Optimizing quality of care for patients with ALS and their family caregivers
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Need and value of case management in multidisciplinary ALS care: A qualitative study on the perspectives of patients, spousal caregivers and professionals

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ABSTRACT

Our objective was to explore the needs and value of case management according to patients with amyotrophic lateral sclerosis (ALS), their spousal caregivers, and health care professionals in the context of multidisciplinary ALS care. We undertook semi-structured interviews with 10 patients with ALS, their caregivers (n=10) and their ALS health care professionals (n=10), and held a focus group (n=20). We transcribed the audio-taped interviews and we analysed all data thematically. Participants indicated that in certain circumstances case management can have an added value. They identified factors for receptiveness to case management: adequacy of usual care, rate of disease progression, and degree of social network support and personal factors of patients and spousal caregivers. Participants valued the time for consultation, house calls and the proactive approach of the case manager. Patients with ALS and caregivers appreciated emotional support, whereas professionals did not mention the importance of emotional support by the case manager.

In conclusion, ALS teams can consider implementation of valued aspects of case management (accessibility, ample time, proactive approach, emotional support) in the usual multidisciplinary ALS care. Additional support might be provided to patients with rapidly progressive disease course, passive coping style and small social network.
INTRODUCTION

Patients with ALS require neuropalliative care because this disease has no cure \[1-4\]. Shortcomings in ALS care have been described, revealing suboptimal collaboration in complex multidisciplinary care, delays in service requests, untreated symptoms, and lack of support for informal caregivers \[3,5,6\]. The concept of case management has been suggested as a strategy to optimize multidisciplinary care \[3,7\]. The aim of case management is to improve the patients’ quality of life (QOL) and reduce caregiver strain \[3,7\].

Recently, a randomized controlled trial (RCT) on the effect of case management, provided in addition to usual care and tailored to patients’ needs, was performed. Case management started by offering a comprehensive coordination of services across the continuum of care as viewed from the patient’s perspective. Using a client-centered approach, the case manager provided additional support for somatic, psychosocial, and environmental problems. The study found no benefits for patients’ QOL and caregiver strain compared to the usual Dutch ALS care, which is provided by multidisciplinary secondary care teams \[3\]. However, some patients did report benefits during the RCT.

Therefore, this qualitative study explores patients’ care needs and the experiences of patients, spousal caregivers and professionals with case management coupled with multidisciplinary ALS care. The article also identifies what aspects of case management may have additional value to the usual multidisciplinary ALS care and factors for receptiveness to case management.

METHODS

Study design
In this study, we were interested in the subjective experiences of patients, caregivers and professionals with case management intervention. We used qualitative methods as these are preferred for gaining an understanding of the experiences and life-world context of people \[8\]. We explored perceptions of case management in ALS care among relevant stakeholders (patients, caregivers, healthcare professionals). More specifically, we aimed to identify factors that might influence how and why people with ALS and their carers engage with case management care \[9\].

Data collection process
Using the responsive evaluation approach, the study consisted of four phases (see Supplementary Appendix 1) \[10\]. Data collection consisted of interviews and a focus group. The process of data collection and analysis was iterative, as the process alternated during the research; we analysed interviews during the process of data collection. In this way, the
emerging themes could be further explored and validated in the following interviews and focus group until saturation was reached.

Participants: interviews
We recruited patients and caregivers from the RCT cohort. Professionals were rehabilitation medicine consultants (RMCs) and the case managers involved in the RCT. We used purposive selection to capture diversity in some characteristics of the patients. Characteristics such as age, gender, rate of progression (defined as change score in ALSFRS-R: slow progression = < 6 points/year, medium progression = 6–12 points/year and rapid progression = >12 points/year) \(^{11}\), and current stage of ALS were taken into account. In addition, to make sure that positive and negative experiences were included, we examined both variation in the extent to which patients and caregivers made an appeal to case management and perceived benefit from case management (judged by the case manager). Also, we enrolled patients from different ALS teams, because the care delivered by the ALS teams may differ.

