Meeting the needs of homebound people: Exploring the views of home care and primary care providers

by

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Abstract

Statement of the Problem

Accessing traditional office-based primary care for homebound patients can be complicated, leading to reliance on acute care. Home care and primary care providers are essential in supporting community-based care for homebound people, and understanding their relationship and how they approach care is imperative.

This study explored how primary care and home care providers identify homebound individuals, determine care approaches, identify and collaborate with partners, and how social and professional identities influence care approaches and interprofessional collaboration.

Methods

This qualitative study employed a social constructionist epistemology. It introduced a novel Collaborative Identity Framework that links social and professional identities to the policy and contextual environments in which home care and primary care providers work. Interviews with home care and primary care providers were developed using appreciative inquiry and a convergent interview approach to explore experiences of caring for homebound people. Data analysis involved descriptive and inductive thematic analysis of interview transcripts.

Results

Nine participants, with diverse social and professional identities, shared their experiences as part of this study. Three foundational enablers of optimal care for homebound people were identified through thematic analysis: team-based care, communication, and collaboration. Macro-level decisions also influence how home care and primary care providers care for homebound people, and identified themes included use and implementation of technology, intentional program and policy design and commitment to relationships. The novel Collaborative Identity Model describes identity evolution at the interface of the foundational and macro levels.

Conclusions

Sustainable, integrated care for the homebound population requires intentional system design, interoperable digital tools, and a shift toward collaborative identities.

This work can inform policy and decision-makers in designing and supporting models of care for homebound people in the community. As team-based care becomes a focus of sustainable primary care delivery, this work can guide the optimal implementation and development of care models and contribute to the existing literature on interprofessional collaboration.

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On to the next adventure…

Dedication

Dedicated to the primary care and home care providers who care for homebound people in a health system that does not make it easy to care for people whose care needs do not easily fit within predefined boxes.

To those willing to colour outside the lines to creatively meet patients' needs.

Finally, to those who find and build teams to experience the joy in work that comes with knowing that, together, you have made a difference by supporting a patient and their family, meeting their needs, and striving to care for them in their home.

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Chapter 1: Introduction and background

Context of research

The Canadian health system is in crisis. There are gaps in access to primary care, acute care systems are overflowing, and emergency departments are variably closed and facing long wait times. The health workforce is also facing shortages in many sectors, particularly in primary care. Increasing clinical complexity and the higher acuity needs of people in the community contribute to greater demands on the health system. Community-based care, such as primary care and home care, is essential to the health system but underappreciated and lacking policy and organizational commitment (Aggarwal et al., 2023; DeVoe, 2020; Glazier, 2024; Kiran et al., 2025a; Phillips et al., 2026). Burnout levels amongst health professionals are also high, leading many to leave or cut back on clinical work (Sheekha et al., 2024), while other factors in the work environment, including administrative burden and other structural barriers impact retention of health professionals in providing longitudinal primary care (Han & Grady, 2025; Okpalauwaekwe et al., 2025). Interprofessional team-based care is often presented as a solution that reduces burnout, improves access to comprehensive care, and enhances the quality of care (Bates et al., 2025; Bodenheimer, 2022a; College of Family Physicians of Canada, 2019; Somé et al., 2020). Various models of integrated care have been proposed; yet, at the core of all of them is team member collaboration.

Addressing these issues requires thoughtful and intentional consideration of the particular needs of various community-dwelling populations. The homebound population represents a subset of the community-dwelling population, of which a portion includes aging adults with increasing comorbidities and disability. The homebound population comprises community-dwelling individuals who rarely or never leave their homes and do so with great difficulty. Proactive attention to the care

of this population segment is essential to optimize patient-centred, high-quality care while also addressing the system impacts of avoidable Emergency Room presentations, acute care admissions, excess in-hospital days, and admissions to long-term care for patients who can and prefer to be cared for in the community.

Community responsiveness and adaptability are key aspects of primary health care, ensuring that health systems are designed to address the health needs of all people (World Health Organization, n.d.). Home care and primary care health professionals and care systems are essential to caring for homebound people in the community. Models of care for homebound people, such as home-based primary care (Stall et al., 2013), describe integration between home care and primary care professionals, and other models include interprofessional collaborative care.

Collaborative care, how members of a team work together, and integrated care, how different programs work together to care for a patient or group of patients, occur within variable contexts. This integration and collaboration occur at the front line, with individual professionals navigating how they work together, and at the program or organizational level, where policy and practice guide decisions and approaches to collaborative and integrative work. At each level, the experiences of health professionals inform how they approach care delivery in a given situation. For homebound people, these contexts include primary care and home care professionals and how they identify a patient as being "homebound", how they approach the care of this population and how they identify partners in care. Collaboration and integration between professionals and programs do not simply happen; rather, they evolve iteratively within the contexts in which they find themselves. Experiences shape individual professionals' identities, and decisions, policy and contextual environments inform experiences. To understand care delivery

and improve patient outcomes, we must examine the environments created and how they influence the professionals who work within them.

Problem Statement

Home care and primary care integration and collaboration (i.e., how these groups of health professionals work together and what structures and supports are necessary for optimal collaboration and integration) are not well described in the literature, particularly for the care of homebound people. This research aims to explore how home care and primary care providers identify homebound people, identify care partners, care for this population, and adapt their approach to care for a homebound patient.

In this study, I argue that professional and social identities influence home care and primary care professionals, their roles and their care of homebound people. Further, policy, funding, and program-level decisions contribute to establishing and reinforcing roles and to shaping how collaboration and integration occur. Identifying opportunities for sustainable and successful program, organization and system development is essential for the optimal care of homebound people. It can inform broader system and program development to support truly collaborative care across the health system. Understanding the dynamics among front-line care providers, how they work together, and the role policy and system planning play in establishing collaborative environments is imperative if we are to achieve the health system transformation necessary for a sustainable future.

Research Aims and Objectives

My research explores the social and professional identities of home care and primary care providers, how these identities shape the identification and care of

homebound people, and how providers identify and work with partners to care for this population. The specific objectives of this research are:

1. To compare and contrast the care needs that primary care and home care providers consider for a person who is "homebound."
2. To describe how primary and home care providers adjust care provision once a person is deemed "homebound."
3. To evaluate how primary care and home care providers collaborate with other care providers in caring for "homebound" patients.

Chapter Synopses

Chapter 1 provided a brief introduction to the topic and objectives of this work. Chapter 2 will build on this with a detailed overview of the relevant literature supporting this work, in particular, describing aging-in-place policies, the health system impact of the homebound population, interprofessional collaboration, and models of care for homebound people. This overview reinforces the homebound population as a segment that warrants focused attention to address and optimize care needs in the community. Further, existing models of care and collaboration between home care and primary care highlight gaps in integrating and collaborating to support the care of homebound people.

Chapter 3 presents the theoretical framework that underpins this work. This chapter introduces theories that can be used to consider how primary care and home care providers care for homebound patients. The linkage of social and professional identity to collaboration between home care and primary care providers, and the influence of the working, cultural, policy, and political environments on collaboration, is novel. This chapter introduces the Collaborative Identity Framework, which

combines theories in a novel way to inform how groups of providers work together in caring for a population, in this case, the homebound population.

Chapter 4 reviews the methods used to explore the research objectives, incorporating appreciative inquiry-based interviews with home care and primary care health professionals who have differing professional and social identities. Thematic analysis and the inclusion of demographic characteristics allowed exploration of various identities among respondents.

Chapter 5 presents the study's results, highlighting the thematic outcomes of this work. The results are summarized by introducing the Collaborative Identity Model, which demonstrates the evolution of identity at the interplay between frontline providers' experiences and realities and macro-level policy decisions and contexts. I identify three foundational elements in the results for optimal care delivery for homebound people: team-based care, communication, and collaboration. These elements are described at a micro, or individual-team level and influence how care is delivered to homebound people. These foundational elements inform how care providers approach collaboration with care partners. Additionally, I reveal in the analysis how macro-level decisions that shape organizational, environmental, and policy contexts impact care providers' experiences, establish or reinforce norms and ways of working that lead to the evolution of a collaborative identity and ultimately affect care provision for homebound people. These themes include the following: 1) macro-level decisions influence provider experience of caring for home-bound people; 2) achieving true collaborative and integrated care requires intentional and ongoing commitment; and 3) relationships between care providers are essential for optimal collaboration and require purposeful action and intention to be established.

Chapter 6 reviews the findings of this research in the context of existing literature. The findings are novel in this context and can inform the development and enhancement of team-based care models, particularly for homebound people.

In Chapter 7, I make recommendations based on these results that policymakers, decision-makers, and funders can consider to optimize community-based care for homebound people through home care and primary care professionals, including ensuring intentional program and policy design that prioritizes integration and collaboration between primary care and home care. Importantly, a key recommendation is to plan for and incorporate expectations for collaboration, rather than simply assuming it will occur. I close this chapter by describing the next steps for further research to advance this work.

Chapter 2: Literature review

In this study, I explore the care of homebound people by home care and primary care providers. In this chapter, I explore the foundational contextual elements that describe how and where care is provided in the community and consider the aging population and its homebound segment. I explore models of care in primary care and for those with multimorbidity, and discuss potential implications for the care of homebound people. Throughout this chapter, I will describe the potential implications and opportunities for home care and primary care providers in caring for the homebound population. I specifically explore the care of homebound people and aim to describe the experiences of home care and primary care health professionals caring for this group, to understand what is needed to optimize the relationship between home care and primary care providers, and how this relationship influences the care of homebound people. The following sections will delve into the context of care for homebound people, the impact on the health system, and the role teams play in their care. A closer look at home-based primary care models is also provided, and I will use this model as a conceptual framework to explore the care of homebound people in the community. In the first section, I review the implications and considerations of aging-in-place policy decisions.

Aging in Place

As the population ages, aging-in-place policies support community living and aim to prolong independence within the community (Boll et al., 2021; Graybill et al., 2014; Iecovich, 2014; Mitty & Flores, 2008; Vasunilashorn et al., 2012). In Canada, 80% of people over age 50 express a desire to live in their own homes for as long as possible (Iciaszczyk et al., 2024). Independence and autonomy are vital for seniors when describing “aging in place.” Further, "place" refers to more than simply a home; it encompasses their community as a whole. Social networks, familiarity, community

support, and resources, including health care, are all part of the "place" where people want to stay (Wiles et al., 2012). Additionally, people want choice when deciding where they live as they age. As people age and develop increasing morbidity and functional disability, a patient-centred and holistic approach to care aims to facilitate and support this patient-determined choice, independence, and autonomy. Ensuring a biopsychosocial approach to care, addressing biologic, psychologic and social needs, is an essential element of models of care and care approaches that prioritize patient-centredness (Scholl et al., 2014). Aging-in-place policy is inherently patient- and community-centred, aiming to design policies that meet patients' needs within the community. The intentional design of programs to support people in the community can be less costly than institutional care (Hollander & Chappell, 2007; Kitchener et al., 2006). Furthermore, community and cultural expectations of care influence the ability to support the aging-in-place philosophy (Jacobson et al., 2025). As people age, the presence of social supports in the community also affects their experience of accessing the health care system (Kervin et al., 2025).

An aging-in-place approach to policy design encompasses many aspects of policymaking and decision-making, both within and beyond the health system. Considerations, including housing, income, social supports, and programming, all influence how an aging population can be successful in the community. The success of these policy choices has both upstream and downstream impacts on the health system. For example, by optimizing the health and functional abilities of the aging population and reducing reliance on acute care, thus limiting health system cost and contributions to emergency department overcrowding in hospitals due to prolonged hospitalizations. Emergency department overcrowding and access block within hospitals occurs due to limitations in being able to transition people to different areas

of the acute care system, for example, from emergency departments to inpatient beds or to discharge to the community, due to beds being occupied by people waiting for other services (Samadbeik et al., 2024; Savioli et al., 2022). Further, as the population ages, with increasing mobility challenges, chronic disease burden, and frailty, optimal community care is essential to ensure care remains in the community and to limit the need for acute care. The following section examines the current impacts of an aging population on the health system.

Health System Impacts of the Aging Population

As the population ages, people experience increased comorbidities, care needs, and functional impairments (C. H. Jones & Dolsten, 2024). Along with these increasing care needs is a desire to remain in the community, requiring additional supports such as home care and other social supports. A preference for "aging-in-place" and maintaining independence for as long as possible guides policy and system design decisions that prioritize the needs of older adults (Iecovich, 2014). As people age, their interactions and use of the health care system also change, with more use of emergency departments and inpatient hospital services. Older adults also access physician services more often and have more prescribed medications (Canadian Institute for Health Information, 2011; Iciaszczyk et al., 2024). Given the complexities of managing multiple chronic conditions and the impacts of functional impairments, care coordination is increasingly required, often managed by multiple specialists (C. H. Jones & Dolsten, 2024). Integrating care delivery and prioritizing holistic care, focused on overall health rather than disease-specific care, leads to better outcomes (Browne et al., 1999).

Primary care can be an essential link between care provision and an access point for patients and families to contact the health system. This linkage can help

connect people with other community programs to support successful aging in place, though navigating these connections can be challenging; a primary care liaison can help establish referrals and connections (Boll et al., 2021). Having a regular primary care professional is essential to ensure optimal management of chronic conditions, to address acute issues as they arise, and to navigate and coordinate care as needs evolve. Access to primary care for seniors in the community is an essential component of the aging-in-place strategy. It is essential to optimize community care while limiting reliance on acute care services and not overburdening informal caregivers (Canadian Institute for Health Information, 2025).

In 2024, 8% of Canadian older adults reported not having a regular primary care provider, a decline from 2014. In 2017, only 2% of Canadians aged 65 or older reported not having a regular primary care provider (Canadian Institute for Health Information, 2025). Those in rural communities and with lower income were more likely to report that they did not have a longitudinal primary care provider. (Canadian Institute for Health Information, 2025). While 92% of older adults report having a regular primary care provider, access remains challenging, with only 25% able to obtain a same-day or next-day primary care appointment. Additionally, 66% of older adults indicate that someone at their primary care provider's office coordinates care with others involved in their care. Notably, this has declined since 2017, when 82% of respondents indicated that this coordination was occurring (Canadian Institute for Health Information, 2025). Given the burden of chronic disease amongst this population and the involvement of multiple care providers and specialists in their care, care coordination is essential to maintain a holistic, patient-centred approach (Scholl et al., 2014). This care coordination role can be provided as part of a primary health care approach (World Health Organization & United Nations Children's Fund,

2020) and often by primary care teams (College of Family Physicians of Canada, 2019).

As the population ages (Dall et al., 2017), the health system's response to these changing demographics requires a commitment to a more holistic approach to care and to considering the policy changes and innovations needed to support this population's care needs (Osareme et al., 2024). Lack of access to regular, ongoing primary care, increased complex care needs and multimorbidity, and a lack of supportive community resources contribute to increased demand and longer waits in the emergency department (Haas et al., 2023). These concerns are increased in an aging population, leading to overcrowding in emergency departments and contributing to access block in acute care settings. Older adults have more hospital admissions and longer hospital stays (Singer et al., 2020). The absence of caregivers affects how older adults access and interact with the health system; responsiveness and adaptation to individual needs are essential to ensure that patients without access to other supports have their needs met (Kervin et al., 2025).

Among older adults, particular attention to frailty can have a greater impact on the health system, policy directions, and the individual experience of care and quality of life. Frailty can be considered a dynamic state in which an individual experiences a decline in functioning, thereby increasing the risk of adverse outcomes (Gobbens et al., 2010). Frailty is associated with mortality, functional decline and need for institutional care (Andrew et al., 2018). Further, "social vulnerability" is a separate measure of risk (Andrew et al., 2008). While frailty is associated with social vulnerability, social vulnerability represents a separate risk factor for older adults (Andrew et al., 2008). These concepts of frailty and social vulnerability highlight the need to specifically consider older adults when planning care delivery in the community, particularly in primary and home care, to ensure additional care needs

are met. These increased care needs also highlight the need for holistic consideration of circumstances to prioritize care in the community, recognizing that acute care environments are not conducive to this necessary wraparound, whole-person care. Optimizing care in the community and limiting the need for acute care where possible is patient-centred and system-supportive.

The acute care system faces significant current challenges with access blocks and flow, with beds occupied by people whose care needs could be managed in other settings, including the community (CADTH, 2023). Optimizing care for older adults, and specifically for homebound people, in the community by ensuring care is accessible in a timely way and that whole-patient care needs are addressed can reduce the number of people presenting to acute care and thereby facilitating the transition back to the community with appropriate supports.

The challenges of access for older adults highlight the opportunity for innovative, flexible care models that can meet patient needs and support longitudinal, patient-centred care in the community. Team-based primary care (College of Family Physicians of Canada, 2019) is often presented as an optimal model for community care, with additional health professionals and team members working alongside primary care providers, patients, and their caregivers to address all aspects of care. A commitment to team-based primary care has evolved, and the Canadian federal government earmarked funding in 2000 to support the establishment of multidisciplinary primary care teams (Government of Canada, 2007). For older adults, given the increasing complexity of their care needs, team-based primary care models are ideally positioned to address them.

Various aspects of care for older adults in the community often involve home care, primary and specialty care, pharmacy services and other social support services. Home care and access to home care services are essential to a successful aging-in-

place policy. I will describe home care supports and delivery in the Canadian context in the next section.

Home Care Services

In the Canadian context, health services are generally publicly funded according to the Canada Health Act. According to the act, essential health services are specified and funded through federal health transfers and delivered at the provincial level. Provinces receive the full health transfer if health care services are delivered in alignment with the five principles: universality, portability, public administration, accessibility, and comprehensiveness, while ensuring there are no user fees or extra charges for accessing health services (Government of Canada, 1984). Health services stipulated by the act include insured hospital services and physician services. Publicly funded home care services are considered as extended health care services in the Canada Health Act. Home care services are defined and delivered at the provincial level, leading to differences across Canada in covered services and program eligibility. Nursing services, personal support services, and case management are among the home care services consistently provided across Canada (Government of Canada, 2019). These services are provided in varying amounts and degrees to people living in the community and are typically allocated according to need. Home care services are meant to provide additional support in the community, allowing people to continue living independently, and can include services such as meal preparation and personal care, as well as health-related services such as medication administration and wound care (Government of Canada, 2019). Access to private home care services, available for purchase by patients or families, varies across Canada. In Manitoba, there is a mechanism for patients and families to allocate publicly funded dollars to coordinate and arrange private home care. Access to this funding is determined by eligibility (Government of Canada, 2019; Government of

Manitoba, 2023). Home care is frequently siloed from other parts of the health system, particularly from primary care services and is not integrated or coordinated (McManus et al., 2025). Primary care delivery can play an important role in supporting care coordination for patients receiving home care services, and home care services can be another aspect of care for older adults who require coordination and integration to ensure seamless, patient-centred, and whole-person care.

Social factors such as the availability of social supports, income, housing stability and self-assessed health are associated with the need and use of home care services (Mah et al., 2021). These social factors and their impact on the use of home care services need to be considered in funding and policy decisions. Additionally, by investing in home care focused solely on home support and nursing services, without also adapting health care delivery as part of aging in place policy directions, particularly primary care provision, the approach fails to consider the care needs of the whole person. An integrated care approach for older, community-dwelling adults aims to provide holistic care and is designed to meet all biological, psychological, and social needs (Scholl et al., 2014; Woo et al., 2021). Access to continuous, comprehensive primary care to support chronic disease management and optimize functional status can be an important element of this work. Evaluation of integrated care models for this population is mixed; investment in integrated care models has led to an increase in the volume of primary care visits (Looman et al., 2019). More use of primary care by this population may reflect the benefits of integrated care, by facilitating connections to primary care professionals and teams and addressing a prior gap in access to care. Determining the optimal evaluation of integrated models of care is essential and may require new definitions of success: cost-neutrality with

improved patient, family, and health team outcomes, and more sustainable and equitable care delivery, aligned with a sextuple aim approach (Alami et al., 2023).

To authentically commit to an aging-in-place approach to policy development and care delivery, a culture shift is needed in how we care for people as they age, specifically by committing to patient-centred care that recognizes the need for nuance and individuality in developing care plans (Jacobson et al., 2025). The homebound, a subset of the aging population, require specific attention, particularly regarding commitment to aging-in-place policy. While not all homebound people are older adults, the homebound older adult population, or those at risk of becoming homebound, represents a distinct subset that would benefit from dedicated care delivery, recognizing their needs and the challenges they currently face in accessing the health system. Adapting care delivery for homebound people, including how home care and primary care are delivered to this group, is part of this adaptation. In the following section, I review the Homebound population, their care needs and opportunities in optimal care delivery for this group.

