go through every page [laughter]." (P2).

Lastly, participants highlighted that some of the available resources in the community do not advertise their services. This results in colleagues, family caregivers, and clients having no knowledge of a potentially helpful service. In this circumstance, the participant described a senior help line that has minimal usage due to a lack of advertising.

> "I know that central line still exists but that usage is not that high. Plus, I said hey you need to advertise that too but I don't see that advertisement." (P6).

It is apparent through participant's experiences that it is important to expand the knowledge of community-based resources between case managers, family caregivers, and clients. In doing this, the most appropriate resources can be linked by case managers to their clients to facilitate optimal case management outcomes.

4.2.5 Physical Environment

The physical environment domain of the sfCare Framework is defined by the spaces and structures in place that minimize vulnerabilities and promote the safety of seniors. Case managers must be able to identify and remedy areas of concern in the physical environment that have the potential to affect the health and well-being of community-dwelling seniors living with frailty. One theme was identified from participant interviews that aligned with the physical environment domain of the sfCare Framework and it is case managers' assessment of the physical environment. This theme is a significant factor that affects a case manager's delivery of case management for community-dwelling seniors living with frailty.

4.2.5.1 Case Managers' Assessment of the Physical Environment.

Case managers' assessment of the physical environment of community-dwelling seniors living with frailty was identified as a key component of case management. Participants indicated that they are always surveying the physical environment when they perform a home assessment for their clients. Participants felt that by assessing the physical environment of their clients they can minimize vulnerabilities which in turn will allow their clients to remain in the community. As one participant explained, they find opportunities to perform interventions to improve the physical environment of their clients, even if the situation seems quite challenging.

> "Depending on what it is, we try to involve other community partners in the city as well. So, let's say we see like a hoarding issue, that could be one of our interventions. So, we break down those barriers. We can't just oh, this is quite challenging we can't do anything about it. We identify barriers as opportunities for our interventions as well." (P5).

Participants indicated that the physical environment provided an opportunity to identify barriers to the health and safety of their client. The participant with the occupational therapist background stated that she relies on her previous training to determine if accessibility problems exist in the client's home.

> "Because of background as an OT, sometimes I see accessibility problems in their own home." (P1).

Although most participants did not have an occupational therapist background, they reported they were still comfortable assessing the home for potential hazards. However,

they indicated they typically do not change their client's physical environment themselves, rather they refer through the LHIN for resources, such as an occupational therapist.

> "Yes, because we can make suggestions and we can say that, but we can't necessarily say that moving things around is your best idea. So, generally, we will make a referral through the LHIN for an occupational therapist." (P4).

Despite referrals to the LHIN for occupational therapists, participants find that their clients do not always have timely access to this resource. One participant reflected on how their client was at an immediate risk of falling in the home and required a professional home safety assessment. Their client's safety was put at risk due to a shortage of occupational therapists employed by the company that the LHIN contracts the service to.

> "So, I was told that the agency that provides OT home safety assessment is short of staff and it will take maybe a few days to take the OT to do home safety assessment. So, it is a kind of a gap on a timely basis." (P2).

Participant's experiences suggest that they feel comfortable performing partial assessments of the physical environments of community-dwelling seniors living with frailty. However, due to participants not being able to change their client's physical environment of their clients, coupled with difficulties associated with the referral process to the LHIN, it may impact the quality of case management provided to community-dwelling seniors living with frailty.

4.3 Summary of Results

The participant interviews resulted in the identification of 13 unique themes that are barriers and facilitators of case management for community-dwelling seniors living with frailty. Each theme identified aligns with a specific domain of the sfCare Framework.

The organizational support domain includes the following themes: intra-professional collaboration, organizational commitment to case managers' well-being, and caseload size. Participant's experiences demonstrate that the implementation of organizational policies and procedures to support case managers' in relation to the aforementioned themes can facilitate optimal case management.

The processes of care domain includes the following themes: the linkage model of care, creativity and adaptability of approach to case management, and continuity of care. Participants indicated that an important process of case management is adapting care to the meet the needs of community-dwelling seniors living with frailty. Furthermore, participants stressed that the current processes in place to support community-dwelling seniors living with frailty are not adequately integrated which affects the continuity of care experienced by community-dwelling seniors living with frailty.

The emotional and behavioural environment domain includes the following themes: sensitivity of care, case manager – family caregiver dyad, and empowering seniors and family caregivers while building rapport. Participants emphasized the importance of providing care that is sensitive and respectful of the unique needs of community-dwelling seniors living with frailty. Recognizing the role of the family

caregiver was also seen as a significant component of case management. Participants further described how empowering seniors living with frailty and their family caregivers is key to successful case management.

The ethics in clinical care and research domain includes the following themes: access to timely resources, affordability of resources, and knowledge of community-based resources. Participants found that ensuring accessibility and affordability of resources to support community-dwelling seniors living with frailty in combination with their own knowledge of local community-based resources is significant in case management. As participants stated, some community-dwelling seniors living with frailty are not able to access the most appropriate services and supports, which is a barrier to optimal case management.

The physical environment domain includes the following theme: case managers' assessment of the physical environment. Participants identified the physical environment as an area where they feel they can make a modest intervention for community-dwelling seniors living with frailty to ensure optimal case management outcomes. **Appendix F** outlines the 13 emerging themes with their corresponding domain and includes a sample significant statement from participants.

Chapter 5. Discussion

The purpose of this research study was to inform future policy and practices related to case management for community-dwelling seniors living with frailty. This chapter includes a discussion of the results from the participant interviews as related to the literature. First, the participant's responses in relation to the socio-demographic form are discussed. This is followed by a discussion of the 13 emerging themes aligned with the sfCare Framework domains. The sfCare Framework domains include: organizational support, processes of care, emotional and behavioural environment, ethics in clinical care and research, and physical environment. This chapter concludes with a summary of the discussion.

5.1 Socio-Demographics of Participants

The socio-demographic information collected from participants prior to the interviews intends to describe the sample under study. All six participants were over the age of 25, with two participants between the age of 25-34, one between 35 to 44, one between 45 to 54 and two over the age of 55. The participants had varying degrees of experience delivering case management to community-dwelling seniors with frailty. Younger participants typically had less experience and older participants greater experience in the role of case manager. A study by You, Dunt, and Doyle (2015) described differences in focus of case management components based on case manager's experience of delivering case management to seniors living with frailty. However, it is not apparent in this study that participant's length of time as a case manager indicates divergent attitudes towards the interview questions. All six participants are female and

full-time employees at the organization that employs them. The participants professional background includes: one occupational therapist, one registered nurse, one certified social worker, and three from non-professional backgrounds. There are no statistics available on the gender breakdown of case managers in Ontario. According to the Canadian Institute of Health Information (CIHI, 2017) females account for upwards of 85 percent of the workforce for registered nurses, occupational therapists, and certified social workers in Canada. Therefore, along with anecdotal reports, this suggests that case managers in Canada are primarily female. Currently, no available literature comments on differences in case management experience between female and male case managers.