Participants: focus group
We recruited participants for the focus group via purposive selection to create a diverse group with equal numerical representation of the different groups of stakeholders. The aim of the focus group was to enhance the credibility of the findings, by checking whether the care needs mentioned in the interviews were recognised by a wider group of patients and caregivers \(^ {12}\). Furthermore, patients, caregivers and professionals discussed whether appreciated aspects of case management could be incorporated in the usual ALS care, with or without case management. Participants formulated suggestions for ALS care improvements to meet patients’ and caregivers’ needs. We chose patients, caregivers and professionals familiar with ALS care (not necessarily involved in the RCT). In addition, we selected participants according to age, gender, a variety in ALS teams and different disciplinary backgrounds of the professionals.

Data collection
To explore the needs and experiences with case management, interviews with patients, caregivers, and professionals were conducted. During the interviews we used an interview guide (see Supplementary Appendix 2). The guide contained topics about experiences with the usual ALS care, case management and the case manager.

Interviews with patients and caregivers took place in their homes, for privacy and comfort. If possible, interviews with patients were held separately from the interview with their caregiver. During some interviews the caregiver attended the interview with the patient for practical reasons such as assisting in the communication with bulbar affected patients. The interviews with professionals took place at their work space. After permission, we audio-recorded the interviews and transcribed them verbatim. Interviews were conducted
between October 2010 and July 2011. Subsequently, a focus group was organized. The focus group session was audio-taped and transcribed verbatim after permission.

Data analysis
For this study we used inductive content analysis 13. This approach moves from the specific to the general, so that particular instances are observed and then combined into a larger whole or general statement 14. Individual research team members read all transcripts and cross-case analysed them with constant comparison. All emerging themes in the transcripts were marked, labelled and compared within the team to increase dependability and to reach consensus on the discussed themes 15. The themes of all transcripts were grouped together. This created a list of recurring themes. The corresponding quotes were compared and the most suitable were selected for the final report.

We added information about the participants’ background in the Results section (Tables II-IX). Additionally, we provided information about age, gender and rate of progression in cases where the quotation is from a patient or caregiver. Quotations from the focus group do not contain this latter information, because participants were not given a respondent number.

Specific quality procedures used to improve dependability and credibility of our research are described in Table I.

Table I. Quality procedures.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Explanation and reason</th>
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<tr>
<td><strong>Member check</strong></td>
<td>To enhance credibility, all participants received an interpretation of their interview or focus group and were asked if they recognised the analysis 15.</td>
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<tr>
<td><strong>Investigator triangulation</strong></td>
<td>Different investigators were involved in the analysis process. The investigators arrived at the same conclusions, which heightened our confidence 24.</td>
</tr>
<tr>
<td><strong>Methodological triangulation</strong></td>
<td>We used interviews as well as a focus group for data collection in order to increase the credibility of the study 24.</td>
</tr>
<tr>
<td><strong>Data triangulation</strong></td>
<td>We interviewed different sources (patients, partners, professionals) in order to increase the credibility of the study 15.</td>
</tr>
<tr>
<td><strong>Saturation</strong></td>
<td>Saturation in data collection is when no new or relevant information emerges and data collection stops. In order to verify whether we reached the saturation point, we conducted the analysis during the process of data collection. After 10 cases in each group (patients, caregivers and professionals) no new codes emerged and therefore saturation was reached. During the focus group no new care needs were identified indicating that saturation was reached 15.</td>
</tr>
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</table>
Ethics considerations
The followed procedures were in accordance with the ethics standards of the Medical Ethics Committee of the VU Medical Centre and Academic Medical Centre. All participants voluntarily took part. Confidentiality was maintained using restricted, secure access to the data, destruction of audio tapes following transcription and de-identifying the transcripts.

RESULTS

We conducted interviews with patients (n=10), caregivers (n=10) and professionals (eight RMCs and two case managers). The group of patients comprised three females and seven males, ranging in age from 51 to 74 years (mean age 61 years), with a disease duration of 0.6 to 66 months (mean, 28.5 months). Rate of progression was slow in four cases, medium in four cases and rapid in two cases. All were married and had children. We held a focus group with six patients, four caregivers, one RMC, one speech therapist, two psychologists, two physical therapists, two occupational therapists and two social workers. Similar themes and issues arose in the interviews and the focus group. Patients and caregivers who participated in the focus group recognized the care needs that emerged from the interviews. We derived two main themes from the interviews and focus group: ‘needs for and receptiveness to case management’ and ‘appreciated aspects of case management’.

Case management: needs and receptiveness

Four factors emerged from the data that appear to influence patients’ and caregivers’ needs for and receptiveness to case management.