Homebound Population

Among older adults, the homebound population is a subset for whom leaving home is increasingly difficult (Lapointe-Shaw et al., 2022; Leff et al., 2024; Mather et al., 2023; Zhao et al., 2019). Definitions of a "homebound" person are variable. Quantifying or qualifying someone as homebound has been characterized by difficulty leaving their home (Ornstein et al., 2015; Soones et al., 2017; Szanton et al., 2016), eligibility for in-home support services/home care (Qiu et al., 2010) and other screening tools. Homebound people have been characterized as either completely or mostly homebound based on how often they leave their homes. Completely homebound people report that they have not left their home at all in the preceding month, while the mostly homebound group reports leaving their home less than once

per week in the preceding month (Ornstein et al., 2015). An additional group has been identified as being at risk of becoming homebound, the semi-homebound, who report needing assistance to leave their homes, or are only able to leave their homes with great difficulty (Ornstein et al., 2015). In one study based on self-report, ~5.6% of adults over age 65 were completely or mostly homebound, with an additional ~15% being semi-homebound; in this study, homebound was defined more broadly as varying degrees of self-reported ambulatory disability (Musich et al., 2015). The variability in definitions of the homebound population and the inherent nuance in self-report highlight the challenges in planning care delivery for this population. Self-reported difficulties leaving home can lead to challenges accessing care and highlight the need for appropriate identification and adjustments in care delivery for these groups. For the semi-homebound, this group is at risk of becoming homebound and may benefit from a change in care approach to optimize function and prioritize services that maintain their independence for as long as possible.

The homebound population has high rates of medical comorbidities, cognitive impairment, and mental health concerns (M. G. Jones et al., 2017). Homebound patients also often have multiple comorbidities, mobility impairments (Wajnberg et al., 2013) and difficulty accessing the health care system due to these impairments (Cheng et al., 2020). Completely homebound patients report more chronic disease burden than non-homebound people and also report more depression and cognitive impairment (McManus et al., 2025; Ornstein et al., 2015). Further, these numerous comorbidities lead to a significant symptom burden (Wajnberg et al., 2013) and homebound people are more likely to have been hospitalized than people more easily able to leave their homes (Ornstein et al., 2015). Care for homebound people often relies on informal caregivers, and the burden on these caregivers also contributes to increased health system use (Reckrey et al., 2013). The homebound

population have high rates of frailty and functional impairment, depression and cognitive impairment. Access to various services that support these needs varies (McManus et al., 2025). Frailty and functional limitations can lead to emergency department visits and hospitalizations (McManus et al., 2025). There are also social factors that differ between homebound and non-homebound people, with homebound individuals having lower levels of education, income and poorer self-reported health (Ornstein et al., 2015). A subset of the homebound population is those with frequent hospitalizations and use of the acute care system; the needs of this population subset further highlight the need for individualized care plans and optimal care delivered in the community (M. G. Jones et al., 2017). Despite demonstrated increased needs, there remains a gap in advanced care planning amongst this group (McManus et al., 2025).

The burden of functional impairment and chronic disease is increased, and the challenges in leaving one's home make accessing primary care regularly even more difficult. For homebound people, access to the health care system often occurs when concerns are more acute, leading to emergency department assessments and hospital admissions (Musich et al., 2015). Discharge planning back to the community for this group of homebound people is challenging, which often leads to a prolonged length of stay in the hospital.

Additional care needs for homebound people include advance care planning, social supports, and attention to social determinants of health, such as income and food access (Haferkamp et al., 2025). Considering advanced care planning and ensuring adequate access to end-of-life and palliative care supports are essential components of an aging-in-place philosophy and people's desire to remain in the community; 80% of Canadians report wanting to remain in their homes for as long as possible (Iciaszczyk et al., 2024). For the homebound population, maintaining

involvement in social activities is a critical component of an aging-in-place strategy. Social clubs, visiting family and friends and attending religious ceremonies are reported as necessary by homebound or semi-homebound people (Szanton et al., 2016). These groups note that their health status and access to transportation can be barriers to participating in these meaningful events. Recognizing the importance of participation in social events is essential in individual care planning and can also inform aging-in-place policy decisions, especially for the subset of homebound people. Incorporating technology into care at home can increase access, better support people at home, and facilitate more connections between patients and health professionals (McDonald et al., 2021). Additionally, a collaborative care team is essential to optimizing community care for people with increasing frailty (McDonald et al., 2021).

Consistent access to care is lacking for homebound people, as the current system is not structured to meet the needs of homebound older adults. Inconsistent, siloed care means homebound patients often rely on emergency rooms and do not benefit from more upstream, preventive interventions (Ornstein et al., 2015). Furthermore, community and cultural expectations of care influence the ability to support the aging-in-place philosophy (Jacobson et al., 2025). As people age, the presence of social supports in the community also affects their experience of accessing the health care system (Kervin et al., 2025).

Innovative care models for homebound people have been implemented across communities to address the unique needs and considerations involved in planning and delivering care for this population. Home-based primary care models (HBPC) (Stall et al., 2013) often include interprofessional teams; collaboration among team members and integration between teams and programs are essential to the successful implementation of these models. HBPC is a care model intended to

address some of the challenges of caring for homebound people. In the following section, I provide an overview of HBPC models and outcomes.

Home-Based Primary Care (HBPC)

Home-based primary care (HBPC) is one model of care designed to meet the needs of homebound patients (Haferkamp et al., 2025; Kim & Jang, 2018; Ouslander & Grabowski, 2020; Soones et al., 2017; Szanton et al., 2016). A vital element of the HBPC model is longitudinal, team-based primary care provided in the home and with an identified primary care provider (Stall et al., 2013, 2014). In an HBPC model, care is delivered in the home, addresses medical and social care needs, and is provided in partnership with home support services (Norman et al., 2018; Stall et al., 2013, 2014). HBPC programs provide a holistic approach to care, consider social needs and prioritize advanced care planning (Haferkamp et al., 2025).

Integration of medical and social support needs is critical to the success of HBPC programs (Leff et al., 2019; Norman et al., 2018). Patients and caregivers highlight the benefits of continuity and relationship with their HBPC provider and team (LaFave et al., 2020). Collaboration with other community programs and support services, another core element of the HBPC model (Stall et al., 2013), is also highlighted by patients and caregivers as ideal. However, despite highlighting the benefits of integrating primary care and social support services for homebound patients, details describing critical success factors for this integrated care are lacking. Further, organizational and contextual factors to support collaborative relationships between home care and primary care are not well described. The use of digital technology as part of HBPC models and, more generally, in caring for homebound people is an evolving component of clinical care delivery (Franzosa et al., 2020; Haferkamp et al., 2025). Digital health technology in the context of HBPC models of

care can include the use of video and phone calls, secure messaging and remote home monitoring; use of digital health technology can lead to improvements in access, care coordination and can support caregivers by making connections with the health system more seamless (Í. de S. Silva et al., 2024). Use of electronic health records for documentation by care providers and patient portals for patient access and contributions to their records can support care coordination in several ways, including communication, transitions of care, proactive care planning, and patient self-management (Fjellså et al., 2022).

Patients enrolled in HBPC models of care can lead to less hospital and subspecialist visits and more primary care visits (Stall et al., 2014; Zimbroff et al., 2021); while there are more visits to primary care and associated increased costs, this represents more appropriate system access, aligns with a patient-centred and holistic approach to care and can lead to less burden on the acute care system. The impact on emergency room presentations is more variable, with some studies showing no effect on rates and others showing stabilization (Edwards et al., 2017; McGregor et al., 2018).

Frequent hospitalization is an indicator in some HBPC programs of the need for additional, more intensive intervention (Jones et al., 2017). For some programs, referrals from acute care are the primary mechanism for enrolment in HBPC programs; broadening and simplifying referrals from community-based supports and programs for homebound people without easy access to primary care is an innovative approach to recruitment (Cahill & Mutter, 2025). Sub-segmentation of the homebound population or the population served by HBPC programs into those with comparatively greater needs highlights the heterogeneity of the homebound population and the lack of a consistent definition or clarity about which populations are most likely to benefit from this model of care. Further, a standard definition of

"homebound" is lacking; determining whether a patient is homebound or in need of HBPC services is not often explicitly within the discretion of the patient, caregiver, or primary care provider. Variability in the target population and the role of HBPC programs in caring for these populations limit understanding of how the HBPC model works, what elements are key to success, and how HBPC team members and partners can best work together to meet patient needs. Interprofessional teams and collaboration, how groups of different health professionals work together to care for homebound patients optimally, is an essential component of HBPC, and the degree of success of collaboration between team members or between health professionals involved in the care of homebound people may impact the outcomes or performance of a given team.

Collaboration among professionals is an important aspect of community-based care for older adults, particularly for homebound people. In the following section, I explore aspects of team-based care more broadly within community-based and primary care settings.

Team-Based Care

Team-based care delivery is included in primary care models, such as the Patient's Medical Home (College of Family Physicians of Canada, 2019). Despite high patient support for accessing care from team members, access to different health professionals within a team is limited and variable (Kiran et al., 2024). In some cases, implementing team-based primary care models has reduced emergency room visits and hospital admissions among patients with chronic conditions; commitment to teamwork initiatives is integral to their implementation (Meyers et al., 2019). In other cases, enrollment in a focused HBPC program or specialized intensive primary care programs demonstrated less clear impact on hospital admissions or emergency

department presentations (Edwards et al., 2017; Kling et al., 2023). This variability highlights the need to explore how teams work together to optimally support people in the community, and to consider outcome measures to assess this work most effectively. Increased access to and use of community resources is anticipated to indicate success, particularly among a patient population that may have difficulty accessing these resources at baseline.

Understanding the components of team-based primary care models, including those focused on the care of homebound people, is essential to their further growth and development. Commitment to team development within HBPC models is limited and poorly described. Multimorbidity care models also describe collaboration between care providers and care coordination as a critical element (Fortin et al., 2007; Muth et al., 2014; Roughead et al., 2011; Stokes et al., 2017), yet they offer little detail on what this collaboration entails. Coordination of care and the use of team-based approaches enable primary care providers to care for people with complex, multidimensional needs (Loeb, Bayliss, Candrian, deGruy, et al., 2016). Policy decisions at the macro level create the conditions for team-based care to develop, including reallocation of funding and positions, changes in criteria that affect the operations of various models, and the allocation of certain professions (Wankah et al., 2025).

Central to understanding and describing how health professionals and interprofessional teams work together is the consideration of interprofessional collaboration. The following section explores foundational competencies in collaboration and their role in caring for people with complex needs, including homebound individuals.

Interprofessional Collaboration

Foundational competencies of successful interprofessional collaboration inform models of team-based care (Canadian Interprofessional Health Collaborative, 2024; Hepp et al., 2015). Within the described competency framework, six competencies are described: team functioning, collaborative leadership, team difference processing, role clarification and negotiation, team communication and relationship-focused care (Canadian Interprofessional Health Collaborative, 2024; Loeb, Bayliss, Candrian, DeGruy, et al., 2016). Additionally, these competencies are considered with the contextual factors of the care setting, complexity, inclusion, access and equity. As discussed above, team-based primary care is a key component of the patient's medical home(College of Family Physicians of Canada, 2019) and is essential to an HBPC model (Kim & Jang, 2018). Some HBPC models highlight contracted social support services to provide in-home care to homebound patients (Kim & Jang, 2018; McGregor et al., 2018). However, neither how these team members are integrated into the HBPC team nor how they interact with homebound patients to alter care delivery for this population is specified in these models. While included in the definition, a complete description of this collaborative work is lacking in many studies. Further, how various team members work together is not well described. Team culture and commitment to a learning environment are essential to successful HBPC teams (Temkin-Greener et al., 2019); however, the steps to achieve this or a specific approach for teams to consider are unknown. The Canadian Interprofessional Health Collaborative Competency Framework for Advancing Collaboration (Canadian Interprofessional Health Collaborative, 2024) provides a valuable model for interprofessional collaboration that can be applied among home care and primary care providers, as well as other professionals involved in the care of homebound people.

Collaboration within HBPC includes shared commitment to care planning between care providers, patients, and caregivers. Successful collaboration within an HBPC team can be facilitated by various elements, including a commitment to team learning, fostering positive relationships among team members built on trust and respect, and ensuring that team members share goals (Smith-Carrier et al., 2015). Further, commitment to team development of collaboration skills is an essential structural element of successful, supportive care delivery (Giosa et al., 2019). Collaboration with primary care providers, or the incorporation of a collaborative care approach into an HBPC model, is not well described.

Differences in outcomes for patients enrolled in HBPC programs compared with those receiving usual care with home support services can be attributed to the degree of collaboration among team members caring for homebound patients within an HBPC care team (McGregor et al., 2018). Collaboration between home care and primary care is often described as "care coordination" and is considered a marker of quality in HBPC programs (Ritchie et al., 2018). While specific elements are described in certain settings, such as regular meetings and shared electronic records for documentation (Kim & Jang, 2018), there are limited explorations into how collaborative teams work together or the actual measurement of team function. Further, there is limited exploration of how team members work together to meet the objectives and goals of collaborative models of care. A balance between macro (system, policy, context) and micro-level (operational) elements is essential for successfully implementing integrated care models; home-based primary care could be considered one such model (Calciolari & Ilinca, 2011).

Integration of care is described in many care models. At the same time, collaboration refers to how individuals work together, and integration reflects how programs or services work together across all organizational levels (Kodner &

Spreeuwenberg, 2002). Integration reflects the funding, administrative, organizational, service delivery and clinical decisions that occur along a continuum from micro to macro and support the care of patients with complex needs (Kodner & Spreeuwenberg, 2002). Integrated care that occurs at the micro level (in the care of individual patients) depends on integration at the organizational and macro (policy) levels (Delnoij et al., 2002). Integration can also refer to the connection between the health system and other social services to improve outcomes (Leutz, 1999). Patient needs guide service integration, which exists along a spectrum from linkage to coordination to full integration, marked by the creation of new programs to address specific needs (Leutz, 1999). Full integration into programs designed for integrated services for a target population must balance integration goals with competing priorities from other responsibilities. When integrated programs include physicians, these additional considerations must be weighed alongside the risks to collaboration posed by developing integrated programs that exclude physicians.

The homebound population has unique needs that require a broad range of services, is often limited in self-direction and self-management, and requires frequent care interventions, all of which highlight the need for full integration of services (Leutz, 1999). HBPC models demonstrate some of these integrated care components. One goal of HBPC models is to provide prolonged, supportive care in the community, thereby delaying or avoiding admission to long-term care facilities. Integration of primary care delivered through HBPC and home support services is essential to reducing reliance on long-term care facilities (Leff et al., 2019). Integration to support aging in place, reduce use of emergency departments and acute care, and reduce the need for admissions to long-term care facilities requires expanded views of partnerships, including health and medical services, housing services, and other social services (Charles et al., 2025).

This chapter provides an overview of considerations for the homebound population and how home care and primary care providers assess and approach their care. In the next section, I will situate this research project within this context.

Research Context

The focus of the research in this thesis is the experience of care of homebound people by home care and primary care providers in Winnipeg, Manitoba. Manitoba has various initiatives supporting home-based primary care, including Home Clinics and My Health Teams (Government of Manitoba, n.d.)and the Interprofessional Team Demonstration Initiative (Slobodian & Huebner, 2015). These Manitoba primary care initiatives aim to partner with allied health care providers (such as pharmacists, nurses, social workers, physiotherapists, and occupational therapists) and primary care providers to deliver patient care in primary care settings. Within these various initiatives, the relationship between care providers and their patients is rarely described. An organizational commitment to team functioning is also not established. Home care initiatives also exist in Winnipeg (Winnipeg Regional Health Authority, n.d.), specifically targeted to support people transitioning from hospital to the community. Within this home care initiative, explicit partnerships with primary care are absent, highlighting a foundational gap in the model. In addition, neither the home care nor the primary care initiatives specify care approaches for homebound people, indicating a gap in care that fails to meet this population's specific needs.

The integration of home care and primary care programs, how home care and primary care professionals work together and how the different programs are designed to work together, is described as siloed and not connected. The sextuple aim links health outcomes and experience of care to the team environment, equity, sustainability and costs (Alami et al., 2023). Optimizing care in the community and

close to home is an essential sustainability strategy to reduce the carbon footprint of the health care system (Selvakumar et al., 2025; Souza et al., 2023). This framework is useful for linking the concepts to guide the care of homebound people and will be described in the next section.

Sextuple Aim

The Sextuple Aim, an evolution from the Quintuple aim (Nundy et al., 2022) with the addition of the sixth aim of sustainability (Alami et al., 2023), is a helpful framework that demonstrates the link between healthcare provider experience and improved patient outcomes and patient and family experience of care, while considering cost, health equity and sustainability. How workers experience their work influences patient outcomes and must be considered when improving patient outcomes. In the context of teams caring for people with multiple chronic conditions, particularly homebound people, how team members work together, how environments are set up to support their work, and the structures and policies in place all influence team members' abilities to provide excellent care. Supporting an aging-in-place philosophy, optimizing care close to home and in the community, and aiming to lower use of acute and emergency care are all part of sustainability and reducing the climate impact of health care delivery (Selvakumar et al., 2025) and can contribute to lower overall costs. An integrated care approach for homebound people demonstrates equity in care, prioritizing the needs of this group with unique care needs. Collaboration and integration between programs, care providers and different groups of health professionals are essential components of this work. Understanding how this necessary collaboration and integration occur, and what support systems are required for optimal collaboration, is essential. Importantly, collaboration does not simply happen; rather, it is created and shaped by environments, expectations, and structures within our work environments.

The work described in this thesis will examine the care of homebound people by home care and primary care providers and, in the next chapter, will use social identity theory and professional identity theory to explore this care.

Conclusion

Understanding the homebound population and the collaboration among team members is essential to the success and care delivered by HBPC models, as well as to caring for homebound people in general. Understanding how different team members, particularly home care and primary care professionals, work together can inform policy, funding, and the organizations supporting optimal care for homebound people in the community. Applying a theoretical framework to these relationships will deepen understanding of success factors to optimize care for the homebound population. The next chapter will explore theoretical frameworks that underpin relationships between home care and primary care providers and the care of homebound people.

Chapter 3 – Theoretical Frameworks

Various care models have been suggested to optimize care for homebound people (Leff et al., 2019; Stall et al., 2013, 2014). Collaboration, team-based care, care coordination, and case management are key tenets of these models (Xiang & Brooks, 2017). Home-based primary care (HBPC) (Stall et al., 2013). The integration of primary care and home care, particularly in HBPC, leads to more days in the community; people can stay in their homes longer, truly aging in place (Leff et al., 2019). Within these models, however, collaboration between home care and primary care professionals is poorly described. The environments that establish norms of collaboration and that foster interprofessional collaboration and integration between groups are also not well understood. Understanding the dynamics by which home care and primary care providers identify and approach the care of homebound people is the primary objective of this work.

This project draws on several existing theories to examine how both home care providers and primary care providers deliver care to homebound individuals. My work integrating multiple theories then results in the articulation of a new framework that describes the application of these pre-existing theories in a practical context, specifically, care provision for homebound people by home care and primary care providers. Building on social constructionism, the new framework integrates social identity theory and professional identity formation theory to highlight the concept of *collaborative identity*.

The use of theories allows the exploration and understanding of experiences and phenomena and is helpful for organizing inquiry and connecting data to the problem (Lewin, 1943). In exploratory research, such as this project, using theories that 'make sense' helps define the naturalistic approach to uncovering similarities and

differences between groups; in this study, differences between home care and primary care providers in caring for homebound individuals. In this chapter, I will describe the theories that inform this project and explain why I selected them. I will introduce a novel framework highlighting the concept of collaborative identity and how it informs who health professionals are as collaborators within their professional roles.

Social Constructionism

Social constructionism theory tells us that realities are created individually (Andrews, 2012; Cunliffe, 2008). Social constructionism posits that realities exist within the context of interactions between individuals and groups (Andrews, 2012; Cunliffe, 2008). Reality is subjective and is informed by life experiences and personal context. In groups, reality is created by both individual and shared experiences. Local, societal, and structural norms influence these experiences. Individuals interpret their experiences, creating the reality within which they operate. Experiences or interactions occur between people within a given social context, all of which inform the reality and meaning that results from the interaction. Knowledge creation or facts also exist within this construct; reality is social and is influenced by the cultural, linguistic, and historical contexts of any interaction. We construct our realities at the micro-level, through individual interactions with others, informed by past experiences that shape social norms and behaviour. The development and interpretation of these realities are also relational and shaped by power dynamics and other factors that affect interactions. These interactions occur as an unspoken dialogue between participants (Cunliffe, 2008). For example, an interaction may be interpreted differently by friends in a social setting than by colleagues in a working environment.

Within organizations, realities are constantly being created through interactions among team members, between teams, and with external partners. These interactions occur within the historical and current contexts of policies, infrastructure, and other factors that shape interactions at any given moment. Created realities are also additive and cumulative, influencing future interactions based on the outcomes and interpretations of past and current interactions. The "truth" of what is forms the subjective and objective culmination of various realities. When considering the care of homebound people and how home care and primary care providers work together to care for this group, social constructionism tells us that the "reality" of this work and of how this group is cared for emerges from multiple interactions and contexts. With that in mind, social identity theory offers an additional lens for understanding how individuals and groups construct realities.

