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ORIGINAL RESEARCH

Exploring Goal-Setting and Achievement Within Reablement: A Comparative Case Study of Three Countries

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Purpose: Over the last two decades, reablement programs have been studied and implemented internationally. Goal-setting and multidisciplinary collaboration are central elements of reablement. Unfortunately, limited intervention descriptions leave questions on how they are applied in practice and how goals set by the user are achieved. As a consequence, healthcare providers and organizations often lack knowledge to implement and align reablement to their national and local context. This study aimed to collect data on goal-setting and achievement, and multidisciplinary collaboration within reablement services to provide insight into how these processes inform reablement practice as well as to explore the experiences of healthcare professionals in Norway, New Zealand, and the Netherlands.

Material and Methods: A qualitative exploratory design was used comprising three focus group interviews with 20 healthcare professionals (nursing and allied health) involved in reablement programs from the three countries. Purposive sampling was employed considering a mix of gender, age and educational level.

Results: Findings reflected healthcare professionals' experiences and reablement processes in three main themes: (1) Goal-setting processes; clearly demonstrating goal-setting as an essential part of reablement and contributing to better understanding of users' motives; (2) Impact of goal-setting on multidisciplinary collaboration; promoting a sense of community, learning climate, job satisfaction and task-shifting; and (3) Behavior change techniques used to reach users' goals, promoting self-reflection and changing users' perspectives.

Conclusion: This study offers valuable insights from three countries. Goal-setting serves a crucial role enabling effective reablement implementation across diverse contexts. More specifically, to facilitate tailoring of reablement programs to the user's needs as well as establish more effective multidisciplinary collaboration by promoting trust, shared vision, and utilizing each other's expertise. However, despite the acknowledgement of the significance of reablement, it was reported by all that a cultural shift is necessary for users, informal caregivers as well as healthcare professionals.

Keywords: restorative care, goal-oriented care, multidisciplinary collaboration, person-centered care

Introduction

Almost every country in the world is experiencing a proportional increase in its older population (65+) and although this is a success story of modern times, aging does result in higher care dependency.[1] To address the aging population, numerous countries have focused on developing services that enable older people to remain as independent as possible in their own homes and continue to participate in society whilst minimizing the use of formal funded services.[2] Therefore, concepts such as reablement have gained much attention within Western countries over the last decades and have been included in various national and international policies aimed at healthy aging.[3] Reablement is defined as a holistic and person-centered approach

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that aims to enhance individuals' functioning, increasing or maintaining their independence in meaningful activities of daily living and reducing their need for long-term care. A trained and coordinated multidisciplinary team delivers interventions to meet individuals' meaningful goals. It is an inclusive approach irrespective of the person's age, capacity, diagnosis, or setting.[4] Although evidence concerning the impact of reablement on user outcomes remains mixed, satisfaction levels are high.[5] Moreover, healthcare professionals indicate that reablement facilitates a shift in work culture through a "different way of thinking", creates higher engagement, promotes professional development and offers a better framework for collaboration and application of reablement.[6–8] There are indications that reablement may be able to reduce the need for ongoing care and permanent admissions.[9,10]

Over the last two decades, reablement programs have been studied and implemented partially or fully in 15 countries.[11] In these countries, levels of experience differ, leading to different stages of reablement implementation within each nation.[12,13] Much of the difficulty in interpreting the value of reablement comes from wide variability between countries and indeed within countries in relation to how it is delivered.[14] However, despite such variability, it is apparent that goal setting, achieving these goals and multidisciplinary collaboration are central aspects of reablement, irrespective of the model or method of delivery.[4,13] Goals serve as guidance, directing the efforts of healthcare professionals and users receiving care toward specific milestones and objectives.[15] These goals also offer a means to measure progress and success throughout the reablement process. By setting clear and individualized goals, healthcare providers can tailor their interventions to meet the users' wishes and needs.[16] Unfortunately, limited intervention descriptions leave questions on how these elements are applied in practice and how the goals set by the user are achieved.[11,17,18] As a consequence, healthcare providers and organizations lack the essential details needed to put reablement into practice and fit their national and local context. A better description of reablement content and implementation aspects can enhance the provision of reablement and allow countries to learn from each other.[19] Relying solely on literature and textbook descriptions falls short of providing a comprehensive understanding. To grasp and uncover the practical aspects, it is imperative to obtain invaluable insights from the real-world experiences of healthcare professionals in their daily practice,[20] particularly when those perspectives arise from health professionals working within established reablement models.[4,21,22]

The current qualitative study aims to (1) collect data on the processes of goal-setting, achievement, and multidisciplinary collaboration within reablement to provide context, and (2) provide insight into experiences of healthcare professionals with these processes within reablement programs in Norway (NO), New Zealand (NZ) and the Netherlands (NL). These three countries were selected because of their contrasting experience with implementing reablement programs, healthcare policies, funding, geography and years since reablement was implemented.[12,13] In NL, implementation of reablement is still in its early stages starting with a local training program in 2015, and has no national guidance or policy.[14] NO and NZ have had centralized policies and plan structures in place since 2011 and 2000 respectively, that have provided a coherent and sustainable base for implementation.[14] Therefore, each country shows a different representation of what reablement can look like in practice, which corresponds to the variation we see internationally. All three countries have conducted larger trials and further developed reablement programs based on their results, providing sufficient background information and experience to draw from.