5.2 Interpretation of Results

5.2.1 Organizational Support

The organizational support domain of the sfCare Framework states that organizational leadership should be committed to delivering an optimal experience for seniors living with frailty. This means ensuring that all relevant policies and procedures support the needs of community-dwelling seniors living with frailty. As case managers are responsible for the delivery of care to community-dwelling seniors living with frailty, they need to be adequately supported by the organization in which they are employed to ensure optimal case management. Analysis of participant interviews identified three emerging salient themes that correspond with the organizational support domain. These themes include intra-professional collaboration, organizational commitment to supporting case managers well-being, and caseload size.

5.2.1.1 Intra-professional Collaboration.

Implementation of intra-professional collaboration in the workplace is a highly valued policy established by the organizational hierarchy at this community-based organization. The literature has described collaboration as a key competency of case managers as it facilitates the case management process (National Case Management Network of Canada (NCMN), 2012). Most literature on the topic of collaboration in case management has focused on the importance of inter-professional collaboration. However, participants in this study emphasized the importance of intra-professional collaboration, which involves the building of relationships within the cadre of case managers. Participants indicated that intra-professional collaboration can be achieved through the format of team meetings or weekly huddles. These team meetings and weekly huddles promote information sharing, build co-worker relationships between case managers, and break down barriers in individual cases. You et al. (2015) found similar results when they reported that peer support in the form of shared knowledge and experiences facilitated case managers' practice. Participants also found the diversity of professional backgrounds, experiences, and cultures was a strength of their team. Similarly, You et al. (2015) reported that differing professional backgrounds of case managers had benefits in supporting practices. These researchers stated that case managers from different backgrounds complemented each other as some were very strong in particular areas and could support their co-workers. It is evident that participants feel that intra-professional collaboration can improve their ability to deliver case management. Therefore, organizations should explore implementing additional intra-professional guidelines in the workplace in order to support case managers, mitigate feelings of isolation experienced

by some participants, and facilitate optimal case management for community-dwelling seniors living with frailty.

5.2.1.2 Organizational Commitment to Supporting Case Managers Well-Being.

It is apparent that participants feel they are at risk of work-related stress and clinical burnout. This has been attributed to the nature of delivering case management to community-dwelling seniors living with frailty, as the complexity of these clients can result in them taking on a greater level of responsibility for their clients than what is normally expected from a case manager. This lack of clarity over case managers' roles resulted in participants performing duties that may not be considered typical case manager duties. These atypical duties can be quite intense, with some participants stating that this affects their well-being and ultimately leads to an increased risk of work-related burnout. For instance, some case managers reported buying necessities for clients, taking clients to appointments, and resolving family issues. The study by Joo and Huber (2017) found similar results in that case managers struggle when they have an unclear scope of practice.

The demands of delivering case management to community-dwelling seniors with frailty means it is necessary to have an organizational commitment to supporting case managers well-being. This concern has been discussed by Sandberg et al. (2014) who noted that because case managers are subjected to various stressors in their role, efforts should be made to support them by the organization while they implement interventions. Participants further emphasized the need for organizational support, as they feel receiving in-house support from their employing organization is paramount to their health and well-being. Without an organizational commitment to ensure supports and resources are

available for case managers, participants will continue to be at risk of work-related burnout. You et al. (2015) discussed the positive impact that management support has on reducing the burden of burnout on case managers. These researchers stated that when the organizational hierarchy provides an "open door policy" in the form of being available to help case managers, it will facilitate the case management process. Therefore, it is clear that having a commitment to case managers' well-being be an organizational priority to ensure optimal case management for community-dwelling seniors living with frailty.

5.2.1.3 Caseload Size

Caseload size is defined by the number of community-dwelling seniors living with frailty assigned to the care of an individual case manager. The manner in which case managers caseload sizes are determined and structured is an administrative responsibility of the employing organization. In this study, every participant stated that their caseload size was at full capacity and they would be reluctant to take on additional cases. Participants who worked with higher complex needs seniors living with frailty stated that they felt a greater level of occupational related stress even with a smaller caseload size based on the demands of their clients. The literature has described the affect high caseload sizes have on case managers. Pardasani (2018) found that high caseload sizes have a critical impact on the nature of services provided to community-dwelling seniors living with frailty and increases occupational stress as well as lowers morale among case managers. Increased occupational stress and lower morale is associated with clinical burnout in healthcare settings (Nowrouzi et al., 2015). Therefore, case managers with highly demanding caseload sizes are not only at risk of providing suboptimal case management to their clients but are also putting their well-being at risk. It is evident that

caseload sizes directly impact the ability of case managers to provide optimal case management to community-dwelling seniors living with frailty. Organizations need to maintain a balanced and manageable caseload size for their case managers. However, further research is needed to determine the optimal size of caseload among this population to ensure caseloads do not impact the quality of care provided or the well-being of case managers.

5.2.2 Processes of Care

The processes of care domain of the sfCare Framework identifies that care must be based on evidence and best practices that are mindful of the unique needs of seniors living with frailty. Furthermore, care across the healthcare system should be delivered in a way that is integrated and providing continuity during transitions is emphasized. Therefore, it is important that throughout the processes of case management, the care provided to seniors living with frailty is patient-centred and seamless. Analysis of participant interviews identified three emerging themes that correspond with the processes of care domain. These themes include the linkage model of care, creativity and adaptability of approach to case management, and continuity of care.

5.2.2.1 The Linkage Model of Care

The linkage model of care refers to the relationship between community-based models of case management and the government funded Local Health Integration Network (LHIN). Case managers at the community-based organization must refer to the LHIN for required services and supports for their clients. This has resulted in the development of a working relationship between case managers at each organization.

However, this relationship has at times been demonstrated to be a barrier to care for community-dwelling seniors living with frailty. Case managers at the community-based organization repeatedly identified the difficulties in communication processes with the LHIN. The significance of this should not be understated, as case managers from the LHIN are the link for services allocated to community-dwelling seniors living with frailty. The barrier to optimal case management was characterized as the lack of cooperation from case managers at the LHIN and is in congruence with Van Mierlo et al. (2014) who concluded that impeding factors found in a linkage model of care were related to how partners collaborate with each other.

Case managers from the community-based organization felt left out of the circle of care by LHIN case managers. Price and Lau (2013) discussed the relationships between providers in the circle of care and the influence that it has on continuity of care for shared patients. These researchers found continuity of care was negatively impacted by a lack of collaboration between healthcare providers. In this study, it is evident that continuity of care for seniors living with frailty may be negatively impacted by the lack of smooth collaboration between community-based and LHIN case managers. As the processes of care domain of the sfCare Framework suggests, a priority of senior friendly care is to ensure an inter-professional and integrated model of care that provides continuity. The linkage model of care as it currently operates is not fulfilling this defining statement of sfCare Framework and is a barrier to optimal case management for community-dwelling seniors living with frailty.