Social Identity Theory

Social identity theory suggests that the groups we belong to inform our worldview and the realities we create (Hogg, 2018; Hogg & Rinella, 2018). Furthermore, we develop identities based on the groups we belong to, and this process begins very early in our development. These identities overlap and combine, then influence our experiences and the realities we create. Social identities develop from the groups one is part of, including those groups one is born into, such as race and gender, and that one chooses to join, such as political parties or community groups. Social identity theory highlights that defining an in-group and, therefore, an out-group helps to set the bounds of the identities created and helps one determine that they are part of a particular group (Afshari et al., 2019; Cornelissen et al., 2007; Ellemers et al., 2004; Reicher et al., 2018). Social identity theory states that individuals develop identities based on the groups to which they belong (Hogg, 2018; Hogg & Rinella, 2018). Groups establish norms and expectations that individuals within the

group adopt as part of their identity. Group norms also establish who is in the in-group and who is in the out-group. These group norms, “the way we do things,” further contribute to the reality created by the group members. Social identity theory also describes the roles of leaders, institutional policies, and organizational structure in creating and reinforcing groups and group norms (Haslam & Ellemers, 2005; Reicher et al., 2018; Stevens et al., 2018).

Shared social identity, the identity that develops when people are part of a group with common and understood norms, leads to the development of shared realities. We internalize this social identity and look to others to validate our experience of reality, just as we seek confirmation that we are not violating an unstated norm through our behaviours and actions. This validation allows us to create a shared reality. Within these shared realities, we can ask whether we see the world the same way others do. Within interprofessional teams, creating a shared reality in which all team members approach care or view their mission as the same can help build a cohesive team (Hogg & Rinella, 2018).

Groups act to reinforce the group’s identity (Tajfel et al., 1971). This group behaviour, both within in-group members and how in-group members act towards out-group members, is determined by the dynamics of the group itself and the individual characteristics of the group members. Social dominance orientation, the degree to which people perceive superiority towards other groups, will influence their interactions with out-groups, and this will be more pronounced as they work to actively distance themselves from the out-group. Whereas individuals with high independence show less influence (Nezlek & Smith, 2005). The dynamics within and between groups influence the realities created and reinforced, both for members within a group and for the identities and realities experienced by those in an "out-group”.

Group norms are those implicitly and explicitly understood and acceptable ways of being and acting within a group. Social identity theory explains that these norms shape the identity that develops within a particular group. This “in-group prototype” (Hogg & Rinella, 2018), which is what is accepted or what it means to be part of a particular group, is internalized by members of the group and informs how they act as members of the group. In the context of caring for homebound people, the various in-group prototypes, for example, "what is a primary care provider (PCP)?”, "What is a home care worker?" or "What is a PCP that looks after homebound patients?" are developed and informed by the local environments in which groups or people work. Aligned with social constructionism, norms and subsequent in-group prototypes are created and shaped by internalized inputs, which then guide behaviours and contribute to and reinforce the "shared reality" within a group (Hogg & Rinella, 2018).

An individual can have many social identities that develop through experiences with various groups. This can occur in both work environments and personal life experiences, continually and iteratively shaping identity and influencing how we view and approach the world, both in our personal life and, as relevant to this study, in our work life. A particular identity that develops in the context of our work is the professional identity that forms as professionals progress through their training and into the work environment. This professional identity then functions as a social identity within the work groups and environments in which the individual finds themselves. For groups of health professionals, professional identity and its formation are explicit, specific aspects of how such groups and teams work, both with one another and in patient care. Professional identity and its formation will be explored in greater depth in the following section.

Professional Identity Formation

Professional identity is the identity that develops as people progress through professional training and is also informed and reinforced by the experiences, rules, power and hierarchy that exist within our work environments (Cruess et al., 2016; Sternszus et al., 2024; Stetson et al., 2020). Professional identity is who we are in our working environments and what it means to be a “professional”. This identity can inform how we approach our work, how we work with others and what we consider as part of our "scope" of work. Within a clinical environment, teams and the policies that define and bound their work further contribute to the development of individual healthcare providers’ professional and social identities. Professional identity develops throughout our career, beginning early in training, and is influenced by our experiences and by implicit and explicit messages from teachers, peers, and colleagues as we progress (Cruess et al., 2014, 2016; Sommerlad, 2007; Sternszus et al., 2024). In healthcare, professional identity is the essence of what it means to be a health professional. The training and mentorship process formalizes the professional identity of that professional ‘group’ and strongly influences how they work with others, how they navigate within and between groups within the overall professional sphere, and how they approach their work in general. Further, the influences to which an individual is exposed within these environments moderate or reinforce behaviours and identity formation. For example, if a mentor reinforces boundary lines of what type of work belongs to a professional identity, it is difficult to override that behaviour when working in an interprofessional setting. However, if one has a mentor who fosters respect for different roles and ways of working together, this can encourage a willingness to be less rigid.

Professional identity develops in stages throughout training; part of this identity formation involves developing an identity related to collaboration and

working with other professions (Stull & Blue, 2016). This evolution of professional identity enables opportunities to reset attitudes and behaviours at different points. A professional identity evolves, beginning with a developmental stage of independent operator, which may be narrower and more in-group-focused, at the exclusion of others. For example, “physicians doing physician work” is how, at this early stage, professionals may work to separate themselves from other health professionals and establish a sense of superiority, creating greater distance between groups. Over time, a professional identity can evolve into a team-oriented idealist, who develops and maintains multiple identities while remaining focused on the profession's unifying identity, and finally becomes a self-defining professional who develops a distinct interprofessional identity that complements their individual professional identity (Stull & Blue, 2016). In this case, the physician maintains their identity as a physician and develops an additional identity as an interprofessional, someone who works collaboratively with other health professionals. This evolution of identities can change how they perceive other groups, reducing the need to distance themselves from an outgroup as they develop a strong interprofessional identity that does not detract from their professional identity. In this study, this progression of professional identity, especially a highly developed interprofessional identity, can be seen as an opportunity to support professionals in home care and primary care as they continue to evolve their identities to become ideal partners in the care of homebound people. The progression of identity development from idealist to self-defining professional continues in the early career. Environments that provide opportunities for professionals to learn from and with one another in practice are essential for creating the conditions that enable this development (Stull & Blue, 2016). In the context of home care and primary care providers, opportunities for collaborative learning during training are likely limited. To foster the development of these relationships, explicit,

purposeful learning during practice is essential to allow collaborative identities between these groups to develop. Perceived differences between physician groups, along with negative perceptions of other groups, can act as barriers to collaboration (Stratil et al., 2018). This phenomenon may be occurring between home care and primary care providers.

Professional identity and social identity theory can be used to explore the relationships between home care and primary care providers and how the inherent differences in identities between these groups can inform their approach to care of homebound people, how they define and identify homebound people, and how they identify partners and collaborate with others to optimize care for this group. The experiences of care providers and their individual identities influence how they approach caring for homebound people. In the following section, I will integrate these theories in a novel way to introduce a new framework, the Collaborative Identity Framework, to describe how home care and primary care providers approach the care of homebound people.

A New Framework for Homebound Care – the Collaborative Identity Framework

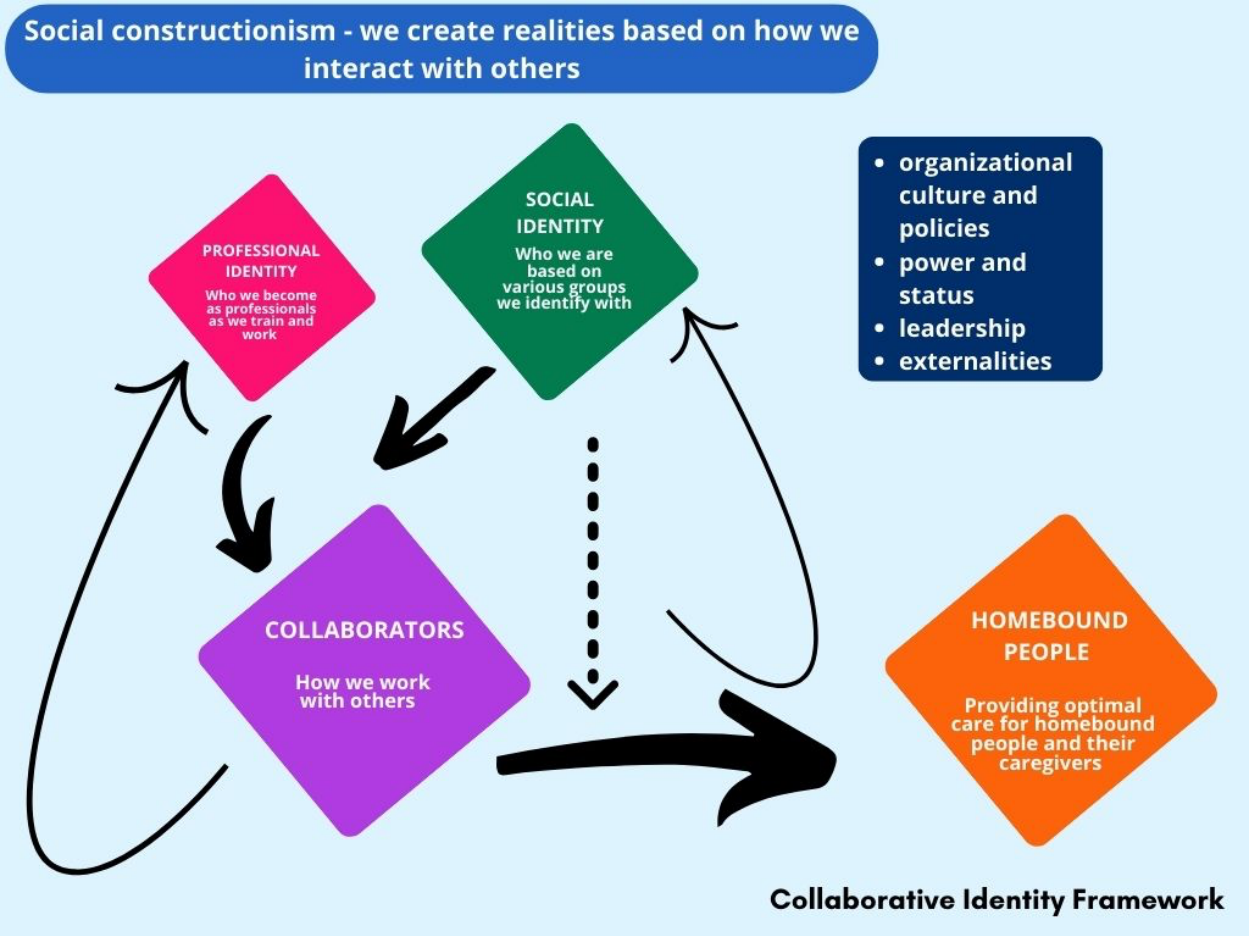
Professional and social identity influence how healthcare providers collaborate with other groups and professionals, as well as how they care for specific groups or segments of the population. A social constructionist view tells us that the realities healthcare providers create arise from the context of what they bring to the table (their individual and professional identities), the structures and environments within which they work, and the identities that form as teams and groups are formed. These identities are further perpetuated and developed over time as group norms are established and reinforced. Policies, organizational structures, funding mechanisms, and decisions about physical space and technological tools all contribute to the

environments in which teams work. Collaboration as a norm and an identity develops in individuals and groups within this context. With home care and primary care providers, particularly when caring for homebound people, we can consider collaborative identity as informing how the approach to care changes or adapts as it develops within and between groups. Do primary care and home care providers see and experience themselves as part of the same group? Do they have shared identities? What norms exist between groups that guide collaboration within and between these groups? What experiences are created that allow for realities that can support the development of shared identities? The collaborative identity framework provides a conceptualization of identities that informs collaborative care efforts and identifies potential levers to optimize collaborative relationships essential to optimal care for homebound people.

This integrated view of identities and collaboration offers new opportunities to assess how teams and groups work together and how structural and environmental factors shape optimal group functioning. Leaders and policymakers can consider how context influences a group's effectiveness in working together and implement organizational and policy changes to better support collaboration. Further, this framework is cyclical: experiences of collaboration can reinforce social and professional identity, which, in turn, reinforces collaboration norms within groups and teams. Importantly, positive and negative experiences shape the realities people create and, in turn, influence how they approach collaboration. Figure 1 depicts the Collaborative Identity framework and the linkage between professional identity formation and social identity, within a social constructionism ontology.

Figure 1

The Collaborative Identity Framework



With an aging population and an increasing burden of chronic disease and multimorbidity, various models of care have been described to address the complex needs of these populations. As described in Chapter 2, the homebound population is a subset of the community-dwelling population with unique needs. Models of care for people with multimorbidity and the chronic disease model, and models of primary care, including the patient's medical home, describe interprofessional collaboration and interprofessional teams delivering integrated and coordinated care as being foundational elements to these models (Muth et al., 2014; Stokes et al., 2017; Wagner et al., 2001). Currently, health system improvement often involves interprofessional

teams in clinical settings. Team-based care is a particular focus in community and primary care environments (College of Family Physicians of Canada, 2019). Within the Primary Care landscape, teams and team-based care are often described as key solutions to increasing access, moving towards universal attachment, addressing administrative burden and protecting providers against burnout (Bodenheimer, 2022a, 2022b). Collaboration, encompassing the competencies and skills required for professionals to work together (Canadian Interprofessional Health Collaborative, 2024), is inherent in team-based care. How that collaboration functions or comes to be within a team, however, is often tacitly assumed rather than described.

For the homebound population, home care and primary care providers are key groups integral to community care. Describing the social and professional identities of home care and primary care providers can provide insights into how care is delivered and how individuals and provider groups can work more effectively together. The working environments, policies and organizational structures also influence the experiences individuals and groups have in providing care and ultimately in the realities and identities they create as a result. The identities and realities created at work are also influenced by external factors, such as politics, which can further shape identity formation and reality construction. Power and status, organizational culture, and the role of leadership also contribute to an individual's experience and the group identities that develop. For example, a health professional working in one setting, with a given team and established ways of working with each other and with partners in other programs, will experience the context. "We do referrals this way," "we don't do home visits," or "physicians don't ask nurses their opinion on management" may be implicit messages that are part of the way of working in each environment. This way of working further develops the professional's identity as they experience realities shaped by these norms and guides their

behaviour and approach to their work. The same professional in a different context with different norms will encounter different realities, and thus their identity may evolve differently. These experiences are cyclical, iterative and additive and can influence how groups view themselves and others.

Figure 2

Collaborative Care Delivery

Importantly, by considering the impact of the work environment on teams and healthcare providers, as well as how they collaborate, we can see that work and clinical outcomes are context-dependent. Figure 2 depicts the cyclical and interdependent nature of professional and social identities and the work environment on Collaborative Care Delivery. The Sextuple Aim links the health professional and team experience to health outcomes and patient experience of care, while considering cost, health equity and sustainability (Alami et al., 2023; Bodenheimer &

Sinsky, 2014; Nundy et al., 2022). The Collaborative Identity Framework links the experiences of health professionals to how they work with others, shaping cultural norms and expectations within a group, as well as ways of working (or not working) together that can impact patient outcomes and the experience of care. In the context of homebound people, how home care and primary care providers work together, considering coordination of information sharing, integration of care planning, shared communication, and collaborative care planning with patients and families, influences patient outcomes and experience of care. Further, given that aging in place, optimal community care, and avoidance of emergency department and acute care use are target outcomes, the team environment and the effectiveness of collaborative teamwork are directly linked to these outcomes. A group comprising the same mix of professionals, with different individuals working in various contexts and employing different leadership approaches, expectations, policy applications, and team cultures, will, ostensibly, yield diverse outcomes and care approaches. Furthermore, investment in the work environment, commitment to policies that support clinical work, and collaboration must be prioritized to optimize outcomes.

Professional and social identities inform how home care and primary care providers approach the care of homebound individuals, as well as their partnerships and collaborative care in this population. Home care and primary care services are often siloed, even though they serve the same community members. If these groups worked together more collaboratively and cohesively, patient outcomes may improve, and patients and their families may have better experiences of the health care system.

Conclusions

This chapter has introduced the theoretical concepts of social constructionism, social identity theory and professional identity formation. Building on this, I articulate the Collaborative Identity Framework, a new framework that integrates these selected existing theories and describes their application in a practical context, specifically, care provision for homebound people by home care and primary care providers. The Collaborative Identity Framework guides how a collaborative identity, who a professional is as a collaborator, develops in the context of social identity and professional identity formation, within a given contextual environment and informs how they approach care provision. In this study, the Collaborative Identity Framework was used to provide theoretical guidance for exploring how primary care and home care providers identify and care for homebound people. In the next chapter, I will review the methodology used and explain how the Collaborative Identity Framework guided the project's development and data analysis.

Chapter 4 - Methods

In this chapter, I describe the methods I used in this study of primary care and home care providers who identify and care for homebound people. The chapter begins with an overview of the overall research design and the context of homebound care that motivated this work. This is followed by integration of the theoretical and epistemological frameworks introduced in Chapter 3 including appreciative inquiry, social constructionism, and the Collaborative Identities Framework. Subsequently, the participant sampling and recruitment, data collection procedures, and data analysis processes used in this study are described. The chapter concludes with a reflection on the researcher's role and positionality, as well as the ethical considerations relevant to this study.

Overall Design

Care for the Homebound

This study examines the experiences of primary care and home care providers in identifying and caring for homebound people. The primary objective of this exploration is to determine how home care and primary care providers provide care to homebound individuals. The Collaborative Identity Framework described in the previous chapter provides a foundation for this work's approach. The Collaborative Identity Framework links professional and social identities that inform realities created by individual professionals, teams, programs, and organizations. These realities lead to the development of an identity as a collaborator: how does one incorporate collaboration into their work, who do they identify as partners in care, and how do they work to integrate care across teams and programs? This study explicitly explores the dynamics of experience and collaboration between home care and primary care providers in the care of homebound people.

Methodological Approach

The methods of this study were informed by the philosophical approach of appreciative inquiry. Appreciative inquiry, when used for research purposes, guides study participants' experiences to broaden their thinking and foster creativity and innovation by sharing positive and successful experiences and encouraging them to consider how things could be even better (Priest et al., 2013; Reed, 2007). This "positive development" focuses on improvement and change while considering future opportunities (Reed, 2007). Appreciative inquiry is also focused on work environments when considering improvement; the questions and explorations seek to understand optimal and successful dynamics within them, rather than on individual participant characteristics (Reed, 2007). Importantly, appreciative inquiry focuses on change to support improvement and guides the conversation in a positive direction, encouraging expansive thinking about what could be rather than limited thinking focused on challenges and what has occurred. While focused on positive experiences, appreciative inquiry can still incorporate critical reflection on experiences and systems, power, and hierarchy, particularly by recognizing that unique experiences and realities arise from and are shaped by individual identities within systemic structures (Grant & Humphries, 2006).

Grant and Humphries (2006) propose using Critical Appreciative Processes to move beyond understanding what may exist within an organization and to ensure critical questions are considered, including how power may influence experiences within a given context. Including a critical lens in appreciative inquiry can provide further reflection and understanding of a given circumstance. In the context of this study, critical appraisal aligns with professional and social identity as the underpinnings of the individual and group experience. Professional identity formation occurs through training and work experiences and is influenced by historical and

current cultural norms and dynamics, the profession's perceived and actual power, and external influences (Sommerlad, 2007). Appreciative inquiry, asking "what is" and "what could be," and critically reflecting on who is sharing their experiences, allows us to understand the foundational elements contributing to an experience or a given outcome. Further, the critical exploration of the local policy, political, social and historical context allows us to appreciate why things are the way they are.

Aligning Methodology with Theory

A key assumption of this work is that home care and primary care providers operate as distinct groups when providing care to the homebound person. Social constructionist epistemology holds that realities are created by groups and defined by the experiences of those within them (Andrews, 2012; Cunliffe, 2008). With this view, home care and primary care providers' realities differ, as they operate within distinct socially (and professionally) constructed groups. Further, these groups (home care and primary care providers) comprise various professionals, including family physicians, nurse practitioners, nurses, and social workers. In addition to the settings in which they work (e.g., home care vs. primary care), the professional group to which each professional belongs also influences their work, experience, and the realities they create. Individual social attributes, such as age, gender identity, race, ethnicity, and family status, also intersect with professional identity to influence how persons interact within a given group and with other groups. Professional and social identity interact at both the individual and group levels to determine the experiences and, thus, the realities created by any one provider (Gioia et al., 2010; Hogg, 2018; Hogg & Rinella, 2018; Sternszus et al., 2024).

The culture and team dynamics of each provider group likely influence the care experience for these providers and how they approach their work. Further, the social

and professional identities of individual health professionals within primary and home care environments likely lead each provider to construct different realities, aligning with a social constructionist view. How primary care and home care providers understand their experiences and roles of caring for homebound patients fits with social identity theory, which describes the groups within which an individual finds themselves and informs that individual's experience within a group (Hogg, 2018; Hogg & Rinella, 2018).