Material and Methods

Study Design

This study employed a qualitative exploratory design and is reported according to the COnsolidated criteria for REporting Qualitative research (COREQ) to ensure transparency.[23] It comprised focus group interviews with health professionals involved in reablement programs from Norway (NO), New Zealand (NZ) and the Netherlands (NL).

Setting

The data were collected from three different cases in the municipality of Bergen (NO), Waikato district (NZ), and the province of Limburg (NL). The ReAble network[24] provided an important method of selecting both countries and programs and only those affiliated with the network were approached. The researchers (HT, MP and SFM) were asked to choose an example of a reablement program in their country. Region-specific programs, namely "Everyday Rehabilitation" (NO),[25] "START"

(NZ),[21,22] and "I-MANAGE" (NL)[26] were selected to recruit participants for data collection. Background information regarding these programs is provided in Table 1.

Sampling and Recruitment

A pragmatic sample of participants was selected based on the assessment of the involved researcher of the respective country. Participants were contacted via email, stating the study's background, objectives, and participation information. The participants were grouped per country, with a minimum of four to a maximum of ten individuals per group. The researchers aimed for a representative mix of healthcare professionals to establish a safe environment and equal distribution of roles and functions. Purposive sampling[30] was used to recruit these healthcare professionals by selecting individuals based on their capacity to provide relevant information regarding the reablement program, considering a mix of gender, age and educational level. Healthcare professionals were defined as home care professionals, such as registered nurses and nursing assistants and allied health professionals, such as occupational or physical therapists.

Data Collection

Focus group interviews were conducted face-to-face in NZ and NL and online using Microsoft Teams in NO. The focus groups were conducted between February 2022 and March 2023 for a duration of thirty minutes to one and a half hours. All participants provided signed informed consent after receiving information about the study and background information (ie age, gender, function and relevant working experience) was obtained. Three researchers (two females and one male), with extensive experience of conducting focus groups, participated in the data

Table 1 Background Information of Reablement Programs in Norway, New Zealand and the Netherlands

	Bergen (Norway)	**Waikato (New Zealand)**	**Limburg (The Netherlands)**
Reablement program since	Bergen-model of Everyday rehabilitation since 2015	START since 2010	I-MANAGE since 2022
Organization and funding[13]	Vague national guidance of implementation, provided by municipalities Free of charge	Integration into national home and community support services, provided by health regions Case-mix funding	No national guidance or coordination, provided by local healthcare organizations/municipalities Fee-per-hour or lump-sum funding
Target group	No lower age limit. Remain in their own home, experience functional decline and are not excluded based on a particular diagnosis	Lower age limit of ≥65 years (Māori ≥55 years). Remain in their own home, medically stable, at risk of (re)admission to the hospital or nursing home and are not excluded based on a particular diagnosis	No lower age limit. Remain in their own home, experience functional decline, can learn and apply new skills and are not excluded based on a particular diagnosis
Patient inflow and initial assessment	The municipality has a multidisciplinary assessment team that evaluates care services applications. Enrolment is also possible based on the request from others, healthcare professionals. COPM is used for the needs assessment and is conducted mostly by OT, PT, or RN	The multidisciplinary team actively "draws" patients to the Older Person's Assessment Liaison (OPAL) service in the hospital, or enrolment through the Needs Assessor Service Coordinators (NASC) linked to the general practitioner. The needs assessment is conducted mostly by an RN, sometimes PT or OT using interRAI Home Care Assessment	After a referral from the GP or ECP, an introductory meeting is scheduled with the OT employed by an elderly care organizationIf eligible, the OT will conduct the needs assessment using the COPM and Positive Health Questionnaire
Duration	4 weeks	Up to 6 weeks	8 weeks

Abbreviations: RN, registered nurse; PT, physical therapist; OT, occupational therapist; GP, general practitioner; ECP, elder care physician; COPM, Canadian Occupational Performance Measurement;[27] TARGET, Towards Achieving Realistic Goal in Elders Tool;[28] InterRAI, Inter-Resident Assessment Instrument[29].

collection. Through a collaborative process, the researchers developed one interview guide for all focus groups, ensuring consistency across all sessions. The main themes addressed in the focus groups included: goal-setting, interventions used to reach set goals; multidisciplinary collaboration; and involvement of the user and informal caregiver. The researchers agreed on how to conduct the interviews to ensure the same principles were used. The focus groups that took place in NO, NZ and NL were moderated by researchers HT (PhD), MP (PhD) and SFM (PhD) respectively. As a moderator, they facilitated the focus groups and encouraged participants to participate in the discussions. Field notes were taken during and after each focus group and all were recorded with written consent and transcribed verbatim using simple orthographic notation. An interpreter translated the transcripts from the native languages to English. Transcripts of the focus groups were checked against the audio recording by the researcher involved and a member check was offered to all participants to make sure everything was interpreted correctly. No comments were made on the transcripts by the participants.