5.2.2.2 Creativity and Adaptability of Approach to Case Management

Creativity and adaptability of approach to case management are significant facilitators of optimal health and wellness outcomes for community-dwelling seniors living with frailty. Participants indicated that seniors living with frailty may be reluctant to receive interventions. Due to this, participants stated that they need to be creative and willing to adapt case management plans for their clients. Sandberg et al. (2014) commented on the need for creativity in approach to case management as creativity allows case managers to find individual solutions to their clients' problems. A common problem experienced by participants in this study is balancing the safety and autonomy with the health and safety risks of their clients in case management interventions. This is especially problematic when delivering case management to seniors living with cognitive impairments. Participants emphasized that seniors living with cognitive impairments may often not see themselves as being in need of case management. Therefore, participants are aware they need to be creative in how they communicate and plan care to mitigate issues related to client compliance. This is consistent with findings by Fairhall et al. (2015) and the NCMN (2012) that identified that frailty treatment plans should be adapted to the goals, context, and capacity of the individual. The sfCare Framework also states that clinical processes must be adapted to meet the needs of seniors. Therefore, it is evident through participants' experiences that implementing creative, adaptable, and flexible approaches to case management are facilitators of optimal case management for community-dwelling seniors living with frailty.

5.2.2.3 Continuity of Care

Continuity of care in case management emerged as a theme from participant interviews. Participants indicated that at times their clients received fragmented care and thus a break in the continuity of their care. This was especially evident in transitions of care for community-dwelling seniors living with frailty. Baillie et al. (2014) described how integrated care systems are supposed to reduce barriers associated with care transitions for seniors living with frailty. Despite the implementation of an integrated care system facilitated by case management, participants still felt that the nature of supports and services in place to assist their clients through care transitions reduce continuity and comprehensiveness of care. This is an important service gap for community-dwelling seniors living with frailty as a key goal of primary care, which is to provide comprehensive care, is not being met. Starfield (2012) elaborated on the importance of providing continuity of care over time, as it is associated with better coordination of care, comprehensiveness of care and the concept of patient-centred care. Furthermore, the processes of care domain of the sfCare Framework underlines the importance of providing continuity especially during transitions for seniors living with frailty. It is clear that care transitions disrupt the continuity of care experienced by community-dwelling seniors living with frailty and that addressing these transitions is beyond the current scope of case managers. Greater vertical integration of care, as in bringing together organizations that deliver different services such as hospital services and case managers, may be required in order to improve continuity of care experienced by community-dwelling seniors living with frailty.

5.2.3 Emotional and Behavioural Environment

The emotional and behavioural environment domain of the sfCare Framework states that care must be compassionate and sensitive to seniors living with frailty. It also states that family caregivers need to be valued and supported as care partners. The development of social connections with family caregivers and seniors living with frailty is significant for case managers to provide optimal case management. This is demonstrated in the three emerging themes that correspond with the emotional and behavioural domain of the sfCare Framework. These themes include sensitivity of care, case manager – caregiver dyad, and empowering seniors and family caregivers while building rapport.

5.2.3.1 Sensitivity of Care

Providing care that is sensitive to the attitudes, feelings, and circumstances of community-dwelling seniors living with frailty is an important component of case management. Participants emphasized that when care is sensitive in nature it helps build the therapeutic alliance between themselves and their clients. The NCMN (2012) stated that an essential competency of case managers is to provide sensitive care to their clients. Participants further indicated that when care is provided that is culturally sensitive it allows patients to feel comfortable accessing resources or programs that are beneficial to their health and wellness. However, participants noted that they do not want to be presumptuous when discussing culturally sensitive resources or programs and it is always the decision of their client to enroll in them. It is well documented in the literature that providing care that takes into account the attitudes, feelings, and circumstances of seniors living with frailty results in the effective delivery of patient-centred care (Tucker,

Marsiske, Rice, Jones, & Herman, 2011). Patient-centred care has been suggested to improve health care outcomes and strengthen the patient and care provider relationship (Delaney, 2018). It is clear that participants recognize that providing sensitive care enables optimal case management. This aligns with the sfCare Framework statement that care needs to respect each individuals' breadth of lived experience, relationships, unique values, preferences, and capabilities. This study's results demonstrate that case managers ability to provide appropriately sensitive care is a facilitator of case management.

5.2.3.2 Case Manager – Family Caregiver Dyad

The relationship between case managers and family caregivers is a crucial component of case management for community-dwelling seniors living with frailty. In this study, participants emphasized the importance of engaging family caregivers in case management. When family caregivers are engaged and work cohesively with case managers, it leads to a reduction in case manager stress and case management intensity as well as perceived better health and wellness outcomes for seniors living with frailty. This finding is consistent with Berthelsen and Kristensson (2015) who noted that active involvement of family caregivers in the care and treatment of their older family members can provide an enhanced effect of treatment and well-being for seniors. However, some participants noted instances when family caregivers can be a barrier to enabling case management for their client. In these circumstances, family caregivers became a barrier to case management by not cooperating with case managers or seniors living with frailty on the care plan. Reasons cited for this included caregivers' lack of understanding of frailty, family caregiver reluctance to send those they care for to beneficial programs, and multiple caregivers disagreeing on the care plan amongst themselves. Berthelesen,

Lindhardt, and Frederiksen (2014) found that if family caregivers are reluctant to collaborate with healthcare professionals it can lead to additional barriers to care for seniors living with frailty. Although it is clear participants in this study value collaboration with family caregivers, it is important that family caregivers also value collaboration with case managers. As the sfCare Framework states that family and other caregivers should be valued and supported as care partners, it is imperative that barriers surrounding family caregiver involvement in case management for community-dwelling seniors living with frailty are mitigated.

5.2.3.3 Empowering Seniors and Family Caregivers while Building Rapport

Empowering seniors and family caregivers while building rapport is a key task to facilitate case management. Participants indicated that educating seniors living with frailty and their family caregivers on how to advocate for themselves in the healthcare system may assist them in order to receive appropriate and required supports. Although case managers act as navigators and advocators of seniors in the healthcare system, when they empower seniors and their family caregivers to navigate, advocate, and make decisions for themselves, it results in better health outcomes. This is consistent with Holroyd-Leduc et al. (2016) found that a key aspect of engagement in health care settings is to move away from provider-led care and towards empowering older adults living with frailty and family caregivers to make their own decisions regarding their care. Furthermore, this study's analysis has identified that building rapport and developing social connections with seniors and family caregivers improves trust between them. Trusting relationships allow seniors and family caregivers to feel confident in their case managers and the information provided to them allowing them to become self-advocates.

The NCMN (2012) identified developing rapport, trust, and ethical relationships with clients and family caregivers as an enabling competency of case managers. Sandberg et al. (2014) commented that trust and confidence are important factors for successful outcomes in case management. It is evident in this study that case managers have an important role in facilitating family caregivers and seniors living with frailty to become self-advocates in order to receive optimal care outcomes in the healthcare system.