Functioning of the multidisciplinary ALS team. The need for case management was determined by the participants’ perception of the ALS team functioning. Some patients and caregivers perceived the level of functioning of the ALS team as suboptimal and reported surplus value of case management for optimizing ALS care (Table II, quote 1, 2). Professionals also recognized that case management can be of surplus value in the case of suboptimal functioning of the ALS team (Table II, quote 3).
Table II. Quotations about the functioning of the multidisciplinary ALS care.

1. “The case manager was the constant factor in the ALS care. Our ALS team had a large turnover and some team members were not very experienced.” (R16, female caregiver, 58, medium progression)
2. “The case manager filled the gaps of the regular care of the ALS team. (...) The regular care consists of separate “isles”.” (R7, male patient, 57, medium progression)
3. “I’ve seen it very often in the intervention group, that if everything in the ALS team functions well, that means that the primary care, the general practitioner, maybe paramedical support, the home care, if everything functions well and the contact is satisfactory, then I have very little to add as a case manager. Maybe even nothing.” (R21, case manager)

Rate of progression. Mostly professionals recognised the influence of the disease process as relevant for the receptiveness to case management among patients and caregivers (Table III, quote 1). With a slow rate of progression, the need for assistive devices, home care services, and other forms of support was often less acute and therefore easier to anticipate by patients and caregivers themselves. In the case of more rapid progression, anticipation was harder and the help from a case manager was often welcomed (Table III, quotes 2, 3).

Table III. Quotations about the rate of progression.

1. “In case of rapid progression, people are more in need of support, to try to get everything organized in time.” (R24, case manager)
2. “If the disease progresses rapidly, you might start to panic. Then you need someone who can arrange things for you.” (R14, female caregiver, 65, slow progression)
3. “I think my need for support will increase as he will suffer from more dysfunctions that we have to deal with. I think he [the case manager, eds] could have meant more for me in the future, because the situation will get harder.” (R17, female caregiver, 51, medium progression)

Personal factors. The degree to which patients and caregivers experienced a need for case management was also influenced by the personal factors of patients. Some couples were independent, self-sufficient and wanted to organize the care themselves (Table IV, quote 1). Other couples were less self-assertive or less self-sufficient, and welcomed support with applications for assistive devices and home adaptations (Table IV, quote 2). The coping style of those involved also influenced the need for case management. The case manager reported the need to support patients and caregivers who could not adequately cope with the situation by informing them about the future disease course and the impacts on daily functioning (Table IV, quote 3).
Table IV. Quotations about the personal factors.

1. “If something needs to be organized, we’ll do it ourselves. We don’t need a case manager for that.” (R15, female caregiver, 74, slow progression)
2. “We already have a lot of experience, because of our son (who has Duchenne, eds). Back then, it felt very different, we still had to learn everything. Now, I was able to arrange things myself, but people who don’t have this experience are not going to arrange things, because they don’t know what the possibilities are.” (R3, female patient, 58, rapid progression)
3. “You should advise people who bury their head in the sand and pretend the problem does not exist. You need to make sure that they won’t be taken by surprise. And people who tend to keep on going, need to be slowed down, to make sure they have some energy left for the long term.” (R27, rehabilitation medicine consultant)

Social network support. The extent to which patients with ALS and caregivers relied on their social network also influenced the need for case management. Professionals recognised a difference in need between patients with and without a partner (Table V, quote 1). Also, the quantity and quality of the social network support influenced the need for case management. Patients with an extended social network showed less need than those with a small network. A small network with enough support also led to a lower demand for case management. For example, in some cases, children supported the patient with the necessary applications and gave practical and emotional support which decreased the need for case management (Table V, quotes 2, 3).

Table V. Quotations about the social network.

1. “I can imagine that maybe people without a partner might need a case manager, to think along with them or to organize things with them.” (R31, rehabilitation medicine consultant)
2. “The kids take care of a whole bunch of things.” (R15, female caregiver, 74, slow progression)
3. “The practical help (is important, eds), for example that people are willing to mow the lawn. That kind of practical support definitely helps this couple to handle the situation.” (R22, case manager)

Case management: appreciated aspects

Most participants appreciated the house calls, ample time for consultation, proactive consultation and emotional support of the case manager.