Data Analysis

The data collection was focused on information regarding the work processes, as well as experiences and perceived barriers and facilitators by the healthcare professionals. The process data were analyzed using a deductive content analysis[31] and described both narratively and in tabular form.

The experience-based data were analyzed using both deductive and inductive content analysis.[31,32] The deductive approach was chosen as the analysis was based on prior knowledge regarding the recurring components of existing reablement programs and the aim was to uncover how these components were applied in different contexts. The collected data were therefore structured based on prior knowledge from a review by three of the current authors.[17] Following the inductive content analysis, researchers (HT, SFM and LEB) first familiarized themselves with the data by reading the transcripts several times. The transcripts were then imported to Atlas.ti software (Windows version 23.4.0).[33] Sentences or parts of sentences with content relevant to the research questions were identified during the coding process as a unit of analysis and recorded under the predefined themes based on the topic guide (Appendix 1). This was performed by LEB and checked by a second researcher (HT or SFM), to increase reliability. Identified open codes that did not fit into the analysis matrix but were still relevant to the aim of the study, were included using inductive content analysis to form additional (sub)themes.

Qualitative Rigor

To increase rigor in terms of credibility, transferability, dependability and conformability;[34] member checking, uniform data collection methods, note-taking and direct quotations were used to analyze and present the data in this study.

Ethical Considerations

The study was registered and approved by the FHML Research Ethics Committee of Maastricht University in the Netherlands for ethics review for all countries, under approval number FHML-REC/2021/118. Informed consent was provided in all countries including publication and anonymized responses. All participants received information about the study's purposes and the right to withdraw from the study. The procedures were conducted following the principles stated in the Declaration of Helsinki.[35] All interview data from NO and NZ were anonymized and stored on the research server of Maastricht University. By General Data Protection Regulation (GDPR), no data were sent outside Europe. Data transfer agreements were established between NL and NZ. In NO, data protection procedures were approved by the Norwegian Agency for Shared Services in Education and Research in February 2022 with reference number 689719.

Results

In total, 20 healthcare professionals participated in the three focus groups. Among the participants, there were four occupational therapists, four physical therapists, three managers, three registered nurses, two certified nurse assistants, one unregulated healthcare assistant, one elder care physician (geriatrician), one nurse practitioner, and

one informal care consultant. Of these, 19 were women, participants ranged in age from 28 to 60 years old (M= 44.5 years) and had on average 3.4 years of experience working with reablement, ranging from ten months to 11 years.

Based on the research questions and the data, three main themes could be identified: (1) Goal-setting processes; (2) Impact of goal-setting on multidisciplinary collaboration; and (3) Behavior change techniques used to reach users` goals. Information regarding the processes of the aforementioned topics is shown in Tables 2–4. The qualitative data are described below.

Goal-Setting Processes

This theme describes participants' experiences with identifying, prioritizing, setting, and evaluating goals. It highlights the collaborative nature of goal-setting in reablement, involving the user, their support system, and the multidisciplinary team. The similarities and differences regarding the goal-setting processes in the three different countries are described in Table 2.

Table 2 Comparison of Goal-Oriented Approaches Within Reablement Programs

	Norway	**New Zealand**	**The Netherlands**
Goal-setting			
Application and assessment	1. Preparation: Collecting and reviewing (medical) information regarding user 2. Assessment visit Assessing eligibility and help request for reablement by two therapists	*Similar to Norway, except for*: Referral through hospital discharge service or charge nurse manager Assessment mostly by an RN, sometimes PT or OT	*Similar to Norway, except for*: Assessment by OT and/ or ECP
Identifying and prioritizing goals	3. Goal meeting: Setting goals with users using COPM semi-structured interview 4. Observation (action meeting): Observing users in the activities relating to the goals.	*Similar to Norway, except for*: TARGET and goal ladder are used for goal-setting.	*Similar to Norway, except for*: Questionnaire Positive Health with COPM used for goal-setting, after goal meeting the next step includes observation of all relevant HCPs
Setting goals	5. Setting final reablement plan during the multidisciplinary team meeting - Going from sub-goals to overall goals and vice versa	*Similar to Norway*	*Similar to Norway*
Type of goals	Everyday activity and social goals	*Similar to Norway*	*Similar to Norway*
Evaluation and follow-up	Revising goals along the way Evaluation at: - Halfway - End of program Flexibility at end of program 1-month follow-up after end of program	*Similar to Norway, except for*: Weekly evaluations Follow-up at 3, 6, 9 and 12 months	*Similar to Norway, except for*: No structural follow-up

Abbreviations: OT, occupational therapist; ECP, elder care physician; HCP, healthcare professional; COPM, Canadian Occupational Performance Measurement;[27] TARGET, Towards Achieving Realistic Goal in Elders Tool.[28]

Formulating Goals Together

The methods used to set goals were perceived as facilitating by the participants, explaining that the goal conversation allowed them to dive much deeper into the problems of the user. However, they indicated that users were often not used to setting goals and looking at their problems and challenges in this manner, or were used to having others (eg, care professionals) formulate the goals for them.