5.2.4 Ethics in Clinical Care and Research

The ethics in clinical care and research domain of the sfCare Framework states that an older adult should not be denied access to care. As case managers link appropriate resources to their clients, they must ensure that seniors living with frailty have access to the necessary services and supports required for them to remain in the community. Analysis of participant interviews resulted in the identification of three emerging themes that correspond with the ethics in clinical care and research domain. These themes include access to timely resources, affordability of resources, and knowledge of community-based resources.

5.2.4.1 Access to Timely Resources

The ability of community-dwelling seniors living with frailty to access timely resources is a significant factor in case management. There are many barriers in the healthcare system facing seniors living with frailty who are trying to access timely resources. These barriers include exclusion from transportation, wait times for urgent community health supports, and a lack of human support in case management. It is important to note that mitigating these barriers to accessing resources is seen as largely

out of the scope for case managers. As participants recognize the urgency of access to resources, they have resorted to performing atypical tasks of case management interventions for their clients. This has included taking clients to appointments themselves and performing additional roles to fulfill client needs. This is consistent with You et al. (2015) as they found insufficient access to resources led to case managers assuming more roles to meet their clients' care needs. When community-dwelling seniors living with frailty have experience limited access to timely resources, their continuity of care is affected as well. As discussed by Wilson et al. (2016) ensuring patients receive access to care when they need it is an important component of integrated and patient-centred care. Due to the fact that barriers to accessing timely resources are prominent in case managers' experiences it is clear that community-dwelling seniors living with frailty are still at risk of receiving fragmented care.

5.2.4.2 Affordability of Resources

The affordability of resources has a significant influence on case managers' ability to provide optimal case management interventions to community-dwelling seniors living with frailty (Fret et al. 2019). Participants in this study expanded upon this issue and stated they were not able to link seniors living with frailty with limited financial means to resources that would be beneficial to their health and well-being. This is consistent with findings by Baer, Bhushan, Taleb, Vasquez, and Thomas (2016) that seniors with financial challenges experience a reduction in their ability to afford and access resources they need to keep them healthy such as food, medication, and community-based supports and services. The issues surrounding affordability of pertinent resources for community-dwelling seniors living with frailty is an issue that is largely out

of the control of case managers. However, as participants stated, budgetary flexibility allows them to assist in extreme cases with their financially challenged clients. Although this is not a long-term solution to the affordability of resources, it gives case managers the ability to temporarily improve case management outcomes for their client. It is evident that for community-dwelling seniors living with frailty, their financial standing greatly affects the case management process.

5.2.4.3 Knowledge of Community-Based Resources

Case managers' knowledge of available community-based resources is an important aspect of case management as it allows them to link community-dwelling seniors living with frailty to the most appropriate services and supports. Participant stated that although they have access to a guide of community-based resources, it is still challenging to be knowledgeable about every single resource. A lack of awareness of community-based resources has been associated with unmet service needs for seniors living with frailty (Casado, van Vulpen, & Davis, 2011). Furthermore, it has previously been reported that some community-based supports and services for seniors living with frailty are underutilized. Siegler, Lama, Knight, Laureano, and Reid (2015) found that a lack of awareness contributes to underutilization and that knowledge of and coordination with community-based services and support are essential if clinicians are to create more flexible and responsive models of care for their clients. Improving case managers' knowledge of community-based resources can optimize case management for community-dwelling seniors living with frailty. However, the burden of increasing case managers' knowledge of community-based resources should not fall completely on them. As indicated by participants community-based resources need to do a better job of

advertising their services and supports to case managers, family caregivers, and seniors living with frailty. When awareness of community-based resources is enhanced, it can facilitate optimal case management for community-dwelling seniors living with frailty.

5.2.5 Physical Environment

The physical environment domain of the sfCare Framework states that the spaces and structures in which community-dwelling seniors living with frailty reside should provide an environment which promotes safety, comfort, functional independence, and well-being. Therefore, case managers must be able to observe the physical environment and intervene when hazards exist, to minimize the vulnerabilities of community-dwelling seniors living with frailty. Analysis of participant interviews resulted in the identification of one theme that corresponds with the physical environment domain of the sfCare Framework. This theme is case managers' assessment of the physical environment.

5.2.5.1 Case Managers' Assessment of the Physical Environment

Case managers' assessment of the physical environment that community-dwelling seniors living with frailty reside is a key component of case management. Participants identified barriers in the physical environment as an area where they can perform meaningful interventions for their clients. This is important as seniors living with frailty may live in environments that pose risks to their health (Dong, Simon, Mosqueda, & Evans, 2012). Furthermore, the literature has suggested that a proportion of seniors living with frailty are unable to make positive changes to their physical environment without external direction and support (Freer & Wallington, 2019). This puts an increased responsibility on those who care for seniors living with frailty to be mindful of the

challenges posed by the physical environment. Although participants do not adjust their client's physical environment, they indicated they feel comfortable making observations, recommendations, and referrals for the appropriate resources to make the necessary changes to their client's physical environment. These referrals usually go to an occupational therapist agency as they are trained to mitigate physical environment concerns. However, as participants pointed out, their clients may be faced with wait times to access an occupational therapist intervention which may put prolong their risk due to their physical environment. Freer and Wallington (2019) commented on the importance of occupational therapists for community-dwelling seniors living with frailty to adapt their environment in order to minimize vulnerabilities and promote healthy living. As linking community-dwelling seniors living with frailty to occupational therapists is a key component of case management, this issue can be seen as a barrier for case managers to provide optimal care to their clients.

5.3 Summary of Discussion

This chapter provided an interpretation of the 13 emerging themes from the participant interviews in relation to relevant evidence. The sfCare Framework guided the interpretation of the results as each theme aligns with a domain. The themes that align with the organizational support domain demonstrate the importance of an organizational commitment to ensuring policies and procedures support case managers to provide optimal case management to community-dwelling seniors living with frailty. The themes that align with the processes of care domain demonstrate the importance of providing evidence-based, patient-centred care throughout every step of care process to facilitate optimal case management. The themes that align with the environmental and behavioural

domain demonstrate the importance of developing strong social connections with family caregivers and seniors living with frailty to provide optimal case management. The themes that align with the ethics in clinical care and research domain demonstrate the importance of ensuring seniors living with frailty have access to the most appropriate resources. The theme that aligns with the physical environment domain demonstrates the importance of case managers being able to perform interventions that minimize the vulnerabilities of seniors living with frailty. It is evident that the 13 themes identified are significant barriers and facilitators of case management for community-dwelling seniors living with frailty.

Chapter 6. Conclusion

The first section of this chapter offers a brief summary of the study. The study's strengths and limitations are then identified. This is followed by the implications of this research and recommendations for future practice, education, research, and policy. Lastly, I conclude this study with closing remarks about the purpose of this study and its relevance.