House calls. House calls were highly appreciated by all stakeholder groups (Table VI, quote 1). The informal and accessible style of case management was perceived as complementary to the usual ALS care (Table VI, quote 2). Although most ALS teams have professionals who visit the patient at home, the combination of the house calls and the time the case manager had for these visits was of added value for most patients and caregivers.
Table VI. Quotations about house calls.

1. “After a short term, he made house calls. That was very nice!” (R1, female patient, 55, rapid progression)
2. “The case manager makes house calls, that is very convenient for the patient, and he was easily accessible. She [the patient, eds] can call us, of course, but that is still different from having a conversation at the coffee table.” (R31, rehabilitation medicine consultant)

Time. All participants experienced the time the case manager had for the patients as a great advantage (Table VII, quotes 1-3). The case manager had ample time to talk with the patient and caregiver. The duration of the visits by the case manager ranged from one to three hours, depending on the needs of the patient and caregiver. This contrasts with the strict time-limits of the ALS team consultations where people work on a much tighter schedule. The combination of time and home visits made it possible for the case manager to provide person-centred care.

A downside of this type of care is that it is relatively expensive; the case manager cannot visit more than one or two patients a day (Table VII, quote 4). A concern expressed by the patients was that, even though case managers did not work on a tight schedule, they visited patients on prearranged days and were not available upon immediate request (Table VII, quote 5).

Table VII. Quotations about time.

1. “I think it’s much easier this way, because the case manager sits here at the coffee table in my own house, not restrained by the idea that he has another appointment. That is very different from an occupational therapist or physical therapist and all that kind of care. They work by the hour, and whether they like it or not, at a certain point the next patient is standing at their door and then he has to finish the session even if we were not finished yet. So the fact that the case manager has ample time makes it very useful for me. The case manager sometimes stayed here for hours.” (R9, male patient, 59, medium progression)
2. “As soon as I walk into a hospital (…) I have the feeling that the time is limited.” (R12, male caregiver, 55, rapid progression)
3. “I think the fact that the case manager makes house calls and has ample time is the most important.” (R33, rehabilitation medicine consultant)
4. “The next couple of years, the possibilities will only decrease instead of increase.” (professional)
5. “You can’t always plan every conversation in advance.” (patient)

Proactive care. Patients and caregivers appreciated the proactive approach of the case manager. Using a proactive approach, case managers felt they were able to adequately list the care needs of patients (Table VIII, quote 1). Most patients felt reluctant to anticipate new care needs beforehand. The case manager prompted them to think about future care needs and informed them about the procedures. Patients felt grateful that the case manager had raised these topics during an early stage (Table VIII, quote 2).
Table VIII. Quotations about proactive care.

1. “I felt the care of the ALS team was quite distant. The occupational therapist had a very “wait and see” attitude and waited for the couple to take the initiative. But this was not a couple that asked a lot of questions. They sometimes had concerns that I could alleviate quite easily.” (R25, case manager)
2. “I tend to think “we’ll see...”, but then you are really too late. The case manager attends to me about things and helps with it.” (R7, male patient, 57, medium progression)

Emotional support. Emotional support of the case manager was valued by most patients and caregivers. Patients reported the case manager enhanced feelings of safety (Table IX, quotes 1, 2), and assisted in coping with their situation through reflections (Table IX, quote 3) and sharing emotions (Table IX, quote 4). Professionals mainly appreciated the practical support, such as gathering information or assisting with the application of a medical device. Professionals did not mention the potential added value of emotional support.

Table IX. Quotations about emotional support.

1. “It is a nice feeling that there is someone there for you. Even if you don’t have any questions, it is nice to know that you could ask him if you wanted to.” (R14, female caregiver, 65, slow progression)
2. “I felt calmer with a case manager than without. I felt reassured that everything was taken good care of.” (R16, female caregiver 58, , medium progression)
3. “The consultations with the case manager helped me to reflect on the situation.” (R2, male patient, 51, medium progression)
4. “It gives you the possibility to tell your story again. That makes it more bearable” (R18, female caregiver, 51, medium progression)

DISCUSSION

Principle findings
This study revealed insight into the experiences of patients, their spousal caregivers and professionals with case management in addition to the usual multidisciplinary ALS care. Appreciated aspects of case management intervention included house calls, with ample time for consultation, and the proactive approach by the case manager. Patients and caregivers appreciated the emotional support while professionals did not mention this. Data revealed factors that may affect the potential need of case management support: perceived quality of the usual ALS care as suboptimal, a more rapid rate of disease progression, passive coping styles and poor social network support.