> But very many have such an expectation that there are others who set the goals for them and almost expect us as health professionals to define what is important to them. (NO)

Consequently, they would ask the users about their request for help and what they would like to achieve. The goals were usually formulated in general terms by the user and often resulted in thinking of long-term goals at first. According to the participants, it was necessary to provide support in breaking down these larger goals (eg, grocery shopping, watching the grandchildren) into more specific sub-goals (eg, walking to the store, being able to bend down) or to help the users get started on formulating the goals differently. This process was perceived as challenging and time-consuming, yet, according to them, part of the very essence of reablement.

> We have sort of focused on the fact that it is important that we spend enough time on the goal-setting process itself that we do not rush there. […] It's so important. It is the very foundation of everything that happens. (NO)

In addition, they emphasized the importance of the users formulating the goals in their own words, taking the time to let them think and letting the users be in the lead. When asked what kind of goals were set by the user, participants indicated that the goals were mainly everyday activity- and social-based. If goals originally were not based on everyday activities, the professionals would help reformulate the goals.

> The importance of having the goals in the person's own words, no one's ever said: 'I want to increase my exercise tolerance, obviously not, or improve my ADLs.' I think it's just having it in that person's own words and then working from there. (NZ)

Participants also indicated when reformulating goals, it was important to go back to their basic needs and sense of purpose in their everyday lives, which were often overshadowed and forgotten due to the intensity of the care situation.

> But I think that what has become so basic, is that sense of purpose that has faded, where you would just go about the things you normally did in everyday life, like having a cup of coffee with the neighbor. Those things suddenly aren't so obvious anymore. (NL)

Participants from NL mentioned that through the goal-setting process, they experienced a better understanding of the users' motives behind certain goals by implementing them through reablement.

> and then you work together for a very long time and when you evaluate that patient has already forgotten what goals he had set himself. I don't have that now [since working with reablement]. (NL)

Participants from all three countries mentioned that a lack of motivation, confidence and cognitive ability could hinder goal-setting. When users were unable to set goals themselves, participants felt that informal caregivers contributed positively to formulating the goals together.

> The next step is that I ask the informal caregiver to join me so that they [user and informal caregiver] can actually formulate the goals together. That's actually already going well. (NL)

Working on a Common Set of Goals

The fact that a goal conversation had taken place and therefore the team was working on a common set of goals, was in their view already facilitative for building a relationship with the user. In addition, users' awareness regarding goals and

subsequent steps increased, which facilitated motivation and further conversations about, for example, more difficult topics and obstacles.

> I think for the healthcare assistants, […] it [setting goals] helps you establish an understanding with patients so that you can build that relationship more quickly. (NZ)

Participants from NZ and NL reported that not every team member had access to the formulated goals and therefore, for example, reporting on the progress of goal achievement was difficult. Participants from NO did not experience these hindrances.

> There's one goal ladder, but I think we don't have the ability to integrate them very easily on the electronic [patient file]… Well, we're using a Word document and so there isn't the ability for the likes of PT to come in and just add their little bit, or the OT to add their little bit. (NZ)

Evaluating Goals

In NO and NZ no specific facilitators and barriers were experienced concerning the evaluation process. In NL however, participants indicated that they experienced the short period of the program as both facilitating and hindering. They appreciated the time-limited approach but noted that users were often fearful of losing care.

> Here, you are very clear in advance about these are the goals and when these goals are achieved, the intention is that we stop the treatment. But by that time, they will have come up with other goals. And of course, that's fine if you work towards something step by step, but actually, people just don't want you to let go of them. They're very afraid of that. (NL)

Impact of Goal-Setting on Multidisciplinary Collaboration

This theme describes participants' experiences and their perspectives on the impact of goal-setting within multidisciplinary teams. It highlights how goal-setting plays a central role in enhancing collaboration and communication among team members. Additionally, it describes how users, informal caregivers and healthcare professionals are involved in reablement programs. Moreover, Table 3 describes the organizational structures of the multidisciplinary teams, the professions standardly involved and roles and task distribution.

Table 3 Comparison of Organizational Structures of Multidisciplinary Teams Within Reablement Programs

	Bergen (Norway)	**Waikato (New Zealand)**	**Limburg (The Netherlands)**
Roles and tasks			
Professions within the reablement team	PT, OT, RN and NA. The team only works with reablement and does not have other tasks within primary care	*Identical to Norway, except for*: HCA instead of NA GP and ECP on a consulting basis	*Identical to Norway, except for*: NA is not involved, IC is standardly involved and GP and ECP on a consulting basis. The team delivers reablement as one of their tasks in primary care
Task distribution	Task shifting: Roles are assigned regardless of occupation and based on availability	*Identical to Norway*	Fixed tasks: Roles are assigned solely based on occupation

(*Continued*)

Table 3 (Continued).