6.1 Summary of Study

It is well documented that the burden of frailty is growing and community-dwelling seniors living with frailty are at an increased risk of adverse health outcomes, including falls, disability, hospitalizations, reduced quality of life, and death (Buckinx et al., 2015). These issues are coupled with an increased economic cost associated with frailty due to a higher consumption of healthcare resources required to treat seniors living with frailty (Canadian Frailty Network (CFN), 2020). Case management has emerged as a promising approach to mitigate the burden of frailty experienced in community-dwelling seniors living with frailty. Case management has been demonstrated to improve health and wellness outcomes for this population, reduce overall costs to the healthcare system, and support seniors aging in place (Gowing et al., 2016). Case managers are responsible for the delivery of case management which includes coordination of care plans and organizing services and supports for community-dwelling seniors living with frailty. As such, case managers offer first-hand knowledge and insight into specific components of case management that may provide the most promise in supporting our aging population to remain in the community (Carter et al., 2018). Exploring case

managers' experiences delivering case management ensured the purpose and objective of this research study were fulfilled. The purpose of the research was to inform future policy and practices related to case management for community-dwelling seniors living with frailty. The objective of the research was to identify the barriers and facilitators of case management from the perspective of case managers.

Six case managers participated in this study. The data analysis resulted in the identification of 13 emerging themes that are considered either barriers or facilitators of case management for community-dwelling seniors living with frailty. The 13 themes are organized by the five domains of the sfCare Framework and outlined in Table 6.1.

Table 6.1: Emerging themes corresponding with the sfCare Framework domain

sfCare Framework Domain	Emerging Theme(s)
Organizational Support	• Intra-professional Collaboration • Organizational Commitment to Supporting Case Managers Well-Being • Caseload Size
Processes of Care	• The Linkage Model of Care • Creativity and Adaptability of Approach to Case Management • Continuity of Care
Emotional and Behavioural Environment	• Sensitivity of Care • Case Manager – Family Caregiver Dyad • Empowering Seniors and Family Caregivers while Building Rapport
Ethics in Clinical Care and Research	• Access to Timely Resources • Affordability of Resources • Knowledge of Community-Based Resources
Physical Environment	• Case Managers' Assessment of the Physical Environment

The identification of these 13 themes are key results of the study and fulfill the purpose of the study. The implications and recommendations for future case management practice, education, research, and policy will be further explored in section 6.4 (**Implications and Recommendations for Case Management**).

6.2 Study Strengths

A notable strength of this study was the use of a conceptual framework to guide the exploration of the research question, the direction of the research, and to connect emerging themes in this study. The sfCare Framework fulfilled the role of the conceptual framework for this study, as its purpose was to provide a foundation for the development and implementation of resources that will improve care for seniors living with frailty. This aligns with the primary goal of case management in this context, which is to ensure the highest quality care for seniors living with frailty to adequately support their needs. There are five domains of the sfCare Framework including: organizational support, processes of care, emotional and behavioural environment, ethics in clinical care and research, and physical environment. All five domains factor crucially in the delivery of high quality, evidence informed case management to community-dwelling seniors living with frailty. Therefore, the five domains of the sfCare Framework provided a foundation for which to construct all knowledge in this study, as it was used to develop data collection and analysis methods. Studies by Balard et al. (2016), You et al. (2016), and Sandberg et al. (2014) that explored case managers' experiences delivering case management to community-dwelling seniors living with frailty either did not use a conceptual framework or did not elaborate on how a framework was utilized in their study. It is evident that the use of a conceptual framework strengthened this study as it

rooted the results in a sound theoretical underpinning that is relevant to current seniors' care approaches.

6.3 Study Limitations

A notable limitation of this study was that the data was collected from a small group of participants from only one community-based organization. Although data saturation was attained when the themes from the initial interviews were replicated in later interviews, it is possible that further interviews from different organizations may have identified additional themes or provided more nuanced explanations. Therefore, the themes elucidated in this study may be expanded upon if additional case managers were involved. Furthermore, there was no representation of case managers who operate under the Local Health Integration Network (LHIN), which is the larger provincial model of case management in Ontario. All participants in this study came from one organization, which provides a smaller community-based model of case management. This is an important limitation as including data from LHIN case managers may provide further insight into another aspect of the linkage model of care, which was identified as both a key barrier and facilitator of case management for community-dwelling seniors living with frailty. The Central East LHIN was contacted on numerous occasions, however, they did not respond to the requests to have their case managers recruited for the study.

6.4 Implications and Recommendations for Case Management

The implications and recommendations of this study are intended to inform future case management for community-dwelling seniors living with frailty. They are separated

into the following four categories: future practice, future education, future research, and future policy.

6.4.1 Future Practice

There is a paucity of current evidence on this topic, as there exists no uniform governing body for case managers that regulates practice for delivering case management to community-dwelling seniors living with frailty. Previously, the National Case Management Network (NCMN, 2009) developed a document that was meant to ensure a standard of excellence in case management practices for community-dwelling seniors living with frailty. This document was entitled, "Canadian Standards of Practice for Case Management". However, as the NCMN ceased operations in 2014 and since case management has rapidly evolved since 2009, an updated version of this document is required. This research study's results have identified current barriers and facilitators of case management for community-dwelling seniors living with frailty. Therefore, the results of this study could be used to improve future case management practice by contributing evidence to update the standards of case management. An updated version of the "Canadian Standards of Practice for Case Management" document should focus on including themes elucidated in this study that were not in the original version such as: creativity and adaptability of approach to care, sensitivity of care, case manager and family caregiver dyad, empowering seniors and family caregivers while building rapport, knowledge of community-based resources, and case managers' assessment of the physical environment.

6.4.2 Future Education

This study's results offer numerous areas for future education in relation to professional and competency development of case managers. The NCMN (2012) developed a document entitled, "Canadian Core Competency Profile for Case Management Providers" with the purpose of describing the skills, knowledge, and competencies required by those delivering case management. The document also was meant to support the evolution of case management in relation to the changing nature of the Canadian healthcare system. This document was published eight years ago and as new evidence is gathered, including this study's results, an updated version is necessary. Future education for case managers, particularly those that intend to serve seniors, should include the following themes elucidated in this study: intra-professional collaboration, creativity and adaptability of approach to care, sensitivity of care, case manager and family caregiver dyad, empowering seniors and family caregivers while building rapport, knowledge of community-based resources, and case managers' assessment of the physical environment.

6.4.3 Future Research

This study, being qualitative and phenomenological in nature, has raised a number of opportunities for future research. First, to confirm the external validity of this study, it must be replicated in a different setting. This study's participants only came from an organization situated in a large urban city. Therefore, it is necessary to determine if participants' experiences delivering case management are unique to their context or are similarly experienced by case managers employed in different organizations. Furthermore, as discussed in the limitations of the study it is necessary to further explore

LHIN case managers' perspectives. Future research that delves into the relationship between the LHIN and community-based models of case management can shed additional light on the linkage model of care and its impact on the quality of case management afforded to community-dwelling seniors living with frailty.