An appreciative inquiry method aligns with social constructionism theory in that reality is created by individuals based on their experiences and co-created by participants, groups or teams as part of a particular phenomenon. Knowledge, how and what people know, is reflected by their experiences and identities; knowledge development is also a social process, influenced by communication and experiences within groups (Reed, 2007). Further, attending to context is important in appreciative inquiry; environments and the people in a situation shape the experience (Reed, 2007). The Collaborative Identity Framework described in the previous chapter links these concepts to enable robust exploration of the interplay between identities and contexts across home and primary care providers in the care of homebound people. This framework also allows a unique way to consider health care providers' experiences in the context of the sextuple aim (Alami et al., 2023). Context and interactions with other team members shape identities as collaborators, which in turn influence health care professionals' experiences in their work environments and impact patient outcomes and experiences of care.

With these epistemological approaches, I explored how each group perceived its relationship with the other in caring for the homebound person. To explore the experiences of home care and primary care professionals caring for homebound people in Winnipeg, Manitoba, I conducted a qualitative interview study comprising

one-on-one semi-structured interviews with representative professionals, as well as key informant and subject-matter expert interviews.

Participant Population and Recruitment Strategies

Sample Population

Recruitment for this study was limited to primary care providers, home care nurses, and home care case coordinators. Patients, caregivers, and home support workers were not included in this project. The experiences of these groups are obviously important; however, the focus of this study was limited to the primary care/home care professional dynamic, particularly how these two groups navigate collaboration and how programs approach integration. Additionally, I wanted to examine the context and work environment and understand the impact of policy decisions on how people work together, particularly in caring for homebound people. The additional layers of complexity in navigating social and professional identities with patients, caregivers, and home support workers, and in understanding how these groups interact with primary care and home care professionals, are important areas for future study.

I limited recruitment for this study to those practicing and working within one health system, specifically Winnipeg, Manitoba and the Winnipeg Regional Health Authority, to minimize other potential variables, such as different policies, resources, and community dynamics. Defining and constraining the environment within which each participant works aligns with social constructionism: experiences are shaped by the environments and contexts in which they occur, allowing for the direct interpretation and application of those experiences to this environment.

Recruitment aimed at ensuring diversity and representation among participants. When recruiting participants, professional roles and practice models

were considered to ensure representation across all groups. Given the local context of primary care delivery in Winnipeg, MB, primary care providers with different professional backgrounds and payment models were intentionally included to reflect the differing social identities that may exist in practice. This approach enabled the consideration of social and professional identity during the thematic analysis of interview transcripts.

Recruitment Strategies

I recruited participants for this project from three participant groups currently working in Winnipeg, Manitoba: fee-for-service primary care providers (FFS-PCP), alternately funded primary care providers (AF-PCP), and home care providers (HCP). Potential participants were recruited purposively by email from a known professional network, through the University of Manitoba Department of Family Medicine newsletter, and via the Manitoba College of Family Physicians member newsletter. The Registered Nurses Association of Manitoba, the Long Term Care Association of Manitoba, and the Manitoba College of Social Work were approached to share the invitation with their memberships and recruit participants working in home care. Snowball sampling was used to identify additional potential participants, particularly to address gaps in representation. Interview participants were asked to identify colleagues they thought might be interested in participating in the study or who work in home care or provide home visits as part of their work.

In addition to frontline participant interviews, two key informant interviews were conducted with current and former health system leaders to gather additional information on the current and historical context of care for homebound patients in Winnipeg and home care delivery more broadly. Interview questions for key informants focused on experiences caring for and identifying homebound patients,

collaborating with identified partners, and perspectives on the care of this population. Appreciative inquiry informed the development of the interview questions, and the interview structure followed a convergent interview approach (Rao & Perry, 2003). A convergent interview approach seeks to identify areas of convergence and divergence among participants' responses. In the context of this study, areas of convergence and divergence among respondents enabled analysis of the impact of identity on responses.

Recruitment Challenges and Mitigation Strategies

The initial study advertisement recruited primary care provider participants from alternative-funding and fee-for-service practices, including family physicians and nurse practitioners. Recruiting home care providers proved challenging, with initial advertisements and email invitations yielding no responses. I expanded outreach to private home care providers. An email invitation was sent to various private home care companies in Manitoba. A Google search identified potential companies to reach out to; only those that indicated they provided both nursing and home support services were included in the initial email invitation. Private home care companies that indicated they provided nursing and home support services in Manitoba were approached by email with information about the study and invited to participate in an interview.

Data Collection

Potentially interested participants were asked to review and complete an electronic informed consent form to participate in the study. They were also provided with links to book a time for a virtual interview and to complete an electronic demographic survey. The demographic survey was designed to capture participants' social and professional identities and included professional role, years in practice,

and current care of homebound patients (see Appendix A for a complete list of questions).

Interview Procedure

Each interview was conducted virtually via Zoom (video software, Version 5.12.x-5.13.x), audio was recorded in Zoom, and the interview was digitally transcribed using Trint transcription software (Trint, 2022). Participants consented to the video and audio recording as part of the informed consent process. Prior to recording, participants were given the opportunity to ask questions about the process and to receive an overview of the interview. Interviews proceeded in a semi-structured format; participants were advised they could choose not to answer any questions they did not feel comfortable answering.

I captured initial interpretations and reflections in field notes following each interview. These field notes included reflections on how people described their interactions with others and my interpretation of how people work together, based on responses to interview questions. I documented regular reflections throughout each step of data collection and analysis as an opportunity for reflexivity and to enhance the trustworthiness of this work (Amankwaa, 2016). With an initial review and reflection of each interview, I identified areas for further clarification in subsequent interviews. In keeping with a convergent interview process, this review and reflection allowed me to identify key areas to explore for convergence among participants.

Developing the Interview Guide

I developed a semi-structured interview guide to provide structure to the interviews (Williams & Lewis, 2005). The interview questions were developed based on the research questions of this study, guided by an appreciative inquiry framework and incorporating a convergent interviewing approach. Appreciative inquiry informed

the development of the interview questions, and the interview structure followed a convergent approach (Rao & Perry, 2003), in which I sought to explore areas of convergence and divergence amongst participants' responses.

I used an appreciative inquiry approach for the interviews, allowing participants to identify current experiences caring for homebound patients and positive experiences collaborating with partners. Further, the social constructionist frame posits that participants will share their experiences, which represent collaboratively co-created meanings or descriptions of the possibilities for caring for homebound patients, based on their individual experiences within the groups in which they find themselves. Applying social and professional identity qualifiers, such as professional role, years since completing training, and gender identity, to responses allowed me to look more deeply across groups for commonalities and differences and to consider possible external factors contributing to differences in individual experiences.

Convergent interviewing seeks areas of convergence and divergence among respondents (Rao & Perry, 2003; Williams & Lewis, 2005). With a convergent interview approach, questions begin with a general, stage-setting question (in this study: “Tell me about your experiences in caring for homebound people”). A general opening question invites participants to share their experiences in an open, undirected way. This is followed by asking participants to think about an ideal state (“Describe what an ideal situation or system in caring for homebound people/clients would look like”). This aligns with an appreciative inquiry framework by starting with the best parts of what is and allows participants to envision a possible future state. With subsequent questioning, I explored how close or far away this ideal state was from the current experience. In subsequent interviews, questions became more specific as I sought to examine potential convergence and divergence in participants’ responses, further probing whether and when statements were true (Williams & Lewis, 2005).

Participants would be presented with a scenario and asked how closely it aligned with their own experience and to describe circumstances in which aspects of the scenario may not be true. Using a convergent interviewing approach was well aligned with supporting understanding of social and professional identities and their impact on experiences; divergence between participants could be considered through the lens of differing identities.

Appendix B has a list of the initial questions used in the interview guide.

Data Analysis

All data analysis was conducted using Dedoose software (Dedoose Version *10.0.59*, cloud application for managing, analyzing, and presenting qualitative and mixed-methods research data, *2026*, Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com). Each transcript was identified and coded with the responses from the initial demographic survey. Each transcript was reviewed for accuracy by re-listening to the audio while reviewing the transcript; edits were applied to the written transcript as necessary. This initial review of the transcript and audio recording, which included playback and review of the written transcript, facilitated further immersion in the data. Reflective field notes were captured during this review and were included as data in the final analysis.

An initial line-by-line analysis of each transcript identified a set of codes to be applied. Codes represent a grouping of similar descriptive content categories to facilitate later thematic analysis. In the initial data analysis, codes were grouped according to the research questions (identification of care needs for homebound patients, approaches to the care of homebound people, and care partners). After an initial set of transcripts was reviewed, the codes were reviewed and refined. I reviewed and discussed this initial set of codes with the project advisors to explore

and refine the data analysis. As the codes were reviewed and discussed, we grouped them into broader themes. Analysis and review of interview transcripts occurred iteratively and continually as interviews progressed.

All field notes and transcripts were analyzed inductively, focusing on areas of convergence and divergence (Thomas, 2006). The comparison of initial interviews identified areas of agreement and disagreement within each interview. This comparison between interviews continued iteratively as interviews progressed and as transcripts were reviewed. I used probing questions to "test" content that appeared to be agreed upon by participants and to explain content that was disagreed upon in subsequent interviews. I explored agreement between participants and themes by asking about situations in which identified themes or ideas might not be true.

Upon completion of the interviews, all transcripts were reviewed. Codes were grouped into theme groups with progressively broader categories. Further refinement of the theme groups and an iterative review of the transcripts took place. Iterative comparisons of responses and identified themes across various professional and social identities were conducted throughout the data analysis. Final grouping of themes occurred upon completion of interviews and analysis of interview transcripts. Iterative groupings were used to establish overarching themes, make sense of the data, and address the study's research questions.

Trustworthiness and Credibility

Within a social constructionist epistemology, each individual experiences and creates their own reality; transferability in this study refers to consistently identified themes across individual participants and identity groups. The method of convergent interviewing and the incorporation of key informant interviews to gather additional context and information, and to test themes identified in earlier interviews, enabled

data triangulation as a means of assessing the data's trustworthiness. Further, following a convergent interview approach provides a structure to data collection that can also contribute to the data's trustworthiness (Amankwaa, 2016).

Researcher Role

In qualitative research, the researcher serves as the primary instrument for data collection and interpretation. Acknowledging positionality, in how the researcher's background, identity, and experiences shape the research process, is therefore essential to ensuring the trustworthiness and transparency of the work. As the primary investigator for this project, I am a family physician currently practicing in rural Manitoba after more than 12 years in Winnipeg. I have worked in long-term and acute care hospitals in Winnipeg and thus have comprehensive experience caring for patients in the Winnipeg context. I worked within an alternately funded, team-based community health centre. I was previously involved in an innovative home-based primary care model that was a partnership between home care and primary care, supporting patients and their caregivers in maintaining independent community living and reducing their use of acute care services. I have held clinical leadership roles within the community, so I have a relatively robust understanding of the organization and the current structure of the primary care system and its delivery in Winnipeg.

Given my experience in this area, reflexivity throughout this project was essential to ensure that I did not focus solely on my own views during data interpretation and analysis and draw premature conclusions. Field notes and memos throughout the interviews and data analysis allowed me to capture my thinking throughout this project. I had regular reviews and discussions with my project

advisors to explore the analysis as the project progressed and to further consider the identified themes.

Ethical Considerations

I have worked clinically in primary care in Winnipeg and Manitoba, specifically in caring for homebound patients, where potential study participants could be current or former colleagues. I have also worked as a family medicine teacher and held administrative leadership roles at the University of Manitoba; thus, physician participants who are newer graduates may have been former students of mine. These existing relationships may have limited some participants' openness to sharing information during interviews. I work clinically as a family physician, which may have introduced dynamics of power and hierarchy into the interviews, particularly when interviewing non-physicians. I do not have any current or planned supervisory roles for any participants, thus limiting potential bias. At the start of all interviews, I reminded participants that my role in this project is as a student and researcher.

The following chapter will summarize the results from the interviews and the data analysis.

Chapter 5 - Results

This chapter presents the results of the data collected and analyzed in this study. It is organized into six sections, including a summary of participants recruited for the study, a thematic data analysis, and an introduction to the Collaborative Identity Model, which allows the identified themes to be interpreted as a model to understand how the components lead to successful care models and delivery. The Collaborative Identity Model is depicted in Figure 3 on page 89 and serves as a reference throughout this chapter, as each section builds toward the complete picture of the model. The initial section provides an overview of the study participants, including responses from the demographic survey completed by all participants before the one-on-one interviews. Subsequent sections review results from the inductive thematic analysis of interview transcripts. These sections are organized into central elements that form the foundations of care for homebound people, micro-level enablers of identity evolution that support collaborative care, and macro-level contextual and environmental factors that enable collaborative care cultures. Finally, examples of successful care models that demonstrate the interplay among the levels will be reviewed. Each section uses direct quotations from study participants as evidence to support the identified themes. Supportive quotations are identified by a code that describes the broad professional group the participant belongs to, including alternately funded primary care provider (AF-PCP), fee-for-service primary care provider (FFS-PCP), or home care provider (HC).

Through my analysis, I describe the interplay among foundational elements that support collaboration, the evolution of identities that support the care of homebound people, and the macro-level influence on context. As interviews progressed, participants described their positive experiences of collaboration and caring for homebound people as occurring despite structural, organizational, and

cultural barriers that often inhibited responsive and patient-centred care. The question of whether success can be scaled and spread more broadly, or whether it is simply the result of the serendipitous alignment of time, space, and individuals, became central to interpreting the identified themes. These relationships are explored throughout the chapter and depicted in the Collaborative Care Model in Figure 3 (page 89).

Study Participants

A total of ten participants completed interviews for this study. Initial recruitment via email and newsletter advertisements yielded nine potential participants who completed the demographic survey; all described their current role as a primary care provider. Not all initial survey respondents were ultimately invited to participate in the one-on-one interviews; due to time constraints and redundancy in some demographic profiles, priority was given to ensuring representation across participant groups (e.g., profession and payment/practice model). Additional recruitment yielded one respondent from a private home care agency and two subject matter experts with experience in direct home care service delivery and program leadership. One of these subject matter experts did not complete the demographic survey; however, their interview transcript and reflective field notes were included in the full data analysis. This participant's scope of practice and contributions were within home care program leadership.

Among the total eleven survey respondents, six identified their professional role as a family physician, while three identified it as a nurse practitioner; only one described the payment model for their primary care work as fee-for-service. Survey responses indicate diversity in years in current role, funding model, and frequency of

home visits. Ninety-one percent of respondents indicated they currently have homebound patients or clients. Survey responses are summarized in Table 1.

Table 1

Demographic survey responses from study participants

Demographic survey response	Categories	N	% of respondents
Professional role			
Physician	Physician	6	55%
NP	NP	3	27%
Other (e.g administrator)	Other	2	18%
Current role			
Primary Care Provider	Primary Care Provider	9	82%
Home Care Provider	Home Care Provider	0	0%
None of the above	None of the above	2	18%
Years in current role			
Less than 5 years	Less than 5 years	2	22%
5–10 years	5–10 years	3	27%

Demographic survey response	Categories	N	% of respondents
11–15 years	11–15 years	2	18%
16–20 years	16–20 years	2	18%
>20 years	>20 years	2	18%
Funding model for primary care (if applicable)			
Fee for service	Fee for service	1	9%
Alternate funding plan	Alternate funding plan	5	45%
Salary	Salary	3	27%
NA	NA	1	9%
Other	Other	1	9%
Currently provide home visits			
Yes	Yes	9	82%
No	No	2	18%
Frequency of home visits			
Daily	Daily	1	13%

Demographic survey response	Categories	N	% of respondents
Monthly	Monthly	3	33%
Annually or less	Annually or less	5	56%
Current homebound patients			
Yes	Yes	10	91%
No	No	1	9%

Thematic Analysis

After the initial coding of the interview transcripts and reflexive field notes, codes were grouped according to their alignment with the initial research questions:

1) To compare and contrast the care needs that primary care and home care providers consider for a person who is "homebound."
2) To describe how primary and home care providers adjust care provision once a person is deemed "homebound."
3) To evaluate how primary care and home care providers collaborate with other care providers in caring for "homebound" patients.

This initial coding identified a group of themes, consistent across participants and participant identities, that described essential elements in the care of homebound people. These essential elements, or foundations of care for homebound people, are described in the next section. These foundational elements were described as necessary facilitators of care for homebound people at the front lines, or micro-level, of care delivery. While participants described them as essential to supporting the care

of homebound individuals, they also considered them central to their teams' overall operations. These elements create an environment in which professional identities are shaped and solidified, and social identities are established within a team. These foundational elements play an essential role in supporting or reinforcing higher-level, macro-level structures. This interplay is explored in subsequent sections.

Foundations for Care of Homebound People

Thematic analysis of interview responses identified three main themes related to how home care and primary care providers approach the care of homebound individuals, how they identify and collaborate with other care providers, and how they can work together to deliver integrated care. Participants identified three essential elements for optimal care of homebound people: team-based care, communication, and collaboration. Each of these essential elements is reviewed in the following sections.

Team-Based Care

Team-based care was described at a local, micro level; for example, how a primary care or home care team works together to support one another in caring for a group of homebound patients. Respondents described primary care teams that recognize the need for flexibility and responsiveness in caring for homebound individuals, as individual providers may not be able to address every need promptly; instead, collective approaches ensure sustainability. Participants described sharing the workload amongst team members, including collaborative assessments in which other team members, such as primary care nurses, contribute to care planning for individual patients. Home care professionals also described a sense of “team” as supporting optimal care of homebound people. In some instances, this might mean a

physician steps in to look after another provider's patient, or primary care nursing team members help provide that direct care:

> Like the primary care nurses for sure would make that easier because they help manage some of these people. And their assessments are probably just as worthwhile as mine. (AF-PCP, participant 4)

> The social worker, the nurse, the physician – we all knew our roles. We weren't stepping over each other. [The nurse] was taking a blood pressure reading. [The physician was] asking the right questions. We were looking at wounds. [The social worker] was at the same time assessing what we could do to get a home care nurse out to start that wound care. (HC, participant 2)

In general, "team-based care" was described at its most basic level as involving more than one person with, each with a different skill set. The benefits of a "team" caring for homebound people included not having to make home visits alone and being able to provide a broader range of care. Participants also described what made up a "team" in their unique context. For some, this was the composition of the team at the clinic where they work; for others, the team included broader groups of professionals, including other interprofessional primary care programs. Several respondents highlighted My Health Teams, a local primary care initiative in Manitoba that aims to increase access to professionals such as physiotherapists, occupational therapists, and social workers for community patients who may be difficult to reach within historic primary care clinics or models (Government of Manitoba, n.d.).

> I think the team thing was always one of the nicest things. When I go with another nurse that way, I feel that it's not just that sole person

> responsible for trying to keep that person aging in place, dying in place, living in place. (AF-PCP, participant 3)

> Now we have a nurse. Some of the other physicians will take someone from My Health Team, like an occupational therapist. So it can be a bit more of a functional assessment. The biggest difference is just that I'm not doing it alone anymore, which makes a big difference on lots of levels and what we can offer as a service. (AF-PCP, participant 6)

Communication

Regular communication between care providers was described as essential in supporting the care of homebound people. Participants highlighted the importance of communication and the conditions that optimize it at the micro level (within their teams) and at the meso level (with other partners). Effective communication was crucial in caring for patients, establishing care plans, and building relationships with other care providers. Participants also described how communication between home care and primary care providers can provide important insight into clinical decision-making, for example, whether a prescribed intervention is helping or whether the clinical situation is improving.

> Any time that I've spoken to [home care], you feel like you know what's going on and have an understanding of their perspective. And often you are on the same page, but then you get different mixed messages from patients in particular. Every time I've talked to a home care coordinator, it's for the most part been a positive experience. (AF-PCP, participant 4)

> The better the care is, the more communication the care team has, […] the outcomes are better – the person is going to heal quicker or get to their maximum level of capability.[…] Everybody, including therapy,

> being on the same page — you can get people back to a different degree of normalcy versus nobody talking, nobody communicating. (HC, participant 1)

Participants also described how communication between home care and primary care provides real-time feedback on patient status that is otherwise difficult for office-based providers to access. However, communication pathways, particularly between home care and primary care groups, were described as inconsistently effective. Respondents indicated that perceived ineffective communication channels created barriers to successful collaboration. While identified as essential for successful care of homebound people, the experiences of home care and primary care providers identified opportunities for improvement in communication tools, expectations, and policy supports.

> And now [the patient] hasn't got out of bed for months. She hasn't done her exercises because they weren't delegated to a health care aide because there wasn't a [physiotherapy assistant] available […] just this conglomerate of miscommunication, and then the outcome just drags on until the point of 'I need more medication', right?… I'm just saying I think there needs to be more communication. (HC, participant 1)

> Sometimes I think it would be nice if home care had my cell phone number. So that it's just a more straightforward communication and they're actually more truly part of the team. (AF-PCP, participant 5)

One primary care respondent described challenges in communication between groups, despite co-location with home care professionals in the same building.