	Bergen (Norway)	**Waikato (New Zealand)**	**Limburg (The Netherlands)**
Roles	1) Home trainer, in charge of daily training Advocate for the user Usually NA 2) Coordinator, team supervision, communication, meeting initiation and leadership, handles operations and logistics Can be OT, PT, or RN 3) Therapists - First therapist: coordinates, in charge of goal conversation, evaluations and development of the rehabilitation plan, supervises and talks to the home trainer daily Can be OT, PT, or RN - Second therapist: primarily consults, and participates in relevant meetings as supervisor/expert Facilitates referrals and dialogues with external HCP Can be OT, PT, or RN	1) Home trainer, in charge of daily training Advocate for the user Usually UNA 2) Coordinator, in charge of goal conversation, rehabilitation plan, team supervision, meeting initiation and leadership, handles operations and logistics Usually RN 3) Therapists Provide weekly training related to the goals and supervise the home care staffCan be OT or PT 4) Physician GP or ECP provides medical treatment and supervision when needed	1) Occupational therapist Coordinator: in charge of goal conversation, user follow-ups, rehabilitation plan, supervision and communication with the team. Provides training and coaching related to the goals for HCP and informal carers when needed 2) Physical therapist Provides training and coaching related to the goals for HCP and informal carers when needed 3) Registered nurse Combines direct care with coordination for home care staff 4) Informal care consultant Works with informal caregivers to increase capacity and reduce burden 5) PhysicianGP or ECP provides medical treatment and supervision when needed 6) Other healthcare professionals Involved when relating to the user's goals
Collaboration			
User-related meetings during the treatment phase	Weekly team meeting Daily dialogue between home trainer and therapists	Weekly team meeting Regular dialogue between home trainer and therapists	Biweekly team meeting Coaching on the job when needed

Abbreviations: RN, registered nurse; PT, physical therapist; OT, occupational therapist; NA, certified nurse assistant; HCA, unregulated healthcare assistant; GP, general practitioner; ECP, elder care physician; IC, informal care consultant; HCP, healthcare professional.

Building Relationships and Trust

All participants experienced the mutual bonds and connection between the team members as valuable as it, amongst other things, strengthened the uniformity of the team towards the user. This promoted continuous coordination and opportunities to review and adapt the care plan.

> I just have to say that the dialogue we have together multidisciplinary is worth its weight in gold. To reach the goal, the collaboration is extremely important. (NO)

Building relationships and mutual trust facilitated the team and their ability to allow themselves to be vulnerable to each other.

> The way the team is built up is that we have a great sense of confidence in one another, the trust… which we have built to each other during the time the team has existed. A lot of people have been involved for quite some time. And there is also great openness. (NO)

Participants all emphasized that the bond built between the user and the reablement team was very important as, in addition to this, continuity of care was also promoted. The continuous dialogue between users and healthcare

professionals was regularly mentioned as important for achieving goals. Moreover, since the user is in the lead, this facilitated active user involvement and a relationship of trust and was seen as a success factor for reablement.

> When it is mostly the same home trainer who goes every day, we build, we get to know the user very well and build that trust and observe the development along the way. (NO)

Participants experienced that working on a common set of goals, strengthened collaboration and kept working according to the reablement philosophy in focus as a team.

> I just feel that it is not a challenge [keeping the reablement philosophy in focus] because we all agree that what is important for the user is in focus. And that we work for what's important to the user. (NO)

Deeper Understanding Within the Team

Contributing to better collaboration, they also obtained a deeper understanding of each other's work and capabilities related to each other's profession. It facilitated a learning climate, where team members learned with and from each other. All participants indicated that working together in a reablement team led to contacting each other faster when they had specific questions.

> We [home trainers] are happy to go with the therapist if we come upon challenges or something we are wondering about. Then they are happy to come in and go through it with us. (NO)

> those lines of communication with everyone (within the team) are very short and you work together on one set of goals. […] And now you can coordinate that very well on who does what part of the overall goal package. So I like that. (NL)

Participants felt this enhanced the satisfaction within the team, as they found their work more fulfilling and rewarding when working with reablement.

> I must say that I experience that multidisciplinary collaboration works very well. Much better than what I have experienced before. Because we work so closely together in teams. So, we learn a lot from each other and it spreads to one another. So, I feel like it really works well. (NO)

Hierarchy Within the Team

Participants also highlighted the fact that there was no hierarchy within the teams. The "higher" educated professionals did not have a superior role. For example, home trainers in NO are seen as advocates of the users' wishes.

> It is not the case that some [team members] are more important than others, we are very equal. So, we do not have such a hierarchy in relation to it. (NO)

Participants from NO and NZ indicated the collaboration process promoted "task shifting"; where roles are assigned based on availability regardless of occupation, while in NL roles are assigned solely based on occupation. Task shifting allows for improved coordination and collaboration and offers flexibility and faster deployment of reablement.