6.4.4 Future Policy

Informing the development of future policy in case management is a key component of this study. Based on the results in this study, three areas of future policy development for case management should be considered. These three areas include: employing organizational policies, Canadian healthcare system policies, and the re-establishment of a case manager network.

6.4.4.1 Employing Organizational Policies

This study has identified three priorities for organizational policy development for case management for community-dwelling seniors living with frailty. These areas are: intra-professional collaboration, organizational commitment to supporting case managers' well-being, and caseload size.

Intra-professional collaboration was highly valued by participants in this study. Intra-professional collaboration promotes information sharing amongst case managers and enhances problem solving in complex cases. Ensuring that intra-professional collaboration is a policy of case management organizations will support case managers to provide optimal care to their clients.

Participants indicated that due to the demands of case management, clinical burnout is a risk factor in their role as case managers. A policy that ensures an

organizational commitment to supporting case managers' well-being is important to prevent the potentially deleterious effects of burnout on case managers and their clients.

Case managers' caseload sizes are another complex issue. A larger caseload does not necessarily result in a greater difficulty managing that caseload size. Participants indicated that at times smaller caseload sizes with patients experiencing higher complexity of needs posed them more challenges. Due to the varying level of challenges that individual clients experience, it is necessary to develop policy to ensure caseload sizes are appropriately balanced and do not become overwhelming for case managers.

6.4.4.2 Canadian Healthcare System Policies

This study identified four priorities of policy development pertinent to the Canadian healthcare system, that if adopted can enable case managers to provide optimal case management to community-dwelling seniors living with frailty. These priorities are: the linkage model of care, continuity of care, access to timely resources, and affordability of resources.

As participants stated, the linkage model of care can be a significant barrier for them to work within. Future policy that reinforces improved communication and understanding between community-based and provincial based models of case management is necessary for community-dwelling seniors living with frailty to receive optimal care.

Community-dwelling seniors living with frailty are still experiencing fragmented care leading to a reduction in the continuity of care experienced. Exploring ways to reduce barriers surrounding continuity of care, such as improving transitions between

care, and comprehensiveness of care will improve case management. Furthermore, it will reduce the need for case managers to go beyond the scope of their duties to ensure their client's safety.

This study's results indicate that access to timely resources greatly impacts case managers' delivery of optimal case management to community-dwelling seniors living with frailty. Lack of resources affects seniors living with frailty directly as it renders the processes of case management irrelevant. This is due to the fact that there is nothing for case managers to manage when there are limited community-based resources for them to link clients to. Emphasis within the Canadian healthcare system needs to be placed on ensuring community-based resources are accessible and plentiful to allow case managers to be successful in their role. Furthermore, wait times for required services such as occupational therapists and personal support workers were identified to have a significant impact on clients with immediate needs. Therefore, policy that reduces wait times, especially for those where it is immediately required, will improve case management for community-dwelling seniors living with frailty.

Lastly, participants found that affordable resources in the community are limited for community-dwelling seniors living with frailty. This means participants' referrals to required resources are challenging for financially limited clients. Looking into the development of additional policy to support increased affordability of community-based resources is important to improve outcomes for community-dwelling seniors living with frailty.

6.4.4.3 Re-establishment of a Case Manager Network

Currently, no formal governing body oversees or supports case managers. The reintroduction of a Canadian case manager's network or professional association may offer the most promise for ensuring future policy is evidence-informed and adequately supports case managers. Related professions, such as nursing, have a professional association that provides policy to support nurses in their role. This is demonstrated by the Registered Nurses' Association of Ontario (RNAO) consistently releasing best practice guideline publications that support optimal client care. An example of a best practice guideline publication from the RNAO (2016) is entitled, Intra-Professional Collaborative Practice among Nurses. This study similarly identified intra-professional collaboration as a key facilitator of case management for community-dwelling seniors living with frailty. However, there exists no formal evidence-informed policy to direct intra-professional collaboration for case managers. If case managers had access to a professional association or regulatory body, this could lead to the development of policy that addresses problems unique to their work.

6.5 Closing Remarks

As the Canadian demographic continues to age and the prevalence of frailty increases, ensuring community-dwelling seniors living with frailty are adequately supported is exceedingly important. The growing significance of case managers in community care can therefore not be understated, as they are the central figures in aiding seniors to remain healthy and well at home. Their role is explicitly identified in the Connecting People to Home and Community Care Act (Government of Ontario, 2020) which received royal assent this past July. This study has contributed additional evidence

from the perspective of case managers about the processes of case management, and its barriers and facilitators. The recommendation made about policies that ought to be developed and implemented by organizations employing case managers and by the Canadian healthcare system can help to optimize case management as a tool to support the best quality of care to our community-dwelling seniors living with frailty.

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Appendix A. REB Consent Form

Date:

Title of Research Study: Models of Case Management Interventions for Community-Dwelling Seniors with Frailty from the Perspective of Case Managers

You are invited to participate in a research study entitled "Models of Case Management Interventions for Community-Dwelling Seniors with Frailty from the Perspective of Case Managers". This study has been reviewed by the Ontario Tech University (UOIT) Research Ethics Board [15456] and originally approved on July 17, 2019.

Please read this consent form carefully, and feel free to ask the Researcher any questions that you might have about the study.

Researcher: Declan Weir, BHSc

Principal Investigator: Manon Lemonde, RN, PhD

Departmental and institutional affiliation(s): Ontario Tech University, Faculty of Health Science

Contact number/email: Manon.Lemonde@uoit.ca 905.721.8668 x. 2706, Declan.Weir@uoit.ca 289.356.3747

Purpose and Procedure:

The purpose of this study is to explore what impacts delivery of case management interventions for community-dwelling seniors with frailty from the perspective of case managers. Your participation involves completing a socio-demographic form and taking part in a semi-structured interview consisting of open-ended questions, where you can speak with the researcher about your experiences as a case manager. Interviews may be conducted over the phone or in person at your workplace. All interview data will be audio-recorded and transcribed verbatim; the researcher may also take notes by hand during the interview. It is anticipated that the interview may take approximately 30-45 minutes to complete. Following the completion of the interview, it will be transcribed and available for you to review within seven (7) days. You will have an opportunity to review the transcript, at your discretion, either in person or via email to confirm meaning in statements and to provide additional information as you deem necessary. If you decide to review the transcript, you may send your comments, changes or approval to the researcher within seven (7) days; otherwise it is presumed that your experiences have

been correctly described and captured in enough detail. If a subsequent meeting is to occur in person, it will take place on a different, mutually agreed upon date and time. This process may need to occur more than once, which is at your discretion, to ensure the meaning has been accurately captured and your experience sufficiently described in as much detail as possible.

Potential Benefits:

You will not benefit directly from participating in this study. However, the results of this study can be used to inform case managers when delivering case management interventions for community-dwelling seniors with frailty.