> You know, we just don't have a [communication] route. It seems like even though they're upstairs, it would be like they work downtown. There doesn't seem to be any interface between the two floors. (AF-PCP, participant 4)

Collaboration

Participants emphasized a commitment to collaborative care delivery as a key facilitator for caring for homebound individuals. "Collaboration" in this context was described as a willingness to work with others. This "collaborative spirit" was not uniformly present across teams and work environments and contributed to the overall team culture. Participants experienced the impact of a commitment to collaboration at both the micro level (within a primary care or home care team) and the meso level (with other partners or programs within the community).

> What makes it easy is talking to [home care workers] and realizing that they're all really working hard to do a good job and are invested in the care of these people out in the community, regardless of how trying and difficult and challenging [patients'] behaviors are. And if there was an easier way to have a team approach for [certain patients] I think it would be even more rewarding and honestly fun. (AF-PCP, participant 6)

> And of course, our nurses and our health care aides work hand in hand. We're all in the same care team, and there's no division. So that communication gets back right away to the nurse to say somebody has to go out immediately. (HC, participant 1)

This commitment to collaboration was best described by one participant: "A collaborative spirit – so I think when we do better at connecting, then we can fully realize our potential to be partners in care." (AF-PCP, participant 6). Despite interest in

working together, some organizational processes inhibited participants from fully committing, raising concerns about trust and about not knowing who the other team members were or how contact information would be used.

> It's just my perception that often there's different home care nurses doing the care, so there's lots of different folks. I have a bit of hesitation about just giving my cell phone number as a blanket option – although if they were on a [secure messaging application], I think that would be a reasonable thing. (AF-PCP, participant 5)

Team-based care, communication, and collaboration formed the foundation or essential elements in successfully caring for homebound people. Participants described experiences at work that highlight the impact of policy, organizational, and cultural decisions on their work environments. Individual experiences shape the realities these professionals create and lead to further development of professional and social identities. These additional contexts are explored in the subsequent sections.

Macro-Level Decisions Influence Provider Experience of Caring for Homebound People

Three high-level themes were identified that reflect macro-level decisions, made at the policy, program, or organizational level, that influenced the micro- and meso-level experiences of home care and primary care providers in caring for homebound individuals. Importantly, these macro-level decisions are reflected in providers' perceptions of how easily the essential elements of care for homebound people (i.e., team-based care, communication, and collaboration) were experienced. The three identified themes address technology & tools, organizational commitment and relationship-building.

1) Technology & Tools

Choices about technology tools and implementation directly impact care delivery and how teams and providers can work together. Respondents reported that home care and primary care documentation were not integrated, which prevented them from following up on their patients' status. The use of antiquated tools, such as fax machines, negatively affected the provider's experience in responding to home care requests.

> To communicate as a fax to home care is just cumbersome and a bit of a barrier. If [home care] want something, they fax me. If I want something, I fax them. We don't always answer each other in a timely way because of the pressures of the day. Often the number that they fax me isn't the number that's actually programmed into the electronic chart. So then I go to fax them back, and I'm not sure if I have the right fax number, because it's not the actual fax that I have to home care . (AF-PCP, participant 6)

In some cases, a lack of technology and reliance on non-integrated paper charts further degrade communication opportunities. One participant described how the home care paper chart in the patient's home is moved or misplaced, which makes opportunities to communicate and collaborate more challenging.

> During home visits, [a primary care provider] would find those little folders [home care charts], like hidden all over the place, on top of the fridge. He had to actually do a police search of the house to find the home care information, and [the home care staff would] start putting it in the freezer and all sorts of unpleasant places. (FFS-PCP, participant 1)

The lack of integration of documentation tools creates additional barriers to communication and collaboration and contributes to administrative burden and time spent locating contact information. This reality can reinforce norms and identities that further entrench communication challenges.

> It's hard sometimes to carve out the time to do that – to track down that one paramedic who wrote a note, or to call the pharmacist after it takes you five different buttons to press in their telephone tree to get a hold of them. (AF-PCP, participant 6)

Respondents also described circumstances in which the creative use of technology facilitated collaboration and communication, highlighting decisions made in other programs that have facilitated communication and the experience of collaboration between groups. Participants also highlighted potential future opportunities with further and more broad information sharing with other partners in care.

> Now with the community paramedic program sharing the [electronic medical record] chart with us, it's so much easier because we can see what they're dealing with. And I think they can now see our notes as well. I honestly wish that there was more integration of all emergency services. We don't see what the police calls are out to people's homes [for]. (AF-PCP, participant 6)

In this specific example, the inclusion of emergency services is particularly relevant in caring for homebound people, as emergency services are often the homebound patient's primary interaction with the health system. One respondent also described how specific choices at an organizational level support collaboration

and communication, specifically, recognition that staff providing care in the home are mobile and thus need mobile devices to support real-time communication.

> The staff are also mobile, so they have mobile devices. If there is a change in the care plan, we're not waiting for the nurse to go back to the office, put it in the system, print it off, take it back to the client's house. It's in real time; it updates on their mobile devices. (HC, participant 1)

2) Organizational Commitment

Achieving true collaborative and integrated care requires organizational commitment and a supportive environment. The type of intentionality described by participants includes physical organization of teams (including but not limited to co-location), programmatic organization (how care teams are meant to work together as designed at an organizational or system level), established cultural norms (what the expectations are within an organization and between programs and how relationships are formed and maintained), and administrative organization (including established and expected reporting structures). These structures can facilitate integrated care in the community by creating a supportive environment for this work and establishing expectations for professionals to work together. Participants provided programmatic examples of integration, specifically in the delivery of palliative care in the community and described the differences in working with home care as part of the palliative care program compared to working with home care as part of the regular home care program.

> Home care in the palliative care program where they're apt to […] pick up the phone and call […]knowing that you know the patient well and you can have a two-way form of communication that may be even synchronous at times. I think that's one of the key ingredients is a robust

> communication so that […] your care is coordinated and integrated and that it's contextual based on their patient's care needs. (AF-PCP, participant 2)

These differences in home care across contexts highlight the impact of programmatic and organizational decisions on front-line care providers' experiences. These experiences of front-line professionals are directly informed by decisions made at higher levels. These experiences shape professionals' identities; participant responses make it clear that their work and ability to provide care are affected by decisions at higher levels.

Participants described limitations in physical organization and co-location, without established expectations for collaborative work between programs and teams.

> A physical building where each of the floors more or less operates completely independently. It's one of those very interesting design features that probably in the initial inception was not how it was expected, but the fact that you're physically co-located doesn't by itself create an environment for collaboration. […] Collaboration takes effort. (AF-PCP, participant 2)

Participants also described feeling limited by the system as currently designed and expressed frustration with the difficulty of navigating within their teams and across programs due to organizational barriers. This was described by home care participants as a lack of coordination and as seemingly duplicative care. The organizational support for home care to work with primary care partners is further complicated in the context of private home care agencies.

> There's a separate section of home care where somebody from a nursing team, separate from your regular team, is going out and doing wound care, communicating with a physician, and not always getting it back to the actual coordinator who was doing the quarterbacking of the actual care plan. […] There was no continuity. Very, very little collaboration. […] The patients had to tell their story over and over again. [Care delivery is] very siloed. […] a home care care plan happening in isolation of a primary care care plan, or the opposite, where there was no primary care at all, and only episodic care being sought by this individual. (HC, participant 2)

> We don't have that connection to primary care because [the system doesn't] allow us. They don't give us any information, even [when] accreditation says […] we have to. […] That's on [the] system to do that medication reconciliation. (HC, participant 1)

Primary care providers reported a lack of system-level support to sustain innovations within their teams or with home care partners, contributing to frustration with the inability to navigate the system to provide optimal care, particularly for homebound patients.

> The ways that it works is when you have a case coordinator, you have a good relationship. But they still can't control some of the staff that don't want to do stuff […] But making intent of connecting […] and communicating and letting people know they shouldn't be afraid to call you to, not, to not jump into the hierarchy of well you shouldn't have my cell phone. (AF-PCP, participant 3)

The lack of intentional discussion and planning between home care and primary care, with a focus on integration and collaboration, is most telling, particularly given participants' apparent desire to do so. Even in situations involving interested parties, an organizational structure to formally support that type of work, including considerations for compensation, is lacking.

Underlying the structural and organizational aspects that can support collaboration are relationships between individual care providers and among professionals within a team. The following section reviews the theme of relationships and how organizational and policy decisions can shape their formation and maintenance.

3) Relationship Building

Relationships between care providers are essential for optimal collaboration and require purposeful action and intention by policy and decision-makers and frontline professionals to be established. Participants reported that maintaining relationships with other care providers facilitated care for homebound patients. They described this as understanding where another health care professional is coming from, reaching a common understanding of a patient's care needs, and building trust between professionals, thereby allowing each to work within their scope of practice. Participants described how taking the first step to reach out to another professional or to establish communication expectations often required stepping outside typical norms. Having an existing relationship made it easier to initiate communication, leading to more valuable collaboration. Participants also described the time required to establish these relationships.

> Any time that I've spoken to [the home care providers], you feel like you know what's going on. And an understanding of, you know, their perspective. And often

> you are on the same pages but then there's [times when] you get different mixed messages from patients in particular. […] Every time I've talked to home care coordination, it's for the most part been a positive experience. (AF-PCP, participant 4)

Participants did not describe relationships as necessarily in-depth; rather, they prioritized a purposeful initiation of contact related to a particular patient situation and then leveraged that initial contact to facilitate future interactions. Those patient-centred interactions helped to address assumptions held about another professional and ultimately led to more valuable and successful patient care. While interactions between home care and primary care professionals were essential, participants described other care partners for whom establishing similar relationships further optimized care delivery for homebound individuals.

> I got a fax from the pharmacist saying 'you've got to do something about their medications'. And I thought, well, that's rather dramatic. But I called [the pharmacist] up and we had this great conversation. [The pharmacist] has known this person for years and is coming from a place where she wants to do better by her and has legitimate concerns about what's happening out in the community. (AF-PCP, participant 6)

Participants described interventions that facilitated discussion and relationship-building among care team members. For some, this occurred within their micro team (e.g., a primary care team). For others, these interactions occurred between programs. Established, regular meetings for case discussion were described as one intervention that provided opportunities for communication, relationship-building, and shared decision-making.

> Case conferences where we can have everybody in the room, it's just amazing when we have a [patient] and we have their family in the room, the physician, case manager, OT […] everybody's talking about [the care plan], where you've got the client right in the center of it. (HC, participant 1)

Participants also described instances in which these relationships do not exist and the challenges this creates in truly meeting homebound people's needs. Policy, program design, and organizational structure impact how people work together and shape expectations and ways of working that guide or direct interactions. Relationships develop when people interact with others, and system design that limits interactions means the benefits to patient outcomes from care team members having established relationships with one another are missing. Participants also described instances in which these relationships do not exist and the challenges this creates in truly meeting homebound people's needs. For some, the structural design limited opportunities for communication or directed communication between team members in certain ways.

> I would hope that the direct service [home care] staff would have way more communication with the case manager. Right now they communicate with the resource coordinator. So [they are] supervised by the resource coordinator, they phone the resource coordinator to say, [the patient isn't] doing well today. It's a game of telephone. And that resource coordinator tells the case [manager]. […] There isn't that ability for [the direct service staff] to proactively [connect with the care manager].(HC, participant 2)

> Probably knowing who [the home care workers] are, I probably fogot about them because I really don't have a lot of contact with them. I don't feel like I communicate with the home care workers that often. I probably talk to family members more about the home care piece than home care themselves. (AF-PCP, participant 4)

Importantly, participants expressed a clear desire for integration between home care and primary care programs.

> If home care was sort of in the tent, so to speak, and not its own entity that had very little to do with primary care, I think that would be extraordinarily helpful[…] in terms of care coordination, things like discharge planning […] We could do that a lot better. (AF-PCP, participant 2)

This commitment or desire for integration highlights the connection between the foundational elements (team-based care, communication, and collaboration) and the macro policy and organizational context, leading to an evolution of identities and a commitment to collaboration. This is the interface where Collaborative Identity is developed and described in the next section.

Evolution of Collaborative Identity

When caring for homebound people, participants described success as finding creative ways within their existing structures, teams, and environments to meet patient needs. These examples highlight the foundational elements of team-based care, collaboration, and communication that persist across organizational and structural contexts. Success may be due to shared values within a team, serendipitous alignment, and social identity. This shared identity almost serves to reinforce recruitment and hiring, which, in turn, further maintains the social identity; hiring

professionals with similar values to join a team that has established norms reinforces an approach to and a prioritization of caring for homebound people. A baseline or inherent commitment to these foundational elements is essential, especially when starting something new or when the organizational structure and culture are not robust enough to support further collaborative identity development. The sustainability of this approach depends on team members' individual will and the dynamics between them. Changes in team members, or local leadership, reduced tolerance for working against the organizational current, and overall burnout and fatigue can weaken commitment to a way of working. Further, attending to the foundational elements is not automatic; simply putting people together on a care team does not ensure optimal micro-team performance. Sustainable and scalable change across sites, regions, and programs requires macro support that enables the foundational elements.

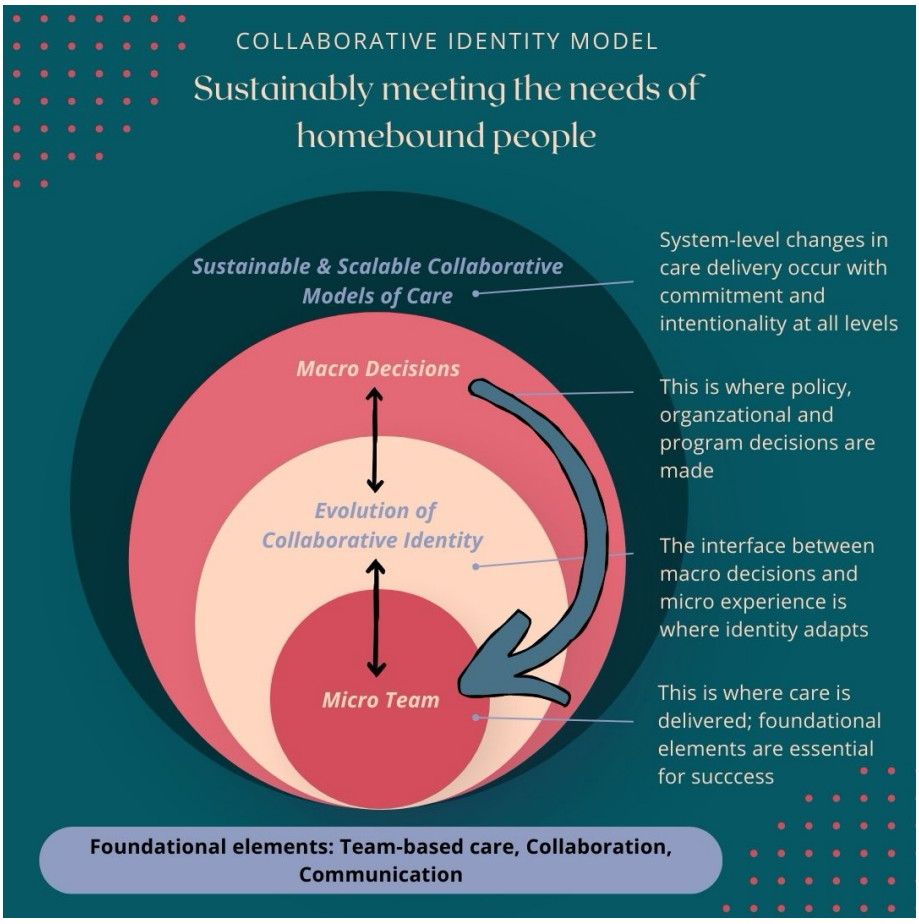
> we've tried to [make improvements] quite a few times, so we had a nurse assigned to [our primary care team] before through home care, to help look after my patients and help coordinate it. […] The idea was to have regular meetings, but they had the wrong nursing person [in the role]. She wasn't interested in collaborating. So I thought that model had a lot of hope, where you actually had […] nurses are attached to the practice, to the community area, to the doctor, to the, and for some reason, it never seems to go anywhere. " FFSPCP-1

> The physician group works well together and we do our best to take care of all the patients in the clinic. And nursing has taken quite a bit of ownership over these folks as well, which has been helpful. (AF-PCP, participant 5)

Collaborative identity evolution occurs when conditions support care delivery and expectation. When caring for homebound people, the micro-environment expects this level of care, and the work experiences are rewarding and meaningful, this further reinforces the identity that forms or evolves from doing the work. Organizational policy and culture create an environment that further supports this, which in turn reinforces or influences the care experiences and identities that result. These relationships are illustrated in Figure 3, depicted below.

Figure 3

Collaborative Identity Model



Note. This image depicts the interplay between care providers' micro-level experiences and macro-level decisions, and how these interactions influence the evolution of a collaborative identity.

When all aspects are considered, care can be delivered successfully through program integration. The following section will review successful examples described by study participants.

Sustainable and Scalable Collaborative Models of Care

Throughout this study, participants described successful care for homebound people at the micro level, and the previous sections reviewed analyses that highlight the necessary criteria for delivering care to homebound people. Importantly, home care and primary care integration were often described as lacking, especially at the macro level and in a sustainable fashion. Participants provided examples of situations in which the alignment between macro-level decisions and micro-level experiences was more intentional, specifically in the delivery of palliative care in the community.

Participants described the foundational elements as incorporated into how they work and into their expectations for interactions and collaborative work with the palliative care program. Participants highlighted established and expected communication pathways and a willingness to work collaboratively across programs.

> [Communication is better with palliative care providers] because they review things with us and they're kind of consultants. So they send information back our way and keep you in that loop of communication. (AF-PCP, participant 4)

Collaboration was also described as an essential element of the palliative care model, and participants experienced this at the micro level, reinforcing the foundational elements of team-based care, collaboration, and communication.

Participants also described experiencing the macro-level decisions; the program's design reinforces the experience of expected and intentional collaborative work.

> [Palliative care providers] proactively engage because they know they need a prescriber, they know they need a clinician, and they proactively send you information: 'Your patient just got [enrolled into the palliative care] program. These are their goals. Will you continue to be their primary care provider? If so, can we have your phone number? How can we look after you? Will you be prescribing their palliative drugs? Yes or no.' [Whereas with regular home care] half the time I wouldn't know that a patient of mine ended up on a hospital discharge in the home care program. (AF-PCP, participant 3)

Participants also described how the collaborative relationship between palliative care and primary care is intentionally evaluated when a patient is enrolled in the palliative care program, with plans to support primary care providers with varying degrees of capacity for collaborative co-management of patients. Participants contrasted their experiences working with home care and palliative care, noting that communication with palliative care was easier because it aligned with the program's structural and cultural expectations for how it operates.

> Home care is not that accessible to get a hold of. It's not easy to get a hold of a [home care] case coordinator, but yet palliative care is super easy. I could be on the phone and call someone on call and say I just can't get these symptoms managed well. So it goes well when you know you can easily get a hold of the case coordinator and you have a nurse with you. (AF-PCP, participant 3)

This experience highlights how individual experiences reinforce identities, shaping ways of working and being. With this example, the primary care provider's experience is that palliative care is accessible and easy to reach. This ease of accessibility is by design of the palliative care program and is part of how they operate and the expectations they have as a team. The primary care provider views this positively and reinforces their desire to work with the palliative care program. If we consider the Collaborative Identity Model described in Figure 3 (page 87), this dynamic drives the evolution of both groups' identities and contributes to the sustainability of the care model. A participant described an intentional decision to use shared documentation tools as a specific example of how frontline providers experience this.

> The palliative care program is just like one of the programs that tends to work very well in our system. The fact that they're on [shared electronic medical record] is quite helpful. So maybe that is something that would help with communication with home care? Yes, for sure. It is definitely more seamless. (AF-PCP, participant 5)

The responses from participants related to their experiences of working with the palliative care program, and contrasting this to their experience working with home care providers, provide an example of how systems can effectively consider macro decisions in program and system design, be intentional about opportunities for collaboration, and centre relationships as part of program design and operations. These successes can be useful to consider in the context of models and approaches to care for homebound people, as well as the optimal organization of home care and primary care programs. The next chapter will consider these results in the context of existing literature and contemplate the implications of this work.

Chapter 6 - Discussion

This study explored the experiences of home care and primary care providers caring for homebound people, with the aim of describing their care needs, approaches to care, and the identification of care partners. The theoretical frameworks that informed this work introduced the Collaborative Identity Framework, which describes the interaction between professional and social identities within a given environment, with external influences such as policy, politics, and organizational culture, contributing to the development of a Collaborative Identity. This Collaborative Identity informs who we are as collaborators, how we work with others, and how we approach our professional role when collaborating. In this study, this Collaborative Identity was considered in relation to caring for homebound people.