> I like to think that we're one of the true multidisciplinary teams. We have nurses setting up […] and ordering equipment and […] setting up a basic exercise program until the PT or OT can see them, which is a really, really, good attribute. (NZ)

Barriers During Collaboration

No barriers in the collaboration process were perceived by NO participants. Participants from NZ mentioned the large time investment for the multidisciplinary team meetings as a barrier. As in NL reablement is a relatively new concept, participants mentioned they experienced difficulties organizing it, more specifically during the start-up phase of a new user.

> It's difficult if I [physical therapist] already get a patient, that might be a reablement trajectory […] but you can't start if the OT hasn't been there yet. […] And that is, when I think about it, often a problem. Being able to involve all professionals on time [at the start of the program]. (NL)

Techniques Used to Reach Users` Goals

This theme describes the behavioral and cultural changes necessary to reach users' goals. It highlights how behavior change techniques play an important role when striving for goal achievement. Creating awareness, self-reflection and changing perspectives of the user played an important role in achieving and maintaining goals. Additionally, Table 4 provides examples of the behavior change techniques groups and techniques mentioned by the participants. Michie et al[36] described 93 behavior change techniques clustered in 16 groups, while in the current study, 10 groups and 16 techniques are identified (Table 4). In the following text, the behavior change technique groups are described as (Group name).

Table 4 Overview of Behavior Change Techniques Used by Reablement Teams

Group	Behavior change technique	Example
1. Goals and planning	Problem solving	Ask user to identify factors of influence and think of strategies to overcome barriers to perform desired behavior
	Action planning	Detailed planning of performance of the desired behavior (context, frequency, duration and intensity)
2. Feedback and monitoring	Feedback on behavior	Observing and providing feedback on performance of behavior
	Feedback on outcome(s) of behavior	Observing and providing feedback on the outcome of performance of the behavior
3. Social support	Social support (unspecified)	Arranging and/or providing practical or emotional help for performing the desired behavior
4. Shaping knowledge	Instruction on how to perform the behavior	Advise or agree on how to perform the desired behavior
5. Natural consequences	Information about health consequences	Providing information about health consequences of performing the desired behavior
	Information about emotional consequences	Providing information about emotional consequences of performing the desired behavior
7. Associations	Prompts/cues	Using environmental or social stimuli to prompt or cue the behavior
	Exposure	Systematically exposing to a feared activity to build confidence
	Associative learning	Teaching the user that certain behaviors or activities lead to positive outcomes or emotional responses
8. Repetition and substitution	Graded tasks	Setting easy-to-perform tasks, making them increasingly difficult, but achievable, until desired behavior is reached
10. Reward and threat	Incentive (self)	Using activities meaningful (end-goal) to the individual as a reward if they put effort in reaching sub goals to achieve the behavioral outcome
12. Antecedents	Restructuring the physical environment	Changing the physical environment in order to facilitate the desired behavior or create barriers to the old behavior (other than prompts/cues, rewards and punishments)
	Restructuring the social environment	Changing the social environment in order to facilitate the desired behavior or create barriers to the old behavior (other than prompts/cues, rewards and punishments)
13. Identity	Framing/reframing	Suggesting to adopt a perspective or new perspective on behavior (eg its purpose) to change cognitions or emotions about performing the behavior

Note: Groups are numbered in accordance with the groupings of the behavior change taxonomy by Michie et al.[36]

Changing User Perception

Participants indicated that techniques focusing on the cognitive aspect of the users` reablement process were as important as the physical aspect.

> Yes, we work almost as much with the mental, I think, than the physical many times. (NO)

The cognitive aspect (eg, changing the way the user perceives certain things surrounding their care or performing activities) can be broken down into several techniques mentioned by the participants, such as techniques creating awareness using feedback on behavior or outcomes (Feedback and monitoring) and using problem-solving techniques (Goals and planning).

> I think, if we can clearly say well we're doing this exercise which will help you with your lunging so you can get back to bowling, then we will have a better understanding of why we're doing it, as opposed to, I'm just doing this, but I don't know why. (NZ)

> The users say: 'I want to learn to walk better.' Okay, but what do you need for that? You know, having that whole conversation beforehand about how are we going to walk better, what it is all about. (NL)

User Motivation

Moreover, participants felt that motivating users, and using techniques offering meaningful incentives (Reward and threat) and knowledge regarding what skills are needed to achieve the goals (Shaping knowledge), also contributed to progress.

> Sometimes I say: 'If you can't get them to exercise, say we're going to go to the cafe and get them to walk to the cafe.' […] We have a win-win. You get the exercise, and you get the coffee. So, we try and be creative about how we can motivate them because motivation is the biggest key here too. (NZ)

By (re)framing the user's or informal caregiver's perspectives (Identity), participants used techniques attempting to change their cognitions or emotions on whether or not to do or take over certain tasks. (Re)framing (Identity) was used combined with techniques providing information on consequences (Natural consequences) to manage (unrealistic) expectations.