Potential Risk or Discomforts:

The risks involved in participating in this study are minimal. It is not likely that there will be any harms or discomforts as a result of your participation in this study. You do not have to answer

any questions you do not feel comfortable answering. All data collected during the interviews are confidential and will only be accessed by the members on the research team listed on this consent form.

Confidentiality and Storage of Data:

Transcripts will be transcribed on Google Docs via Google Apps for Education (UOITnet server) and will therefore only be accessible to the researcher and principal investigator via the shareable link. Your privacy shall be respected. Your identity will be kept anonymous in the study by assigning you a digital identifier number. All information and data collected will be kept completely confidential. Your names and contact information will not appear on any forms or any publication. Moreover, no information about your identity will be shared or published without your permission, unless required by law. All audio recordings will be destroyed after the transcripts have been confirmed. The transcription will be kept for two (2) years after the completion of this study. After the two (2) year period, all data will be destroyed in an appropriate manner. Any confidential research data and records in paper format will be shredded. Confidential research data and records in electronic format will be destroyed by reformatting, rewriting or deleting. All the information provided by you will remain confidential and will only be utilized for the purpose of this research. For further information about security of data within Google Apps for Education, please visit http://support.google.com/work/answer/6056693

Right to Withdraw:

Your participation is voluntary, and you can answer only those questions that you are comfortable with. The information that is shared will be held in strict confidence and discussed only between the researcher and the principal investigator. If you decided to be part of the study, you can stop (withdraw) from the interview for any reason even after signing the consent form. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal after the interview has been performed, you have seven (7) days to let the research team know if you want your data excluded from the study or it will be included in the final results.

Conflict of Interest:

There are no conflicts of interest in this study.

Compensation:

There will be no compensation for participating in this study.

Debriefing and Dissemination of Results:

The results of the study may be published or presented at professional meetings, or in journals as well. If participants are interested in learning the final results of this study once it is published they may contact the principal investigator at 905.721.8668 x. 2706 or manon.lemonde@uoit.ca.

Participant Concerns and Reporting:

If you have any questions concerning the research study or experience any discomfort related to the study, please contact the principal investigator Manon Lemonde at 905-721-8668 x. 2706 or manon.lemonde@uoit.ca. Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Research Ethics Officer – researchethics@uoit.ca or 905.721.8668 x. 3693. By consenting, you do not waive any rights to legal recourse in the event of research-related harm.

Consent to Participate:

Written Consent

1. I have read the consent form and understand the study being described;

2. I have had an opportunity to ask questions and my questions have been answered. I am free to ask questions about the study in the future;
3. I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this Consent Form has been made available to me.

_____ _____

(Name of Participant) (Date)

_____ _____

(Signature of Participant) (Signature of Researcher)

Oral Consent

1. I have read the consent form to the participant they have indicated that he/she understands the study being described.
2. The participant has had an opportunity to ask questions and these questions have been answered. The participant is free to ask questions about the study in the future.
3. The participant freely consents to participate in the research study, understanding that he/she may discontinue participation at any time without penalty. A physical/digital Consent Form has been made available to him/her.

_____ _____

(Name or identifier of Participant) (Date)

_____

(Signature of Researcher)

Online Consent

1. I have read the consent form and understand the study being described.
2. I have had an opportunity to ask questions and my questions have been answered. I am free to ask questions about the study in the future.
3. I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this Consent Form has been made available to me.

☐ I Agree

Appendix B. Request for Permission to Conduct Research

Models of Case Management Interventions for Community-Dwelling Seniors with Frailty from the Perspective of Case Managers

Declan Weir, Faculty of Health Sciences,

Ontario Tech University

Email Subject Line: Request for Permission on a Study Entitled: Models of case management interventions for community-dwelling seniors with frailty from the perspective of case managers.

To Whom It May Concern:

I am writing to invite [insert organizations name] to participate in a research study. As a master's student from the faculty of health sciences at Ontario Tech University (UOIT), I am currently conducting a research study under the supervision of Dr. Manon Lemonde, RN, PhD from Ontario Tech University. This study has been approved by the Ontario Tech University Research Ethics Board REB [15456] on [July 17, 2019].

The purpose of this study is to explore the experiences of case managers on utilizing case management interventions for community-dwelling seniors with frailty. Particularly, we want to gain an in-depth understanding from case managers' lived experiences on what barriers and facilitators may impact the implementation of case management interventions specifically within the Ontario healthcare system. [insert organizations name] has been selected because you employ case managers that currently deliver case management interventions to community-dwelling seniors with frailty.

Attached to this email you will find a one page outline of the study and the letter of invitation that could be sent to the case managers, if you agree to participate.

Thank you for your consideration. If you would like to participate or have any questions about the study, please feel free to email me at: declan.weir@uoit.ca or contact me at: 289.356.3747

Sincerely,

Declan Weir, BHSc

Appendix C. Recruitment Script Email

Models of Case Management Interventions for Community-Dwelling Seniors with Frailty from the Perspective of Case Managers

Declan Weir, Faculty of Health Sciences,

Ontario Tech University

Email Subject Line: A study on models of case management interventions for community-dwelling seniors with frailty from the perspective of case managers.

I am writing to invite you to participate in a research study. As a master's student from the faculty of health sciences at Ontario Tech University (UOIT), I am currently conducting a research study under the supervision of Manon Lemonde, RN, PhD from Ontario Tech University. This study has been approved by the Ontario Tech University Research Ethics Board REB [15456] on [July 17, 2019].

The purpose of this study is to explore the experiences of case managers on utilizing case management interventions for community-dwelling seniors with frailty. Particularly, we want to gain an in-depth understanding from case managers' lived experiences on what barriers and facilitators may impact the implementation of case management interventions specifically within the Ontario healthcare system. You are eligible to participate in this study because you are an active case managers and currently deliver case management interventions to community-dwelling seniors with frailty.

We would like to audio record your interview. Participation in this study would take approximately 30-45 minutes of your time.

The risks involved in participating in this study are minimal and it is not likely that there will be any harms or discomforts as a result of your participation in this study. You do not have to answer any question that you do not want to. To protect your privacy, all data collected during the interviews will be kept confidentially and will only be accessed by the principal investigator and researcher associated with this study. Additionally, digital identifier numbers will be used and thereby your name will not be presented on any data, for the purpose of your privacy.

Remember, this is completely voluntary, and you can answer only those questions that you are comfortable with. If you decide to be part of the study, you can stop (withdraw) from the interview for any reason even after signing the consent form. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you provided will be destroyed unless you indicate otherwise.

If you express interest in the study the next step for you is to review and sign-off on the consent form that will be provided to you. The consent form is a protective document for you and the researchers and provides further detail on the study and your involvement in it.

Thank you for your consideration. If you would like to participate or have any questions about the study, please feel free to email me at: declan.weir@uoit.ca or contact me at: 289.356.3747. Additionally, you may email the principal investigator at manon.lemonde@uoit.ca or contact her at 905.721.8668 x. 2706.