Homebound people, often defined by the ease with which they can leave their homes, have high rates of comorbid chronic disease, often have difficulty accessing primary care, frequent emergency departments and require inpatient admissions and have social circumstances that may contribute to the challenges they experience in leaving their homes (Lapointe-Shaw et al., 2022; Leff et al., 2024; Ornstein et al., 2015). Higher severity of frailty and dementia can also predict homeboundedness (Leff et al., 2024). Navigating community services available to support the increased care needs of an aging population can be challenging for primary care providers (R. Valaitis et al., 2020). Given the high needs of this population and the interplay of medical comorbidities, social needs and functional limitations, interprofessional teams are often described as supportive models of care for this population. Further, attention to program integration and to fostering collaborative working is essential. Home-based primary care (HBPC), for example, describes primary care delivered by a team in the patient's home that works collaboratively with home support services (Stall et al., 2013, 2014). When care is delivered for homebound people in this coordinated and

integrated model, this can lead to lower emergency department visits and hospital admissions (McGregor et al., 2018). The provision of home visits by family physicians alone, in the absence of other supports and without integration into a more holistic approach to care may lead to further fragmentation of care (Salahub et al., 2023). Given the current context of long waits in emergency departments and access block in hospitals with admitted patients waiting for transitions to other parts of the system, optimizing care in the community and preventing hospitalizations and emergency department visits is imperative (CADTH, 2023; Haas et al., 2023). This focus on optimal care in the community is especially important for homebound people, given their increased needs and challenges they face upon hospital discharge. Further, explicit integration of home-based primary care and community support services can lead to lower rates of long-term institutionalization and more months spent living in the community (Leff et al., 2019; Valluru et al., 2019).

Access to these explicitly integrated models or formal home-based primary care models is not universal. While it is important to understand the dynamics of formal programs, it is also essential to understand how care is provided to homebound people in the absence of such programs. Prioritizing the homebound population as an important segment within the primary care ecosystem is essential to achieving whole-system impact in care delivery. Considering how we care for homebound people in the community and how to optimize that care is an essential contribution to integrated, longitudinal care. Success in optimizing care for homebound people depends on collaboration and integration, or on considering how home care and primary care providers work together to meet the needs of this population. This study introduces the Collaborative Identity Framework to inform our understanding of how different professionals see themselves as collaborators, how they develop a collaborator identity, and how this identity informs their approach to

the care of homebound people. This framework informed the data analysis, culminating in the development of the Collaborative Identity model, which describes how various influences shape the development of a sustainable collaborative identity and how collaborative identity can evolve, in the context of micro- and macro-level elements. This work acts as a foundational guide to optimal integration and collaboration between home care and primary care providers and considers how professional identity formation and social identity shape and frame care providers' experiences.

This study identified foundational elements for the care of homebound people; these elements are core to optimal care delivery and must be considered and prioritized for successful care in the community.

Foundational Elements in Caring for Homebound People

Home care and primary care providers identified team-based care, communication and collaboration as essential foundational elements for caring for homebound people. Previous work has described models of care for those with multimorbidity (Muth et al., 2014; Roughead et al., 2011; Stokes et al., 2017; Sturmberg et al., 2021) and for homebound patients (Kim & Jang, 2018; Reckrey et al., 2015, 2018; Stall et al., 2013, 2014; Totten et al., 2016). These care models describe integrated, collaborative interprofessional care as foundational, yet they provide limited detail on the critical elements that enable integration and collaboration. This study provides further insights into the foundational elements that must be considered at an individual team level to optimize care for homebound people. The team-based care component highlights the perceived value of a team approach when caring for homebound people. The Patient's Medical Home model (College of Family Physicians of Canada, 2019) lists interprofessional team-based care

as one essential pillar to support optimal primary care delivery for patients in the community. For patients, a longitudinal relationship with a family physician or nurse practitioner, working as part of a primary care team that knows them, along with easy access to this team, is described in the national OurCare standard (Kiran et al., 2025b). This standard was developed through engagement with the Canadian public and describes the foundational elements of primary care delivery that all Canadians should be able to expect from the primary care system (Kiran et al., 2025b; MAP Centre for Urban Health Solutions, 2024). This study highlights the application of these concepts in caring for the homebound population, a segment of the community population for whom access to primary care is often difficult (Oseroff et al., 2023).

Specific models of care have been developed to serve homebound patients, such as HBPC models, which are designed around a team-based approach (Stall et al., 2013, 2014; Zimbroff et al., 2021). This study provides insights from primary care and home care providers caring for homebound people in the absence of formal, targeted programs for longitudinal care, suggesting that improving care for this population is possible within existing primary and home care programs and approaches. Additionally, this study reinforces the intentionality and commitment required for collaboration and team-based care to succeed, even in focused teams designed for that purpose. Programs in which different professionals communicate only through referrals fail to achieve collaboration or the desired patient outcomes, particularly for homebound patients with complex needs (Anwari et al., 2022). Collaboration and communication have previously been described as facilitators of team-based care for older adults living in the community (Montano et al., 2023); this work provides further insight into the experiences of home care and primary care providers caring for homebound people. Developing communication protocols

among groups of professionals in the community who care for homebound people has been one attempt to address this concern (Alvey, 2024).

"Collaboration" is a set of skills and competencies that describe how people work together (Canadian Interprofessional Health Collaborative, 2024). This study reinforces the competencies described in the Canadian Interprofessional Health Collaborative competency framework (Canadian Interprofessional Health Collaborative, 2024), particularly related to communication, role clarity, team functioning, disagreement management, and relationship-focused care. Participants identified collaboration, working with others, and an intentional commitment to collaboration as another essential element for optimally caring for homebound people. In this study, this commitment to working collaboratively was described within teams (both primary care and home care) and between home care and primary care.

Collaboration is described in many models of care, yet the conditions and operational aspects of collaborative work are often not specified. Others have described barriers to collaboration between home care and primary care, including a lack of understanding of roles and scopes of various team members and a lack of structured, seamless pathways for communication and collaborative care review (J. L. da Silva et al., 2021). Patients and families will often assume the role of "integrators" as they navigate the lack of seamless care delivery (Sekanina et al., 2024). "Integration" refers to how providers, systems and organizations are set up (Goodwin, 2016; Valentijn et al., 2012). Designing programs and care delivery with intentionality, incorporating and planning joint visits with different professionals, and offering shared decision-making and care-planning opportunities can improve patient-centred care and provide more holistic care (Kari et al., 2022). Designing a program to include shared visits and case reviews aligns with the outcomes of this study, in

which participants highlight intentional program design as integral to optimal care delivery for homebound patients. This study provides insights into these critical elements of homebound care.

Previous work, dating back to 1999, highlighted the lack of integration between home care and primary care and described efforts to establish integrated partnerships between these groups. In the development of a new model, the project team identified the need for structured communication processes, tools, and resources, and a commitment to partnership development (Korabek et al., 2004). In this work by Korabek et al., they purposefully sought interested and committed physicians and home care case coordinators to participate in the project. The authors describe a group of physicians readily interested in participating in the program, while case coordinators were more apprehensive and ultimately, some case coordinators were assigned to participate in the project by their manager (Korabek et al., 2004).

Several factors are telling from this previous work: 1) more than twenty years later, the same challenges and lack of integration between home care and primary care exist; 2) one wonders about the inherent professional and social identity of home care coordinators and how that limits or influences their willingness to engage in collaborative efforts and 3) Purposeful integration is not automatic and requires organizational commitment to be successful and to have sustainable change. The results of our study reinforce this interplay between front-line care delivery and organizational policy and decision-making.

Macro Decisions and Impacts on Care Delivery

This study identifies three themes describing how macro-level organizational, program, and system policy decisions influence the experiences of care providers at

the micro, or direct patient care, level. These themes include the choice and implementation of technology, organizational commitment to collaboration and integration, and action and intentional design to support relationship development among care providers.

Decisions about technology are examples of macro-level decisions with hierarchical impacts at the micro level of care provision. Participants in this study identified technology as an enabler of integrated care for homebound patients. Shared documentation, access to information about care provision and decision-making from other groups were identified as enablers of collaborative and integrated care; the absence of a common space for information sharing was perceived as a barrier. Participants also described circumstances in which decisions were made to integrate technology across programs, particularly in communication and mobile device use, and how these decisions positively influenced care providers' experiences. Methods of communication, for example, in person, by telephone or in writing, have previously been described as influencing collaboration (Alpay et al., 2023; Korabek et al., 2004). Interestingly, participants in this study did not describe concerns related to multiple logins, security or managing data to inform care delivery (Alpay et al., 2023). This discrepancy with previous work highlights the lack of foundational digital tools to support the care of homebound people in this study. Participants did not describe challenges or opportunities with more complex tools due to the lack of connection or interoperability with current tools.

The experiences shared by study participants provide a clear example of why the interoperability of digital records and documentation is critical and how decisions about the deployment of digital resources must be considered, especially for patients with complex needs, such as homebound patients. Digital interoperability is a current topic within the digital technology space (Digital Health Interoperability Task Force,

2024) and is supported by proposed federal legislation, the "Connected Care for Canadians Act", Bill S-5 ((Government of Canada, 2026). This project provides a specific example of the impacts on care delivery of the presence or absence of an interoperable digital system, and, importantly, of how providers experience their work because of decisions about digital tools and their implementation. Others have described the barriers created when technology solutions are not well supported or developed intentionally without appropriate infrastructure and policy support (Yutong et al., 2023). Shared electronic medical records have previously been described as supportive in effective collaboration for homebound people (Fathi et al., 2016); participants in this study also described instances where shared documentation records were used and how that decision positively influenced their work and experiences in caring for homebound people. Use of secure messaging between care professionals (Fathi et al., 2016) led to increased frequency of responses between home care nurses and primary care providers (Lyngstad et al., 2014). Participants in this study describe how leveraging existing secure messaging tools could help optimize communication between home care and primary care providers. Tools exist within the organizational and policy context of this study but have not been implemented to support work among home care and primary care provider groups. This example reinforces organizational and policy decisions that impact the frontline care delivery experience, as well as the need for intentional, thoughtful planning and consideration of care providers when developing and implementing digital technology solutions.

In this study, organizational commitment to integration and collaboration was another theme that highlighted the influence of macro decisions on micro-level care-provider experiences. Co-location of home care and primary care teams within the same buildings, as noted by some participants as one example, was observed despite

limited interactions and irregular, asynchronous communication about shared clients. In this case, a macro decision for co-location in the absence of explicit and purposeful decisions about integration, such as collaborative case discussions between teams, shared documentation tools, and commitment to building relationships between home care and primary care providers, further contributes to individual experiences of providers as being separate and not integrated. Co-location can foster collaboration and integration when other aspects, such as information technology, are also considered. Additionally, recognizing the role of existing professional identities, a baseline understanding of roles, and a commitment to shared values and goals have been identified as essential enablers of successful and meaningful integration in the context of co-location (Lalani & Marshall, 2022). This study reinforces the view that co-location without intentional integration does not lead to collaboration between groups.

The need for intentional design and consideration of how groups work together must occur at the organizational level. Professional and social identities within provider groups in a given context will influence the willingness and openness with which they approach integration with a new group or professional within their team (Wankah et al., 2022). In this study, home care and primary care providers mostly operated as separate groups, despite some instances of co-location, supporting the notion that groups' professional identities and cultures need to be considered for the collaboration and integration benefits of co-location to be realized. In the absence of intentional design for collaboration and integration, professional and social identities are further reinforced as separate between groups, and the established norms that ensue further reinforce these separate identities.

Previous work has explored integrating public health and primary care to improve population health outcomes. Similar challenges with communication and a

lack of common goals between groups have been described, along with the need to commit time to collaboration, as well as the benefits of relationships and trust in supporting optimal collaboration and integration (R. K. Valaitis et al., 2020). My work further expands this understanding, describing the dynamic between macro decision-making and care delivery and experiences at the micro or front-line level. Social and professional identity are variables that can be dynamic at the intersection of these decisions and experiences and can reinforce optimal integration goals for program and service delivery.

The enablers and barriers to collaborative and integrated care described in this study also demonstrate the bidirectional influence of micro- and macro-level decisions on the experiences of home care and primary care providers and on their ultimate approach to the care of homebound people. These bidirectional influences are circular in establishing and reinforcing social identities within provider groups and describe an Identity Evolution that occurs between these interfaces. Formal and informal boundaries are drawn around groups. Group members experience working within these boundaries, with explicit and implicit norms and expectations that reinforce identities that form in this context. Group identities and norms can override and shift what is typical or expected as a baseline within and between groups; however, the sustainability and scalability of these norms across a system remain unclear. Previous work has highlighted the organizational commitment required to shift historic ways of work and the challenges with the sustainability of these changes (Korabek et al., 2004). Navigating rigid and historical boundaries between acute care and community care, and between health and social programming, is challenging to overcome; this has been described outside the North American context (Woo et al., 2021), highlighting the pervasiveness of this challenge. Further, evaluating the implementation of integrated models of care, particularly those focused on older

adults, is challenging (Billings et al., 2020). These challenges with evaluation and implementation speak to the sustainability of change, particularly with new models of care and with changes in how professionals are expected to work.

Participants in this study described a "collaborative spirit." The team culture within their local micro teams was described as enabling collaborative care, which influenced how they worked together to care for homebound people. Within a primary care team, established norms of collaboration would prompt proactive outreach to potential care partners to support homebound patients. These proactive connections can begin to establish some of the enablers of integrated care described: communication, collaboration, and team-based care. As these connections are made, providers experience a different reality, and their social identities adapt to incorporate or begin to consider collaboration and care integration as part of the expected norms within the groups they find themselves. This change in participants' experiences and perceptions of reality is part of what is necessary for sustainable change.

The outcomes of this study highlight that individual commitment of a group of professionals is insufficient for sustainable change. Individual willingness, paired with organizational commitment, is essential for long-term success. Further, organizational commitment, through intentional policy decisions, can affect how professionals experience and view their work and can be leveraged to establish environments that support identity formation and evolution aligned with the goals of collaborative and integrated care. Participants in this study reported that their experiences were individual-specific and occurred at the micro-level, within the context of macro-level interventions and policy decisions that were perceived as directly supportive of or aligned with their work. Participants also provided examples of macro-level decisions that enabled collaboration and integration, resulting in care delivery perceived as

more seamless and integrated. The positive experience of working collaboratively with this program led participants to describe their experiences more in line with an integrated approach and as being on the same team. Participants in this study highlighted their experiences with the palliative care program as an example of alignment of macro-level decisions and micro-level front-line provider experience. Participants described as foundational to program delivery, for example, using a shared documentation tool and collaborative communication with primary care providers as part of clinical workflows.

Participants highlighted this experience as integrated and, in turn, described the collaborative identity they developed. “We work collaboratively with the palliative program, and the palliative works collaboratively with us” was a consistent sentiment from participants. Essential is that this way of being and working collaboratively was described as established within the program's operations. It was not contingent on the individual will of professionals in either program, nor on either program developing new ways of working, nor on requesting a new way of working to meet collaborative care goals. This way of being highlights the potential success of the Collaborative Identity model, the iterative, circular roles of policy and identity, and the necessity of both for the identity evolution that results from organizational policy and commitment. Further, moving beyond pilot projects, short-term funding, and initiatives is essential for long-term impact in how professionals work together to achieve collaborative, integrated care for homebound people.

Study Limitations

This study was conducted within a single provincial health system and a single, urban geographic area. This approach enabled the identification of themes within a relatively stable policy environment. This environmental stability enabled the

exploration of the interactions between policy decisions and providers' experiences. Despite this, we were able to explore experiences in various primary care provider compensation models and both private and public home care delivery models. This diversity of perspectives highlighted the pervasiveness of challenges of historic and structural siloing of home care and primary care, the opportunities for improvement within smaller spheres of influence, namely small, local teams of providers and the bridging of these small areas of change into broader collaboration and integration, requires organizational, policy and program commitment to be successful. The focus on recruitment within a select policy environment may limit applicability in other contexts.

Recruitment of home care providers was challenging in this study, so their experiences are not fully represented in the outcomes, a limitation. Further, the experience of direct service staff providing home care support was outside this project's scope; we focused our recruitment on home care case coordinators or home care nurses to better capture and reflect the dynamic within the existing system of established communication pathways with primary care providers. The experiences of this key group of care providers of homebound patients with collaboration and integration are important to explore. This study focused on recruitment from providers in an urban environment; rural and remote work may entail additional nuances and complexities not represented here. Homebound patients and caregivers are essential partners in this work, and recruitment was out of scope for this project; engagement with them is an important future area of work. I also focused primarily on the care of homebound people as a specific population segment to explore and understand the approaches to care by home care and primary care providers for this group. The larger home care population, and how home care and primary care

providers navigate care for this group, may involve additional complexities and nuances that were not captured in this study.

Additionally, I primarily focused our exploration on the care of homebound older adults. There are also additional subsets of people, such as younger adults with physical or cognitive disabilities, for whom care is delivered in the community with differing perspectives. We also did not delve deeply into what was considered "home" or the role the home environment and associated supports play in care delivery. Additionally, we focused on recruiting home care and primary care providers to explore their experiences of caring for homebound patients. We did not recruit other clinical partners, such as those in emergency medicine, acute care, and community agencies. These additional perspectives are essential for future exploration of collaboration and integration in the care of homebound people.

Our recruitment of primary care and home care providers for this study focused on those currently or previously caring for homebound people. This may have introduced response bias and desirability bias, given the primary investigator's positionality as a primary care provider and health system leader.

This study highlights the importance of intentionality at all levels of planning and decision-making when considering integrated, team-based care for homebound patients. The outcomes of this project can be used to inform the implementation of team-based and integrated care across the health system and provide a novel framework for considering integrated and collaborative care. The concluding chapter will summarize the study's findings, highlight important areas for future work, and outline how this work can inform and guide policymakers and decision-makers in optimally supporting collaborative and integrated care.

Chapter 7 – Conclusion

The current landscape of the health care system has challenges in access to primary care, long waits in emergency rooms and a shortage of health care providers. Combined with an aging population, increasing complexity and comorbidities, and high rates of burnout amongst clinicians, team-based care is an essential strategy for sustainability and optimal care delivery. The homebound population is a segment of community-dwelling individuals with complex, multimorbid needs. These functional limitations affect their ability to leave their homes easily, and they have difficulty with consistent, easy access to longitudinal primary care. This group often accesses care in the emergency department and in acute care facilities, which leads to prolonged stays and challenging disposition plans. Given the current state of long waits and hospital beds full of patients challenging to move within the acute care system, finding opportunities to optimize care in the community is essential. The homebound population is one group for whom the system, as currently designed and implemented, does not optimally meet their needs. In this thesis, I set out to explore the experiences of home care and primary care providers in caring for homebound people, to better understand how these groups approached their care, how they identified care partners, and how they worked together to care for this group. In this concluding chapter, I summarize the research findings on how home care and primary care providers work collaboratively to care for the homebound population. By linking the research objectives, results, and the novel Collaborative Identity Framework and Collaborative Identity Model, this chapter describes opportunities for improvement and guides recommendations for policymakers and decision-makers to enhance integrated care for homebound people in the community, as well as essential areas for future research. I will explore the potential applicability of this work

beyond the homebound population and explain why the project's outcomes are timely.

Summary of Research Objectives and Findings

This research was driven by the need to explore how to optimize community-based care for the complex, often "invisible" homebound population. With this work, I aimed to explore the following research questions:

1. To compare and contrast the care needs that primary care and home care providers consider for a person who is “homebound.”
2. To describe how primary and home care providers adjust care provision once a person is deemed “homebound.”
3. To evaluate how primary care and home care providers collaborate with other care providers in caring for “homebound” patients.

Care Needs and Adjustments: In this study, the results demonstrated that home care and primary care providers must adopt flexible, team-based approaches that prioritize communication and collaboration among care team members to manage the complex care needs of this group.

Evaluating Collaboration: In the study, I identified a significant gap between the "collaborative spirit" of individual providers and the structural siloes of the health system. While collaboration is a marker of quality, it often occurs through "serendipitous alignment" rather than intentional system design. This study also highlighted how the intentionality of decision-making at the macro policy, organizational, or program level directly impacts how professionals view their work and their collaboration with others at the micro or frontline level.

The Collaborative Identity Framework and Model

A central contribution of this thesis is the novel theoretical Collaborative Identity Framework, which posits that professional and social identities are not static but are co-created through work experiences and environmental contexts. Applying this framework, this study found that micro-level foundational elements (team-based care, communication, and collaboration) are essential to daily operations. However, these are profoundly influenced by macro-level decisions regarding technology, policy, and organizational commitment. For example, the use of antiquated tools like fax machines creates administrative burdens that reinforce siloed identities, whereas shared electronic medical records (EMRs) and access to mobile devices facilitate a shared reality and a sense of being "in the tent" together. The evolution of identity, shaped by micro- and macro-level experiences, is described in the novel Collaborative Identity Model developed as a result of this work. The study highlights the local palliative care program as a successful model of integration. In this model, macro-level decisions (shared EMRs, proactive communication protocols) directly enable micro-level identity evolution, where primary care and home care providers view themselves as part of a single, cohesive team.

Significance and the Sextuple Aim

This project underscores the application of the Sextuple Aim: for the care of homebound people to be sustainable in the community and close to home and for people to have better outcomes and better experiences of care, the health system must prioritize the experiences of health care team members and the environmental sustainability of the system by prioritizing community-based care delivery. By fostering environments that consider and prioritize collaborative identities, health systems can improve health equity for homebound patients by enhancing their

access to and experience of care. An intentional commitment to this work at the policy and organizational levels can lead to less reliance on overburdened emergency departments and acute care for this population, and to a focus on maintaining and optimizing their care in the community.