Comparison with RCT on case management
The RCT on case management showed no significant benefit to patients’ QOL, caregiver strain, or increased satisfaction with care of patients and caregivers when added to the
usual multidisciplinary ALS care. Our findings describe why not all patients and caregivers experienced a need for case management. Responsiveness to ALS case management is lower when there is satisfaction with the usual ALS care, low or medium rate of progression, independence and self-sufficiency, adequate coping and a supportive social network.

**Comparison with other studies**

Experiences with case management in the context of ALS care have, to our knowledge, not to date been investigated. Relevant studies in other fields corroborate the appreciated aspects of case management found in our study, including accessibility, time, and personal contact.

Studies concerning the emotional support by professional caregivers in ALS care show that patients and caregivers feel that their need for emotional support is not always met. This is remarkable, as different studies describe that emotional support is one of the primary expectations of service users in ALS care. The results of our study point in the same direction, revealing that the need for emotional support is mentioned by the patients and caregivers, but not by the professionals.

**Study limitations**

The results of our study must be viewed in the context of the Dutch ALS care setting in which specialized ALS teams provide multidisciplinary care according to international guidelines. The Dutch ALS care, its financing and reimbursement are well organized. Responsiveness to case management might be influenced by this specific context. Readers can assess whether findings can be transferred to their situation. Another limitation was the limited variety of the patient group. We did not capture the full diversity of the syndrome of ALS, and our sample did not include patients with cognitive and behavioural dysfunction (as this was among the exclusion criteria for the RCT). Furthermore, patients with young families, single patients and caregivers with health problems were not included. Those patients and caregivers might have care needs different from those mentioned in the current data. Further research is required to explore the impact of other medical, interpersonal and financial factors on care needs.

**Clinical implications**

Experiences with case management can be used to improve the usual ALS care. Our results suggest that in specific circumstances aspects of case management can be of added value to the multidisciplinary ALS care. Therefore, it is important to identify the specific circumstances of individual patients and their caregivers. These specific circumstances — perceived suboptimal quality of ALS care, a progressive disease course, personal factors, e.g., inability to ask for support, a passive coping style, and poor social network support — could be used as a decision guide to tailor care to the needs of patients and caregivers.
Additional support can be drawn from the ALS care team, with one of the team members providing extra support.

**CONCLUSIONS**

This qualitative study has increased our understanding of the particular care needs of patients with ALS and their caregivers. ALS teams might consider implementation of valued aspects of case management (accessibility, ample time, proactive approach, emotional support) in the usual ALS care. Because not all patients experienced a need for case management, additional support especially might be offered to vulnerable patients with a rapidly progressive disease course, passive coping style and restricted social network.

**ACKNOWLEDGEMENT**

We thank the patients, their caregivers and the professionals for sharing their stories and experiences with us. We also thank H. van den Oever and R. Janssens for their contribution to data collection and analysis.
REFERENCES

Chapter 5


### Appendix 1. Study phases.

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<tr>
<th>Phase</th>
<th>Activities</th>
<th>Goal</th>
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<tbody>
<tr>
<td><strong>Exploration</strong></td>
<td>Reading literature and stories of patients.</td>
<td>Getting insight into living with ALS and getting input for the topic list.</td>
</tr>
<tr>
<td></td>
<td>Getting insight into living with ALS and getting input for the topic list.</td>
<td>A topic list is used in order to check if all relevant topics are discussed during an interview.</td>
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<tr>
<td></td>
<td>Selection of patients from the list of the intervention group of the RCT on case management.</td>
<td>To arrive at a selection of patients who are going to be contacted and informed about the study. To get maximal variation, to get as many perspectives as possible and to learn as much as possible.</td>
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<tr>
<td><strong>Consultation</strong></td>
<td>Recruiting participants.</td>
<td>Making contact by telephone, sending the information letter about the content of the study.</td>
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<td></td>
<td>Semi-structured interviews (n=30).</td>
<td>Getting information about the experiences with the case manager and the care needs of the patients with ALS and their caregivers and what possibly should improve. The conversations were furthermore aimed at getting information on how physicians in PMR experienced case management.</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td>Thematic content analyses of the interviews.</td>
<td>Obtaining a first insight into relevant themes. To use the information as input for the following interviews.</td>
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<tr>
<td></td>
<td>Meeting of the research team.</td>
<td>Validating and deepening the analyses of the interviews.</td>
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<tr>
<td></td>
<td>One focus-group (n=20)</td>
<td>Validating and deepening the information from the interviews and clustering the data from the interviews leading to an overview of factors (personal and environmental) that support and are associated with patients’ and caregivers’ needs and improvements of ALS care.</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>A meeting of the research team.</td>
<td>Formulation of methods and actions that may lead to the availability of case management for patients with ALS and their caregivers.</td>
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<td></td>
<td>Writing the research report.</td>
<td>Describing the project and results in order to disseminate knowledge, in order to improve the care for patients with ALS and their caregivers.</td>
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<tr>
<td></td>
<td>A meeting of the research team.</td>
<td>Getting feedback on research report and getting ideas for implementation of results and needed actions in order to improve the care for patients with ALS and their caregivers.</td>
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Appendix 2. Interview guides.