Sincerely,

Declan Weir, BHSc

Appendix D. Interview Guide

Models of Case Management Interventions for Community-Dwelling Seniors with Frailty from the Perspective of Case Managers

Declan Weir, Faculty of Health Sciences,

Ontario Tech University

Interview Questions:

These interview questions cover what I would like to learn about your experiences implementing case management interventions for community-dwelling seniors with frailty. Interviews will be conducted over the phone, with a potential for an in-person meeting, if you choose. The interview will be semi-structured and open-ended (not just "yes or no" answers). Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: "So, you are saying that…?"), to get more information ("Please tell me more?"), or to learn what you think or feel about something ("Why do you think that is…?").

1. What does frailty mean to you?
    a. Tell me about how you assess frailty when you initiate a case management intervention?
2. Take me through the processes of care of a typical case management intervention for community-dwelling seniors with frailty.
    a. Tell me about how you communicate with the seniors with frailty and their caregivers.
    b. How do you incorporate seniors and their caregivers in the care plan?
    c. What are barriers to optimizing the physical, social, psychological and functional abilities of seniors with frailty?
    d. How often do you interact with a senior with frailty during a case management intervention?
3. How does degree of frailty influence your work?
    a. How do you adapt care plans to account for varying degrees of frailty?
    b. How do seniors and their caregivers respond to their care plans?
    c. Does degree of frailty impact how often you carry out interventions for seniors with frailty?
4. What are the barriers to ensuring that community-dwelling seniors with frailty rights are protected in clinical care?
    a. What impacts an interventions ability to ensure autonomy, choice and dignity of seniors with frailty?
    b. What limits accessibility of care for seniors with frailty?

5. Can you tell me about the emotional and behavioural environment that is created while you are delivering a case management intervention to community-dwelling seniors with frailty?
    a. What are some barriers to identifying and addressing issues related to seniors with frailty safety?
    b. Can you tell me about how you view family and other caregivers as partners in care?
    c. What are barriers to planning and delivering interventions that align with senior's personal goals?
6. Can you tell me about the physical environments that you work in?
    a. What are the barriers related to the physical environments you deliver a case management intervention in?
7. Can you tell me about the organizational supports at your work place?
    a. Tell me about any barriers you feel your organization places on your ability to deliver a case management intervention to seniors with frailty.
    b. What type of standards has the organization implemented and how does it monitor indicators relevant to the care of seniors with frailty?
    c. How many seniors with frailty are in your caseload and how does this number impact your ability to achieve goals of case management interventions?

Appendix E. Socio-Demographic Form

1. What age group do you belong to?

- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55+

2. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Non-Binary
- ☐ Prefer Not to Answer
- ☐ Other

3. What is your professional background?

- ☐ Registered Nurse
- ☐ Occupational Therapist
- ☐ Physiotherapist
- ☐ Certified Social Worker
- ☐ Speech Language Pathologist
- ☐ Other

4. What is your employment status?

- ☐ Full-Time
- ☐ Part-Time

5. How long have you been delivering case management interventions to community-dwelling seniors with frailty?

- ☐ Less than 5 years
- ☐ 5-10 Years
- ☐ 10+ Years

Appendix F. Emerging Themes and Corresponding Significant Statement

sfCare Domain	Emerging Theme	Significant Statement
Organizational Support	• Intra-professional Collaboration	• "It is important. Sometimes it may not be helping you out with the work but as a listening ear. Through the conversation you might get some insight. Because we are all different personalities, we are all different experience, background all these. So, obviously talking to co-worker, the team member is very important."
	• Commitment to Supporting Case Managers' Well-Being	• "I think the barrier might be that if we don't receive the proper support in-house, the barrier is the burn out rates. This is a high burnout field right."
	• Caseload Size	• "I think it would be nice if we actually shared client load. To me I would rather have 100 clients but share…You could also be like oh this client is kind of burning me out could you take over for another week or two."
Processes of Care	• The Linkage Model of Care	• "In the morning, they could not get themselves ready to get picked up by our bus. Then we try to call LHIN, oh do you think you can give her additional hours just to get ready in the morning. The door is shut. OK."
	• Creativity and Adaptability of	• "That is why we have to be really creative sometimes, we can't cookie cutter every

	Approach to Case Management	situation. If the person is capable we have no problem. Like everybody has their own entitlement we try to support the individual the way they want to. But when we are dealing with incapable or we think they are incapable but we haven't don't any assessment, then how can we balance things out between their autonomy and independence and their safety risks?"
	• Continuity of Care	• "Even though now they have one thing called transitional care. That means they want the client to go home but actually the client is not safe. They will have a transitional centre to provide care but sometimes it is not enough."
Emotional and Behavioural Environment	• Sensitivity of Care	• "Very much. Because I do have Mandarin speaker, Cantonese speaker and one that I have seen is an even more rare dialect. With knowing the culture is very important. My experience over the 17 years, take for example you need help to apply for old age pension. An English speaker and a Chinese speaker come into my office I need to have a different approach to work with them because of the level of knowledge. I have a client that is fairly new to this culture, even to make a phone call it can be a barrier."
	• Case Manager – Caregiver Dyad	• "If the family is very involved in the care, if they are very supportive, you just see less of

		our resources and our time, we will still do the linking, we will still do everything to support the family and we have caregiver supports separate from the client support. It's just the outcome is always better when the family is involved…Even in like in terms of stress wise for us, or at least from me I am going to say, is that when the family is very involved, it makes my job easier essentially."
	• Empowering Seniors and Family Caregivers while Building Rapport	• "Besides the knowledge part the emotional part is also very important. Because very often client has adult children they have their own family, their own job and then they have to take care of their parents. So, they really burnout. I have clients they just want to talk just tell me how difficult they are facing their daily life. Actually, sometimes I can't provide any real solution. But after talked it out it is a kind of support just spending time listening."
	• Access to Timely Resources	• "I'll give you an example I have clients with dementia, recently they are not allowed to ride on their own in Wheel-Trans to get here because of their dementia behaviour – because of the behaviour issue. They need someone to be with them to control the behaviour so that they won't have anything drastic happen inside the ride OK"

Ethics in Clinical Care and Research	• Affordability of Resources	• "One of our responsibilities is to coordinate resources. What I mean is if a client lives alone and had a fall and sends to hospital before my client is discharged home sometimes hospital social worker knows OK they have a care manager. They will call me to ask about services we can provide in the community. Basically none. I mean for free services"
	• Knowledge of Community-Based Resources	• "There are a lot of resources and I don't think everybody knows about them. Like yeah, I know some resources but I think there are a lot more resources that I don't know about right so, the more resources the better it is. So definitely I think knowledge of resources that's a lack in general for everyone."
Physical Environment	• Case Managers' Assessment of the Physical Environment	• "Depending on what it is, we try to involve other community partners in the city as well. So, let's say we see like a hoarding issue, that could be one of our interventions. So, we break down those barriers. We can't just oh, this is quite challenging we can't do anything about it. We identify barriers as opportunities for our interventions as well."