In the current health system context, with a focus on team-based care as a solution for sustainable primary care delivery, and with the system needing to optimize care in the community, this work can inform policy and decision-makers on key elements to prioritize in developing and optimizing community-based models of care. The outcomes of this study can also reinforce the need for investments in teams and collaboration; importantly, these investments must include an intentional commitment to structures, technology, and processes that support collaboration, rather than simply placing professionals in proximity to one another. The absence of intentional commitment, structure, and process will limit opportunities for sustainable, measurable change and ensure we remain stuck with many pilot projects that do not move forward and with models of care that cannot adapt to the changing needs of the population and the health system.

Opportunities for Future Research

While this study provides a foundational understanding of the professional dynamic in an urban setting, in Winnipeg, MB, several areas remain for future exploration:

- Inclusion of Patients and Caregivers: This study focused on professionals; future work must include the voices of homebound patients and their caregivers to fully understand the impact and opportunities for improvements in home care and primary care integration.

- Homecare Direct Service Staff: The experiences of home support workers and health care aides, who provide the most frequent direct care, were outside the scope of this project and represent a critical area for study. Study participants noted that the internal structure of the home care program offered opportunities for improvement in how team members worked together. Understanding the limitations to collaboration within the structure of the home care program itself is essential to moving forward with developing opportunities for partnership with primary care providers or to understanding the experiences of direct service staff in the context of collaboration and integration.
- Rural and Remote Contexts: Research is needed to determine how the Collaborative Identity Framework and Collaborative Identity model applies in rural environments where resource constraints and community dynamics differ, and to identify additional considerations that impact collaboration and the development of a collaborative identity.
- Digital Interoperability: Further investigation into the implementation of secure messaging and interoperable systems between home care and primary care programs is necessary to move beyond current "fax-based" barriers and to understand the implications of the choice of tools for communication and how to optimize implementation of these tools to support optimal care delivery, collaboration and integration between home care and primary care providers.

Conclusion

Optimizing care for the homebound population is a social problem within the health system that requires a culture shift in how home care and primary care

providers approach their work, and how the system facilitates and enables this shift. This project concludes that individual will and a collaborative spirit are insufficient for the long-term success and sustainability of innovative care models at the community and population levels. Sustainable change requires alignment between macro-level organizational commitment and micro-level identity evolution. By intentionally designing systems that foster relationship-building and integrated communication, health leaders can create a reality where collaborative care between partners is the norm rather than the exception.

References

Afshari, L., Young, S., Gibson, P. & Karimi, L. (2019). Organizational commitment: exploring the role of identity. *Personnel Review*, *49*(3), 774–790. https://doi.org/10.1108/pr-04-2019-0148

Aggarwal, M., Hutchinson, B., Abdelhalim, R. & Baker, G. R. (2023). Building High-Performing Primary Care Systems: After a Decade of Policy Change, Is Canada "Walking the Talk?" *The Millbank Quarterly*, *101*(4), 1139–1190. https://doi.org/10.1111/1468-0009.12674

Alami, H., Lehoux, P., Miller, F. A., Shaw, S. E. & Fortin, J. (2023). An urgent call for the environmental sustainability of health systems: A 'sextuple aim' to care for patients, costs, providers, population equity and the planet. *The International Journal of Health Planning and Management*, *38*(2), 289–295. https://doi.org/10.1002/hpm.3616

Alpay, L., Siemonsma, P., Koster, Y., Verhoef, J., Kassens, E., Flaton, P., Baars, K., Kessel, F. van & Dallinga, J. (2023). Technology-based interprofessional collaboration in primary care for home rehabilitation of the older adults: A dutch exploratory study. *Health Informatics Journal*, *29*(2), 14604582231169299. https://doi.org/10.1177/14604582231169299

Alvey. (2024). *Reducing 30-day Hospital Readmission in the Older Homebound Population: Using an Interprofessional Communication Protocol Within a Multidisciplinary Hospital at Home Program - ProQuest* [Yale University ProQuest Dissertations & Theses]. https://www.proquest.com/openview/d88c9271b17533ae42cc14437adfed75/1?pq-origsite=gscholar&cbl=18750&diss=y

Amankwaa, L. (2016). CREATING PROTOCOLS FOR TRUSTWORTHINESS IN QUALITATIVE RESEARCH. *Journal of Cultural Diversity*, *23*(3), 121–127.

Andrew, M. K., Dupuis-Blanchard, S., Maxwell, C., Giguere, A., Keefe, J., Rockwood, K., John, P. St. & Network, C. F. (2018). Social and Societal Implications of Frailty, Including Impact on Canadian Healthcare Systems. *The Journal of Frailty & Aging*, *7*(4), 217–223. https://doi.org/10.14283/jfa.2018.30

Andrew, M. K., Mitnitski, A. B. & Rockwood, K. (2008). Social Vulnerability, Frailty and Mortality in Elderly People. *PLoS ONE*, *3*(5), e2232. https://doi.org/10.1371/journal.pone.0002232

Andrews, T. (2012). What is Social Constructionism? *Grounded Theory Review: An International Journal*, *11*(1), 39–46. http://groundedtheoryreview.com/2012/06/01/what-is-social-constructionism/

Anwari, C., Balasubramanian, S., Sawant, P. S., Kuri, U., Anand, A. K., Rao, B. C. & Prasad, R. (2022). Elder care: The need for interprofessional collaboration between Family Physicians,

Clinical Pharmacists, and Physiotherapists in home-based primary care teams. *Journal of Family Medicine and Primary Care*, *11*(9), 5170–5175. https://doi.org/10.4103/jfmpc.jfmpc_2282_21

Bates, S. M., Lin, J., Allen, L. N., Wright, M. & Kidd, M. (2025). Can multidisciplinary teams improve the quality of primary care? A scoping review. *eClinicalMedicine*, *88*, 103497. https://doi.org/10.1016/j.eclinm.2025.103497

Billings, J., Bruin, S. R. de, Baan, C. & Nijpels, G. (2020). Advancing integrated care evaluation in shifting contexts: blending implementation research with case study design in project SUSTAIN. *BMC Health Services Research*, *20*(1), 971. https://doi.org/10.1186/s12913-020-05775-5

Bodenheimer, T. (2022a). Revitalizing Primary Care, Part 1: Root Causes of Primary Care's Problems. *The Annals of Family Medicine*, *20*(5), 464–468. https://doi.org/10.1370/afm.2858

Bodenheimer, T. (2022b). Revitalizing Primary Care, Part 2: Hopes for the Future. *The Annals of Family Medicine*, *20*(5), 469–478. https://doi.org/10.1370/afm.2859

Bodenheimer, T. & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *The Annals of Family Medicine*, *12*(6), 573–576. https://doi.org/10.1370/afm.1713

Boll, A. M., Ensey, M. R., Bennett, K. A., O'Leary, M. P., Wise-Swanson, B. M., Verrall, A. M., Vitiello, M. V., Cochrane, B. B. & Phelan, E. A. (2021). A Feasibility Study of Primary Care Liaisons: Linking Older Adults to Community Resources. *American Journal of Preventive Medicine*, *61*(6), e305–e312. https://doi.org/10.1016/j.amepre.2021.05.034

Browne, G., Roberts, J., Gafni, A., Byrne, C., Weir, R., Majumdar, B. & Watt, S. (1999). Economic evaluations of community-based care: lessons from twelve studies in Ontario. *Journal of Evaluation in Clinical Practice*, *5*(4), 367–385. https://doi.org/10.1046/j.1365-2753.1999.00191.x

CADTH. (2023). Emergency Department Overcrowding in Canada. *Canadian Journal of Health Technologies*, *3*(11). https://doi.org/10.51731/cjht.2023.791

Cahill, B. J. & Mutter, J. B. (2025). Innovative Patient Access to Home-Based Primary Care in Central Virginia. *Journal of the American Medical Directors Association*, *26*(7), 105608. https://doi.org/10.1016/j.jamda.2025.105608

Calciolari, S. & Ilinca, S. (2011). Comparing (and learning from) integrated care initiatives: an analytical framework. *Journal of Integrated Care*, *19*(6), 4–13. https://doi.org/10.1108/14769011111191412

Canadian Institute for Health Information. (2011). *Health Care in Canada, 2011. A Focus on Seniors and Aging*. CIHI.

Canadian Institute for Health Information. (2025, 25. June). *Survey shows how health care experiences of older adults in Canada compare internationally | CIHI*. https://www.cihi.ca/en/survey-shows-how-health-care-experiences-of-older-adults-in-canada-compare-internationally

Canadian Interprofessional Health Collaborative. (2024). *CIHC Competency Framework for Advancing Collaboration*.

Charles, J., Ziegler, N., Landau, S., Smith, J., Howells, A., Fine, K., Addis, L. J., Jeyabalan, V., Mcgarvey, K. & Sauer, R. (2025). Neighbourhood Care Team - Integrated care-model for team based primary care and aging at home. *International Journal of Integrated Care*, *25*(S2), 120. https://doi.org/10.5334/ijic.nacic24120

Cheng, J. M., Batten, G. P., Cornwell, T. & Yao, N. (2020). A qualitative study of health-care experiences and challenges faced by ageing homebound adults. *Health Expectations*, *23*(4), 1–9. https://doi.org/10.1111/hex.13072

College of Family Physicians of Canada. (2019). *A new vision for Canada: Family Practice—The Patient's Medical Home 2019.* College of Family Physicians of Canada.

Cornelissen, J. P., Haslam, S. A. & Balmer, J. M. T. (2007). Social Identity, Organizational Identity and Corporate Identity: Towards an Integrated Understanding of Processes, Patternings and Products. *British Journal of Management*, *18*(s1), S1–S16. https://doi.org/10.1111/j.1467-8551.2007.00522.x

Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L. & Steinert, Y. (2014). Reframing Medical Education to Support Professional Identity Formation. *Academic Medicine*, *89*(11), 1446–1451. https://doi.org/10.1097/acm.0000000000000427

Cruess, R. L., Cruess, S. R. & Steinert, Y. (2016). Amending Miller's Pyramid to Include Professional Identity Formation. *Academic Medicine*, *91*(2), 180–185. https://doi.org/10.1097/acm.0000000000000913

Cunliffe, A. L. (2008). Orientations to Social Constructionism: Relationally Responsive Social Constructionism and its Implications for Knowledge and Learning. *Management Learning*, *39*(2), 123–139. https://doi.org/10.1177/1350507607087578

Dall, T. M., Gallo, P. D., Chakrabarti, R., West, T., Semilla, A. P. & Storm, M. V. (2017). An Aging Population And Growing Disease Burden Will Require ALarge And Specialized Health Care Workforce By 2025. *Health Affairs*, *32*(11), 2013–2020. https://doi.org/10.1377/hlthaff.2013.0714

Delnoij, D., Klazinga, N. & Glasgow, I. K. (2002). Integrated care in an international perspective. *International Journal of Integrated Care*, *2*(2), e04. https://doi.org/10.5334/ijic.62

DeVoe, J. E. (2020). Primary Care Is an Essential Ingredient to a Successful Population Health Improvement Strategy. *The Journal of the American Board of Family Medicine*, *33*(3), 468–472. https://doi.org/10.3122/jabfm.2020.03.190294

Digital Health Interoperability Task Force. (2024). *Digital Health Interoperability Task Force Report*. https://www.infoway-inforoute.ca/en/component/edocman/6498-digital-health-interoperability-task-force-report/view-document?Itemid=103)

Edwards, S. T., Peterson, K., Chan, B., Anderson, J. & Helfand, M. (2017). Effectiveness of Intensive Primary Care Interventions: A Systematic Review. *J Gen Intern Med*, *32*(12), 1377–1386. https://doi.org/10.1007/s11606-017-4174-z

Ellemers, N., Gilder, D. D. & Haslam, S. A. (2004). Motivating Individuals And Groups At Work: A Social Identity Perspective On Leadership And Group Performance. *Academy of Management Review*, *29*(3), 459–478.

Fathi, R., Sheehan, O. C., Garrigues, S. K., Saliba, D., Leff, B. & Ritchie, C. S. (2016). Development of an Interdisciplinary Team Communication Framework and Quality Metrics for Home-Based Medical Care Practices. *Journal of the American Medical Directors Association*, *17*(8), 725-729.e10. https://doi.org/10.1016/j.jamda.2016.03.018

Fjellså, H. M. H., Husebø, A. M. L. & Storm, M. (2022). eHealth in Care Coordination for Older Adults Living at Home: Scoping Review. *Journal of Medical Internet Research*, *24*(10), e39584. https://doi.org/10.2196/39584

Fortin, M., Hudon, C., Bayliss, E. A., Soubhi, H. & Lapointe, L. (2007). Caring for Body and Soul: The Importance of Recognizing and Managing Psychological Distress in Persons with Multimorbidity. *The International Journal of Psychiatry in Medicine*, *37*(1), 1–9. https://doi.org/10.2190/41x8-42qw-2571-h20g

Franzosa, E., Gorbenko, K., Brody, A. A., Leff, B., Ritchie, C. S., Kinosian, B., Ornstein, K. A. & Federman, A. D. (2020). "At home, with care": Lessons from New York City Home-based Primary Care practices managing COVID-19. *Journal of the American Geriatrics Society*, *69*(2), 300–306. https://doi.org/10.1111/jgs.16952

Gioia, D. A., Price, K. N., Hamilton, A. L. & Thomas, J. B. (2010). Forging an Identity: An Insider-outsider Study of Processes Involved in the Formation of Organizational Identity. *Administrative Science Quarterly*, *55*(1), 1–46. https://doi.org/10.2189/asqu.2010.55.1.1

Giosa, J. L., Holyoke, P. & Stolee, P. (2019). Let's Get Real about Person- and Family-Centred Geriatric Home Care: A Realist Synthesis. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, *38*(4), 449–467. https://doi.org/10.1017/s0714980819000023

Glazier, R. H. (2024). Addressing unmet need for primary care in Canada. *Healthcare Management Forum*, *37*(6), 451–456. https://doi.org/10.1177/08404704241271141

Gobbens, R. J., Luijkx, K. G., Wijnen-Sponselee, M. T. & Schols, J. M. (2010). Toward a conceptual definition of frail community dwelling older people. *Nursing Outlook*, *58*(2), 76–86. https://doi.org/10.1016/j.outlook.2009.09.005

Goodwin, N. (2016). Understanding Integrated Care. *International Journal of Integrated Care*, *4*(16), 1–4.

Government of Canada. (1984). *Canada Health Act*. https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html#h-151500_

Government of Canada. (2007, 3. July). *ARCHIVED Primary health care transition fund - Canada.ca*. https://www.canada.ca/en/health-canada/services/primary-health-care/primary-health-care-transition-fund.html

Government of Canada. (2019). *CORE COMMUNITY SUPPORTS TO AGE IN COMMUNITY*. https://www.canada.ca/content/dam/canada/employment-social-development/corporate/seniors/forum/core-community-supports/core-community-supports-to-age-EN.pdf

Government of Canada. (2026, 4. February). *The Government of Canada introduces legislation to build a more connected health care system*. https://www.canada.ca/en/health-canada/news/2026/02/the-government-of-canada-introduces-legislation-to-build-a-more-connected-health-care-system.html

Government of Manitoba. (n.d.). *Home Clinic and My Health Teams*. Retrieved July 1, 2026, from https://www.gov.mb.ca/health/primarycare/homeclinic/

Government of Manitoba. (2023). *Your Guide to Home Care Services in Manitoba*.

Grant, S. & Humphries, M. (2006). Critical evaluation of appreciative inquiry. *Action Research*, *4*(4), 401–418. https://doi.org/10.1177/1476750306070103

Graybill, E. M., McMeekin, P. & Wildman, J. (2014). Can Aging in Place Be Cost Effective? A Systematic Review. *PLoS ONE*, *9*(7), e102705. https://doi.org/10.1371/journal.pone.0102705

Haas, R., Brundisini, F., Barbara, A., Darvesh, N., Ritchie, L., MacDougall, D., Spry, C., Mason, J., Hall, J., Ma, W. & Cheng, I. (2023). Emergency Department Overcrowding: An Environmental Scan of Contributing Factors and a Summary of Systematic Review Evidence on Interventions. *Canadian Journal of Health Technologies*, *3*(11). https://doi.org/10.51731/cjht.2023.786

Haferkamp, T., Ing, S., Weyer, G. & Gleason, L. J. (2025). Home-Based Primary Care (HBPC): Aging in Place in 2025. *Current Geriatrics Reports*, *14*(1), 3. https://doi.org/10.1007/s13670-025-00429-y

Han, H. & Grady, C. (2025). Retaining family physicians in comprehensive primary care: Scoping review. *Canadian Family Physician*, *71*(9), e223–e231. https://doi.org/10.46747/cfp.7109e223

Haslam, S. A. & Ellemers, N. (2005). *Social Identity in Industrial and Organizational Psychology: Concepts, Controversies and Contributions. In International Review of Industrial and Organizational Psychology 2005* (G. P. Hodgkinson & J. K. Ford, Eds.). https://doi.org/10.1002/0470029307

Hepp, S. L., Suter, E., Jackson, K., Deutschlander, S., Makwarimba, E., Jennings, J. & Birmingham, L. (2015). Using an interprofessional competency framework to examine collaborative practice. *Journal of Interprofessional Care*, *29*(2), 131–137. https://doi.org/10.3109/13561820.2014.955910

Hogg, M. A. (2018). Social Identity Theory. In P. J. Burke (Ed.), *Contemporary Social Psychological Theories: Second Edition*. Stanford Univeristy Press.

Hogg, M. A. & Rinella, M. J. (2018). Social identities and shared realities. *Current Opinion in Psychology*, *23*, 6–10. https://doi.org/10.1016/j.copsyc.2017.10.003

Hollander, M. J. & Chappell, N. L. (2007). A Comparative Analysis of Costs to Government for Home Care and Long-term Residential Care Services, Standardized for Client Care Needs*. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, *26*(S1), 149–161. https://doi.org/10.3138/cja.26.suppl_1.149

Iciaszczyk, N., Gallant, G., Bronstein, T. & Sinha, A. B. & S. (2024). Perspectives on Growing Older in Canada:The 2024 NIA Ageing in Canada Survey. *National Institute on Ageing*. https://static1.squarespace.com/static/5c2fa7b03917eed9b5a436d8/t/6797b8f938443c11169dfe79/1737996543936/2024SurveyReport_accessible.pdf

Iecovich. (2014). Aging in place: from theory to practice. *Anthropological Notebooks*, *1*(20), 21–33.