> But also, just to do it differently, because the daughter also found it very difficult to let go of the fact that her father folds laundry, so to speak, while he considers that as very important. And then I simply asked her the question, But what would happen if he did it his way and you in your way? And by making her think about that, you got another entrance. And she's really, as she just said and which then confirms a lot, she has radically changed certain things. [by not taking over certain tasks] (NL)

All participants emphasized the importance of techniques that ensured conscious (re)iteration of goals and the use of graded tasks (Repetition and substitution). Graded tasks included setting easy-to-perform tasks and gradually increasing the difficulty while keeping it achievable, while reiteration of the goals led to a heightened awareness and deliberate practice of the objectives.

> There is a lot of focus on gradually challenging, so they should gradually do things more and more independently. (NO)

This was often combined with techniques such as action planning (Goals and planning), but also using prompts and cues, associative learning and gradual exposure (Associations) to do it independently.

> Because they take the challenge right there […] And the next time we likely make a deal that the person walks to the store on their own and talk on the phone on the way. Or meet at the front door or. That you quietly move yourself away […] when the user starts to achieve the goal themselves, it is very important we must pull out when we see that the user has achieved the goal. (NO)

Involvement of Others

Social support was also a technique frequently used by the participants, where informal caregivers were considered to be a resource (Social support).

> Yes, there are many […] wonderful relatives who want everything for their own and fix things almost faster than we come up with the idea to put it that way. (NO)

However, when involving an overburdened informal caregiver, there was little room to expect anything from them during the program as they quickly felt overwhelmed.

> The only thing that can hold back is when the informal caregiver is really overburdened and then has even more appointments to attend. (NL)

Participants felt that focusing on techniques restructuring the physical and social environment (Antecedents) was beneficial, which was necessary to facilitate performance, improve the users' independence and remove the related barriers to reaching the goals. Participants experienced hindrances when informal caregivers and external healthcare professionals had different expectations of the program or when they had other goals in mind than the user.

> I think there is a barrier at times for us with the expectations that they (users) come out of hospital with [hospital creates false expectations], so goals really have to start right at the beginning. (NZ)

As a consequence, the participants had unrealistic perceptions of what the reablement team would do, which in turn were projected onto the user. The lack of knowledge about reablement was referred to as a main cause.

> We've gotten to some different expectations here from the patient in START [due to prior misinformation] so we slowly ease them into how we do things here because they can be very adamant there. The users may state: 'I was promised six weeks of START. I was promised someone would come and do my house this weekend. I was promised they'd make my bed and stuff'. (NZ)

Discussion

The purpose of this study was to collect data on the process of goal-setting, achievement, and multidisciplinary collaboration within reablement to provide context and facilitate meaningful interpretation as well as to provide insight into the experiences of healthcare professionals with these processes within reablement programs in NO, NZ, and NL. The focus groups findings reflected healthcare professionals' experiences and the processes in three main themes: (1) Goal-setting processes; (2) Impact of goal-setting on multidisciplinary collaboration; and (3) Behavior change techniques used to reach users' goals.

Both the results of this study and previous research state the users' needs and preferences as the foundation of goal-setting, considering the user an active partner which promotes users' motivation, the user-healthcare professional relationship and a deeper understanding of users' motives.[16] The three countries followed a comparable process of goal-setting, despite the differences in patient inflow to the programs (Table 1), which is comparable to the stages of goal-oriented care.[16] Compared to NO and NZ, NL had little experience with reablement, consequently they faced several challenges in the organization of work processes (eg, planning team meetings, sharing tasks, or offering regular evaluations). All countries acknowledged the difficulty of setting goals together with the users, especially when users were not used to looking at their problems and challenges in this manner or setting goals. In NZ and NL, exchanging data about goals and the corresponding care plans was challenging due to the use of diverse systems by professionals.

Trust and respect, continuous communication and shared vision were considered important factors for effective collaboration within a multidisciplinary team across all three countries, which is acknowledged by previous research.[37] Examples of such beneficial collaboration features are creating a sense of community, a feeling of shared responsibility within the team, a deeper understanding of each other's roles, increasing job satisfaction, and stimulating a learning climate.[6,38–40] In addition, some differences were seen regarding the organization of the multidisciplinary teams and their level of collaboration between countries. First, within reablement teams in NO and NL, allied health appeared to play a more dominant role. This stands in contrast to NZ, where home care teams worked alongside home trainers without formal healthcare training, taking the primary responsibility for reablement delivery. Beresford et al made a distinction between "multidisciplinary reablement" (comparable with NO and NL) and "home-care reablement" (comparable with NZ).[41] Multidisciplinary reablement is associated with