The topic guides are based on professionals’ experiences with ALS care and on literature providing insight in patients’ experiences with living with ALS \(^\text{26,27}\) and on aspects that might influence the experiences of patients with case management, i.e. disease duration \(^\text{28}\).

**Interview guide for patients and caregivers**

*General information about the interview*
- Personal introduction
- Brief explanation about the project
- Aim of the interview
- Anticipated duration of the interview
- Informed consent to record the interview
- Information about anonymising the interview
- Member check possible?
- Explain that the respondents will receive a copy of the final report

*Personal details*
- Diagnosis
- Date of diagnosis
- Age
- Gender
- Education
- Marital status
- Formal or informal health care (or both)
- Job (before and after the diagnosis)
- Most important limitations (complaints, quality of life, limitations)

*Life with ALS*
- Period prior to the diagnosis (i.e. complaints, emotions, doubts, consultations)
- Period during the diagnosis and shortly after the diagnosis
- Life with ALS since the diagnosis until now (outlook on life, attitude towards the illness, approach to managing changing circumstances, orientation to time)

*Formal and informal care prior to and during the case manager project*
- Did you receive formal or informal support before the case manager started?
- If yes, what kind of support?
- How have you experienced this support?
- Was there anything lacking in the support/counselling?
- If yes, what?
Motives and expectations
- For what reason did you sign up for the case manager?
- What were your expectations beforehand regarding the case manager support?
- What needs did you have beforehand regarding the case manager support?

Experiences with the case manager
- What kind of support did you receive from the case manager (practical as well as emotional)?
- How did you experience the actions of the case manager?
- What is your opinion on the expertise of and support from the case manager? (expertise, treatment, communication)
- Did it yield anything for you? Why?
- Did it meet your expectations?
- Did you receive other forms of support besides the case manager?
- Could someone else have given you the support the case manager provided? If yes, who?

The period after case management
- How did you feel about finishing case management (i.e. is anything missing, is someone else giving additional support)?
- Do you think case management has changed something for the foreseeable future? What?
- What kind of support/counselling do you receive? From whom?

Advice
- What could be improved?
- What should be preserved?
- Would you advise peers to get a case manager? Why (not)?

Conclusion
- Is there anything you would like to add to this interview?
- Thank you for your time
- Explanation about the report

Interview guide for professionals
General information about the interview
- Personal introduction
- Brief explanation about the project
- Aim of the interview
- Anticipated duration of the interview
- Informed consent to record the interview
- Information about anonymising the interview
Chapter 5

- Member check possible?
- Explain that the respondents will receive a copy of the final report

**Personal details**
- Education
- Experience with ALS care
- Age
- Gender

**Experiences with the case manager**
- What did the case manager offer in your opinion?
- What do you think the case manager could offer (potentially)?
- What do you think of the existing ALS care? Are there any gaps? Who should fill them?
- Could someone else have given the support the case manager provided? If yes, who?

**The period after case management**
- What is the ALS care like now, after the case manager finished (is there anything missing, is someone else giving more support now etc.)?

**Advice about this form of support**
- What could be improved?
- What should be preserved?
- Would you advise other patients to get a case manager? Why (not)?

**Conclusion**
- Is there anything you would like to add to this interview?
- Thank you for your time
- Explanation about the report