a more "comprehensive reablement", addressing goals across both functional and social domains, rather than focusing solely on one aspect over the other.[41] Whereas home-care reablement focuses more primarily on the functional rather than the social domain.[41] However, the NZ approach is noteworthy as the daily training was provided by unregulated healthcare assistants, meaning that they had undergone training but lacked formal healthcare education, exempting them from adhering to specific standards and regulations. This approach presents an appealing solution amidst global workforce challenges. Second, the organizational structures and processes within the teams in NO and NZ promoted "task shifting", which means that team members are assigned tasks and roles based on availability regardless of one's occupation. For example, the district nurse initiated an exercise program with the user when the physical therapist was unavailable at that time. This phenomenon is described in several reablement studies, improving flexibility when allocating roles and tasks.[39,40,42] In contrast, NL reablement teams utilized "fixed tasks", which can be disadvantageous as it limits the programs and teams' flexibility. Nevertheless, the common set of goals ensured that the NL team members worked on the same tasks and had some degree of overlapping responsibilities. We argue that goal-setting can be used as a means to improve multidisciplinary practice, as it plays a crucial role by providing focus, fine-tuning, motivation, ownership and a way to measure results. When multidisciplinary teams establish clear and shared goals, they are better equipped to utilize the diverse expertise and perspectives of each team member to tackle complex problems and achieve meaningful results.

The findings confirm that reablement is a behavior change intervention, which was also indicated by Azim et al.[19] Identifying the behavior techniques used in reablement provision contributes to determining the active components of this intervention. Examining the techniques used to achieve goals, all three countries employed similar BCTs. Using behavior techniques empowers users to regain or enhance their independence and functional abilities and addresses behavioral patterns that might hinder progress.[43,44] For instance, addressing the need for a safety net, leading to apprehension when care was diminished or engaging in activities more independently when using graded tasks. In addition to behavioral change, a cultural shift is necessary not only among users and informal caregivers but also among healthcare professionals. Promoting behavioral and cultural change can not only optimize care but also establish a more sustainable and user-centered healthcare system for the future, allowing for preventive and early interventions.

Reablement aligns with the broader goal of social responsibility by promoting inclusivity, well-being, and support for vulnerable populations.[45] Social responsibility states that individuals and organizations should contribute positively to the well-being of society.[46,47] By providing reablement services, societies and healthcare systems show their commitment to helping individuals overcome challenges, promoting autonomy, and facilitating their active participation in the community. In addition, there is a global obligation to deliver high-quality care and services despite workforce challenges and aging populations.[45,47] By investing in reablement services, societies and healthcare systems contribute to a more inclusive and supportive environment, fulfilling their social responsibility to care for the needs of all members. Our study shows that despite the various ways in which reablement is integrated, each country experiences its successes and offers important lessons contributing to the design and implementation of reablement programs in new contexts. For example, structuring the system around the reablement team to promote task-shifting consequently enables rapid care delivery regardless of the available healthcare professional.

Strengths and Limitations

Several methodological considerations should be taken into account in this study. Purposive sampling was used to recruit participants, aiming for a mix of gender, age, and educational level. However, no guarantee can be made whether the participants were a representative sample of the population in their respective countries. Additionally, we chose to use a pragmatic sample resulting in three focus groups conducted as part of our case study with no repeated interviews, therefore data saturation might not have been not reached. Lastly, one of the focus groups took place online due to COVID-related circumstances, which may have resulted in less depth of data in this group. However, data analysis showed that on certain topics more depth and detail emerged from this group in comparison to the others. One of the strengths of this study is that it is the first study to offer a comparison of goal-setting in reablement programs, combined with healthcare professionals' attitudes and perceived challenges across three countries with different healthcare contexts. In addition, meticulous attention was dedicated to the translation process of the Norwegian and Dutch focus groups, aimed at correctly presenting subtle nuances and minimizing the presence of potential misinterpretations.

Conclusions

In conclusion, this study offers valuable insights from three countries in relation to the delivery of reablement programs. Goal-setting serves a crucial role in enabling effective reablement implementation across diverse contexts. Specifically, goal-setting was found to facilitate tailoring reablement programs to the user's needs and can help define overarching objectives for the program delivered as a whole. Furthermore, our study clarified that goal-setting fosters multidisciplinary collaboration and emphasizes the importance of a collaborative environment to promote trust, shared vision, and utilizing each other's expertise improving the effectiveness of multidisciplinary teams within reablement programs. However, despite the acknowledgement of the significance of reablement, it was reported by all that a cultural shift is necessary for users, informal caregivers as well as healthcare professionals.

Abbreviations

COPM, Canadian Occupational Performance Measurement;[27] ECP, elder care physician; GP, general practitioner; HCA, unregulated healthcare assistant; HCP, healthcare professional; IC, informal care consultant; InterRAI, Inter-Resident Assessment Instrument;[29] NA, certified nurse assistant; OT, occupational therapist; PT, physical therapist; RN, registered nurse; TARGET, Towards Achieving Realistic Goal in Elders Tool[28].

Data Sharing Statement

Data are available upon request from author Lise Elisabeth Buma (l.buma@maastrichtuniversity.nl).

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Author Contributions

All authors - LEB, HT, MP, SZ and SFM - made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis, and interpretation, or all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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