Jacobson, D., Parker, T., Baek, J., Cadel, L., Wodchis, W. P., Mansfield, E., Rosella, L., Bird, M. & Kuluski, K. (2025). "Why do i have to get naked to have a sandwich made?": The social problem of aging and cultural shift needed to facilitate aging in place. *BMC Geriatrics*, *25*(1), 725. https://doi.org/10.1186/s12877-025-06199-8

Jones, C. H. & Dolsten, M. (2024). Healthcare on the brink: navigating the challenges of an aging society in the United States. *Npj Aging*, *10*(1), 22. https://doi.org/10.1038/s41514-024-00148-2

Jones, M. G., Ornstein, K. A., Skovran, D. M., Soriano, T. A. & DeCherrie, L. V. (2017). Characterizing the high-risk homebound patients in need of nurse practitioner co-management. *Geriatric Nursing*, *38*(3), 213–218. https://doi.org/10.1016/j.gerinurse.2016.10.013

Kari, H., Kortejärvi, H. & Laaksonen, R. (2022). Developing an interprofessional people-centred care model for home-living older people with multimorbidities in a primary care health centre: A community-based study. *Exploratory Research in Clinical and Social Pharmacy*, *5*, 100114. https://doi.org/10.1016/j.rcsop.2022.100114

Kervin, L. M., Riadi, I., Chamberlain, S. A., Teo, K., Churchill, R., Beleno, R., Hung, L. & Cosco, T. D. (2025). Barriers in Health and Social Care Access and Systems Navigation among Older Adults without Advocates: A Scoping Literature Review and Framework Synthesis. *Journal of Population Ageing*, *18*(2), 221–256. https://doi.org/10.1007/s12062-023-09430-9

Kim, C.-O. & Jang, S.-N. (2018). Home-Based Primary Care for Homebound Older Adults: Literature Review. *Annals of Geriatric Medicine and Research*, *22*(2), 62–72. https://doi.org/10.4235/agmr.2018.22.2.62

Kiran, T., Daneshvarfard, M., Wang, R., Beyer, A., Kay, J., Breton, M., Brown-Shreves, D., Condon, A., Green, M. E., Hedden, L., Katz, A., Keresteci, M., Kovacina, N., Lavergne, M. R., Lofters, A., Martin, D., Mitra, G., Newbery, S., Stringer, K., … Linden, C. van der. (2024). Public experiences and perspectives of primary care in Canada: results from a cross-sectional survey. *CMAJ*, *196*(19), E646–E656. https://doi.org/10.1503/cmaj.231372

Kiran, T., Thelen, R., Szymanski, K., Daneshvarfard, M., Rajendra, K. L., Lim, J., Garabet, M., Mayer, L., Black, S., Waterbury, J. D., Katz, A., Condon, A., Lavergne, M. R., Stringer, K., Breton, M., Kovacina, N., Buss, M., Kay, J., MacLeod, P. & Mitra, G. (2025a). Public priorities for primary care in Canada: Report on insights and actionable recommendations from 5 provincial reference panels. *Canadian Family Physician*, *71*(6), 396–405. https://doi.org/10.46747/cfp.7106396

Kiran, T., Thelen, R., Szymanski, K., Daneshvarfard, M., Rajendra, K. L., Lim, J., Garabet, M., Mayer, L., Black, S., Waterbury, J. D., Katz, A., Condon, A., Lavergne, M. R., Stringer, K., Breton, M., Kovacina, N., Buss, M., Kay, J., MacLeod, P. & Mitra, G. (2025b). Public priorities for primary care in Canada: Report on insights and actionable recommendations from 5 provincial reference panels. *Canadian Family Physician*, *71*(6), 396–405. https://doi.org/10.46747/cfp.7106396

Kitchener, M., MA, T. N., Miller, N. & Harrington, C. (2006). Institutional and Community—Based Long-Term Care. *Journal of Health & Social Policy*, *22*(2), 31–50. https://doi.org/10.1300/j045v22n02_03

Kling, S. M. R., Garvert, D. W., Lessios, A. S., Yefimova, M., Martin, M., Sheffrin, M. & Winget, M. (2023). Home-Based Primary Care for Older Adults: Matched Case-Control Evaluation of Program's Impact on Healthcare Utilization. *Home Health Care Management & Practice*, *35*(3), 213–221. https://doi.org/10.1177/10848223231151975

Kodner, D. L. & Spreeuwenberg, C. (2002). Integrated care: meaning, logic, applications, and implications – a discussion paper. *International Journal of Integrated Care*, *2*(4), e12. https://doi.org/10.5334/ijic.67

Korabek, B., Rosenau, P., Slauenwhite, C. & Ross, L. (2004). Home Care/Physician Partnerships in the Community: A Canadian Model in Development. *Home Health Care Management & Practice*, *16*(4), 261–268. https://doi.org/10.1177/1084822303262273

LaFave, S., Drazich, B., Sheehan, O. C., Leff, B., Szanton, S. L. & Schuchman, M. (2020). The Value of Home-Based Primary Care: Qualitative Exploration of Homebound Participant Perspectives. *Journal of Applied Gerontology*, *40*(11), 1611–1616. https://doi.org/10.1177/0733464820967587

Lalani, M. & Marshall, M. (2022). Co-location, an enabler for service integration? Lessons from an evaluation of integrated community care teams in East London. *Health & Social Care in the Community*, *30*(2), e388–e396. https://doi.org/10.1111/hsc.13211

Lapointe-Shaw, L., Jones, A., Ivers, N. M., Rahim, A., Babe, G., Stall, N. M., Sinha, S. K. & Costa, A. P. (2022). Homebound status among older adult home care recipients in Ontario, Canada. *Journal of the American Geriatrics Society*, *70*(2), 568–578. https://doi.org/10.1111/jgs.17501

Leff, B., Lasher, A. & Ritchie, C. S. (2019). Can Home-Based Primary Care Drive Integration of Medical and Social Care for Complex Older Adults? *Journal of the American Geriatrics Society*, *67*(7), 1333–1335. https://doi.org/10.1111/jgs.15969

Leff, B., Ritchie, C., Szanton, S., Shapira, O., Sutherland, A., Lynch, A., Powers, B. W., Siddiqui, M. & Ornstein, K. A. (2024). Epidemiology of Homebound Population Among Beneficiaries of a Large National Medicare Advantage Plan. *Annals of Internal Medicine*, *177*(9), 1199–1208. https://doi.org/10.7326/m24-0011

Leutz, W. N. (1999). Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom. *The Milbank Quarterly*, *77*(1), 77–110. https://doi.org/10.1111/1468-0009.00125

Lewin, K. (1943). Psychology and the Process of Group Living. *The Journal of Social Psychology*, *17*(1), 113–131. https://doi.org/10.1080/00224545.1943.9712269

Loeb, D. F., Bayliss, E. A., Candrian, C., deGruy, F. V. & Binswanger, I. A. (2016). Primary care providers' experiences caring for complex patients in primary care: a qualitative study. *BMC Family Practice*, *17*(1), 34. https://doi.org/10.1186/s12875-016-0433-z

Loeb, D. F., Bayliss, E. A., Candrian, C., DeGruy, F. V. & Binswanger, I. A. (2016). Primary care providers' experiences caring for complex patients in primary care: A qualitative study. *BMC Family Practice*, *17*(1), 34. https://doi.org/10.1186/s12875-016-0433-z

Looman, W. M., Huijsman, R. & Fabbricotti, I. N. (2019). The (cost-)effectiveness of preventive, integrated care for community-dwelling frail older people: A systematic review. *Health & Social Care in the Community*, *27*(1), 1–30. https://doi.org/10.1111/hsc.12571

Lyngstad, M., Grimsmo, A., Hofoss, D. & Hellesø, R. (2014). Home care nurses' experiences with using electronic messaging in their communication with general practitioners. *Journal of Clinical Nursing*, *23*(23–24), 3424–3433. https://doi.org/10.1111/jocn.12590

Mah, J. C., Stevens, S. J., Keefe, J. M., Rockwood, K. & Andrew, M. K. (2021). Social factors influencing utilization of home care in community-dwelling older adults: a scoping review. *BMC Geriatrics*, *21*(1), 145. https://doi.org/10.1186/s12877-021-02069-1

MAP Centre for Urban Health Solutions. (2024). *Primary Care needs OurCare: the final report of the largest pan-Canadian conversation about primary care.* Primary Care Needs OurCare: The Final Report of the Largest Pan-Canadian Conversation about Primary Care. https://online.fliphtml5.com/sgdvg/Final-Report--Eng--Final/#p=2

Mather, H., Kleijwegt, H., Bollens-Lund, E., Liu, B., Garrido, M. M., Kelley, A. S., Leff, B., Ritchie, C. S. & Ornstein, K. A. (2023). The heterogeneity of the homebound: A latent class analysis of a national sample of homebound older adults. *Journal of the American Geriatrics Society*, *71*(7), 2163–2171. https://doi.org/10.1111/jgs.18295

McDonald, A. P., Rizzotti, R., Rivera, J. M., D'Arcy, R. C. N., Park, G. & Song, X. (2021). Toward improved homecare of frail older adults: A focus group study synthesizing patient and caregiver perspectives. *Aging Medicine*, *4*(1), 4–11. https://doi.org/10.1002/agm2.12144

McGregor, M. J., Cox, M. B., Slater, J. M., Poss, J., McGrail, K. M., Ronald, L. A., Sloan, J. & Schulzer, M. (2018). A before-after study of hospital use in two frail populations receiving different home-based services over the same time in Vancouver, Canada. *BMC Health Services Research*, *18*(1), 248. https://doi.org/10.1186/s12913-018-3040-y

McManus, C., Oseroff, B. H., Zimbroff, R. M., Riser, T. J., Ornstein, K. A. & Sheehan, O. C. (2025). Shedding Light on an Invisible Population in Geriatric Medicine: A Scoping Review of Older Adults Who Are Homebound. *Journal of the American Geriatrics Society*. https://doi.org/10.1111/jgs.19620

Meyers, D. J., Chien, A. T., Nguyen, K. H., Li, Z., Singer, S. J. & Rosenthal, M. B. (2019). Association of Team-Based Primary Care With Health Care Utilization and Costs Among Chronically Ill Patients. *JAMA Internal Medicine*, *179*(1), 54–61. https://doi.org/10.1001/jamainternmed.2018.5118

Mitty, E. & Flores, S. (2008). Aging in Place and Negotiated Risk Agreements. *Geriatric Nursing*, *29*(2), 94–101. https://doi.org/10.1016/j.gerinurse.2008.01.001

Montano, A., Cornell, P. Y. & Gravenstein, S. (2023). Barriers and facilitators to interprofessional collaborative practice for community-dwelling older adults: An integrative

review. *Journal of Clinical Nursing*, *32*(9–10), 1534–1548. https://doi.org/10.1111/jocn.15991

Musich, S., Wang, S. S., Hawkins, K. & Yeh, C. S. (2015). Homebound older adults: Prevalence, characteristics, health care utilization and quality of care. *Geriatric Nursing*, *36*(6), 445–450. https://doi.org/10.1016/j.gerinurse.2015.06.013

Muth, C., Akker, M. van den, Blom, J. W., Mallen, C. D., Rochon, J., Schellevis, F. G., Becker, A., Beyer, M., Gensichen, J., Kirchner, H., Perera, R., Prados-Torres, A., Scherer, M., Thiem, U., Bussche, H. van den & Glasziou, P. P. (2014). The Ariadne principles: How to handle multimorbidity in primary care consultations. *BMC Medicine*, *12*(1), 223. https://doi.org/10.1186/s12916-014-0223-1

Nezlek, J. B. & Smith, C. V. (2005). Social Identity in Daily Social Interaction. *Self and Identity*, *4*(3), 243–261. https://doi.org/10.1080/13576500444000308

Norman, G. J., Wade, A. J., Morris, A. M. & Slaboda, J. C. (2018). Home and community-based services coordination for homebound older adults in home-based primary care. *BMC Geriatrics*, *18*(1), 241. https://doi.org/10.1186/s12877-018-0931-z

Nundy, S., Cooper, L. A. & Mate, K. S. (2022). The Quintuple Aim for Health Care Improvement. *JAMA*, *327*(6), 521–522. https://doi.org/10.1001/jama.2021.25181

Okpalauwaekwe, U., MacPhee, B. K., Balezantis, L., Ramsden, V. R. & Baerwald, A. (2025). To stay or leave: an integrative review of factors, personas, and recommendations for retaining family physicians in Canada. *BMC Primary Care*, *27*(1), 6. https://doi.org/10.1186/s12875-025-03128-x

Ornstein, K. A., Leff, B., Covinsky, K. E., Ritchie, C. S., Federman, A. D., Roberts, L., Kelley, A. S., Siu, A. L. & Szanton, S. L. (2015). Epidemiology of the Homebound Population in the United States. *JAMA Internal Medicine*, *175*(7), 1180–1186. https://doi.org/10.1001/jamainternmed.2015.1849

Osareme, J., Ogugua, Muonde, M., Maduka, C. P., Olorunsogo, T. O. & Omotayo, O. (2024). Demographic shifts and healthcare: A review of aging populations and systemic challenges. *International Journal of Science and Research Archive*, *11*(1), 383–395. https://doi.org/10.30574/ijsra.2024.11.1.0067

Oseroff, B. H., Ankuda, C. K., Bollens-Lund, E., Garrido, M. M. & Ornstein, K. A. (2023). Patterns of Healthcare Utilization and Spending Among Homebound Older Adults in the USA: an Observational Study. *Journal of General Internal Medicine*, *38*(4), 1001–1007. https://doi.org/10.1007/s11606-022-07742-8

Ouslander, J. G. & Grabowski, D. C. (2020). COVID-19 in Nursing Homes: Calming the Perfect Storm. *Journal of the American Geriatrics Society*, *68*(10), 2153–2162. https://doi.org/10.1111/jgs.16784

Phillips, R. L., Fisher, Jackson, Martin, Hartman & Goodyear-Smith, &. (2026). Sufficient and Efficient Spending on Primary Care Benefits National Health and Health Systems. *The Millbank Quarterly*. https://doi.org/10.1111/1468-0009.70075

Priest, K. L., Kaufman, E. K., Brunton, K. & Seibel, M. (2013). Appreciative Inquiry: A Tool for Organizational, Programmatic, and Project-Focused Change. *Journal of Leadership Education*, *12*(1), 18–33. https://doi.org/10.12806/v12/i1/18

Qiu, W. Q., Dean, M., Liu, T., George, L., Gann, M., Cohen, J. & Bruce, M. L. (2010). Physical and Mental Health of Homebound Older Adults: An Overlooked Population. *Journal of the American Geriatrics Society*, *58*(12), 2423–2428. https://doi.org/10.1111/j.1532-5415.2010.03161.x

Rao, S. & Perry, C. (2003). Convergent interviewing to build theory in under-researched areas:principles and an example investigation of Internet usage in inter-firm relationships. *Qualitative Market Research: An International Journal*, *6*(4), 236–247.

Reckrey, J. M., Brody, A. A., McCormick, E. T., DeCherrie, L. V., Zhu, C. W., Ritchie, C. S., Siu, A. L., Egorova, N. N. & Federman, A. D. (2018). Rationale and design of a randomized controlled trial of home-based primary care versus usual care for high-risk homebound older adults. *Contemporary Clinical Trials*, *68*, 90–94. https://doi.org/10.1016/j.cct.2018.03.011

Reckrey, J. M., DeCherrie, L. V., Kelley, A. S. & Ornstein, K. (2013). Health Care Utilization Among Homebound Elders. *Journal of Aging and Health*, *25*(6), 1036–1049. https://doi.org/10.1177/0898264313497509

Reckrey, J. M., Soriano, T. A., Hernandez, C. R., DeCherrie, L. V., Chavez, S., Zhang, M. & Ornstein, K. (2015). The Team Approach to Home-Based Primary Care: Restructuring Care to Meet Individual, Program, and System Needs. *Journal of the American Geriatrics Society*, *63*(2), 358–364. https://doi.org/10.1111/jgs.13196

Reed, J. (2007). *Appreciative Inquiry*. https://doi.org/10.4135/9781412983464

Reicher, S. D., Haslam, S. A. & Platow, M. J. (2018). Shared social identity in leadership. *Current Opinion in Psychology*, *23*, 129–133. https://doi.org/10.1016/j.copsyc.2018.08.006

Ritchie, C. S., Leff, B., Garrigues, S. K., Perissinotto, C., Sheehan, O. C. & Harrison, K. L. (2018). A Quality of Care Framework for Home-Based Medical Care. *Journal of the American Medical Directors Association*, *19*(10), 818–823. https://doi.org/10.1016/j.jamda.2018.05.020

Roughead, E. E., Vitry, A. I., Caughey, G. E. & Gilbert, A. L. (2011). Multimorbidity, care complexity and prescribing for the elderly. *Aging Health*, *7*(5), 695–705. https://doi.org/10.2217/ahe.11.64

Salahub, C., Kiran, T., Na, Y., Sinha, S. K., Stall, N. M., Ivers, N. M., Costa, A. P., Jones, A. & Lapointe-Shaw, L. (2023). Characteristics and practice patterns of family physicians who provide home visits in Ontario, Canada: a cross-sectional study. *Canadian Medical Association Open Access Journal*, *11*(2), E282–E290. https://doi.org/10.9778/cmajo.20220124

Samadbeik, M., Staib, A., Boyle, J., Khanna, S., Bosley, E., Bodnar, D., Lind, J., Austin, J. A., Tanner, S., Meshkat, Y., Courten, B. de & Sullivan, C. (2024). Patient flow in emergency departments: a comprehensive umbrella review of solutions and challenges across the health system. *BMC Health Services Research*, *24*(1), 274. https://doi.org/10.1186/s12913-024-10725-6

Savioli, G., Ceresa, I. F., Gri, N., Piccini, G. B., Longhitano, Y., Zanza, C., Piccioni, A., Esposito, C., Ricevuti, G. & Bressan, M. A. (2022). Emergency Department Overcrowding: Understanding the Factors to Find Corresponding Solutions. *Journal of Personalized Medicine*, *12*(2), 279. https://doi.org/10.3390/jpm12020279

Scholl, I., Zill, J. M., Härter, M. & Dirmaier, J. (2014). An Integrative Model of Patient-Centeredness – A Systematic Review and Concept Analysis. *PLoS ONE*, *9*(9), e107828. https://doi.org/10.1371/journal.pone.0107828

Sekanina, U., Tetzlaff, B., Mazur, A., Huckle, T., Kühn, A., Dano, R., Höckelmann, C., Scherer, M., Balzer, K., Köpke, S., Hummers, E. & Müller, C. (2024). Interprofessional collaboration in the home care setting: perspectives of people receiving home care, relatives, nurses, general practitioners, and therapists—results of a qualitative analysis. *BMC Primary Care*, *25*(1), 79. https://doi.org/10.1186/s12875-024-02313-8

Selvakumar, P., Muralidharan, V., Kumar, G. S., Kumar, D. S., Anand, T. & Manjunath, T. C. (2025). Reducing the Carbon Footprint in Healthcare. *Journal of Environmental Nanotechnology*, *14*(1), 453–463. https://doi.org/10.13074/jent.2025.03.2511154

Sheekha, T. A., Rohatinsky, N., Alhassan, J. A. K., Kendel, D., Levandoski, C., Dmytrowich, J., Lafontaine, T., Cardinal, M. & Peña-Sánchez, J. N. (2024). Health Care Providers' Well-being Indicators are Associated With Their Intention to Leave Their Positions: A Cross-Sectional Study From Saskatchewan, Canada. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, *61*, 00469580241306548. https://doi.org/10.1177/00469580241306548

Silva, J. L. da, Teston, E. F., Marcon, S. S., Arruda, B. C. C. G., Ramos, A. R. & Batiston, A. P. (2021). Perception of health professionals about shared care between primary care and home care. *Revista Gaúcha de Enfermagem*, *42*, e20200410. https://doi.org/10.1590/1983-1447.2021.20200410

Silva, Í. de S., Araújo, A. J. de, Lopes, R. H., Silva, C. R. D. V., Xavier, P. B., Figueirêdo, R. C. de, Brito, E. W. G., Lapão, L. V., Martiniano, C. S., Nunes, V. M. de A. & Uchôa, S. A. da C.

(2024). Digital home care interventions and quality of primary care for older adults: a scoping review. *BMC Geriatrics*, *24*(1), 507. https://doi.org/10.1186/s12877-024-05120-z

Singer, A., Kosowan, L., Katz, A., Ronksley, P., McBrien, K., Halas, G. & Williamson, T. (2020). Characterizing patients with high use of the primary and tertiary care systems: A retrospective cohort study. *Health Policy*, *124*(3), 291–297. https://doi.org/10.1016/j.healthpol.2020.01.011

Slobodian, I. & Huebner, L.-A. (2015). *Interprofessional Team Demonstation Initiative (ITDI) toolkit*. Interprofessional Team Demonstration Initiative (ITDI) Toolkit. https://www.gov.mb.ca/health/primarycare/providers/myhts/docs/itdi.pdf

Smith-Carrier, T., Pham, T.-N., Akhtar, S., Nowaczynski, M., Seddon, G. & Sinha, S. (2015). "A More Rounded Full Care Model": Interprofessional Team Members' Perceptions of Home-Based Primary Care in Ontario, Canada. *Home Health Care Services Quarterly*, *34*(3–4), 232–251. https://doi.org/10.1080/01621424.2015.1108892

Somé, N. H., Devlin, R. A., Mehta, N., Zaric, G. S. & Sarma, S. (2020). Team-based primary care practice and physician's services: Evidence from Family Health Teams in Ontario, Canada. *Social Science & Medicine*, *264*, 113310. https://doi.org/10.1016/j.socscimed.2020.113310

Sommerlad, H. (2007). Researching and Theorizing the Processes of Professional Identity Formation. *Journal of Law and Society*, *34*(2), 190–217. https://doi.org/10.1111/j.1467-6478.2007.00388.x

Soones, T., Federman, A., Leff, B., Siu, A. L. & Ornstein, K. (2017). Two-Year Mortality in Homebound Older Adults: An Analysis of the National Health and Aging Trends Study. *Journal of the American Geriatrics Society*, *65*(1), 123–129. https://doi.org/10.1111/jgs.14467

Souza, M. de, Lee, A. B. & Cook, S. (2023). Healthy Patients, Workforce and Environment: Coupling Climate Adaptation and Mitigation to Wellbeing in Healthcare. *International Journal of Environmental Research and Public Health*, *20*(22), 7059. https://doi.org/10.3390/ijerph20227059

Stall, Mark, N. & Sinha. (2013). Back to the future: home-based primary care for older homebound Canadians Part 1: where are we now. *Canadian Family Physician*, 237–240.

Stall, N., Nowaczynski, M. & Sinha, S. K. (2014). Systematic Review of Outcomes from Home-Based Primary Care Programs for Homebound Older Adults. *Journal of the American Geriatrics Society*, *62*(12), n/a-n/a. https://doi.org/10.1111/jgs.13088

Sternszus, R., Steinert, Y., Razack, S., Boudreau, J. D., Snell, L. & Cruess, R. L. (2024). Being, becoming, and belonging: reconceptualizing professional identity formation in medicine. *Frontiers in Medicine*, *11*, 1438082. https://doi.org/10.3389/fmed.2024.1438082

Stetson, G. V., Kryzhanovskaya, I. V., Lomen-Hoerth, C. & Hauer, K. E. (2020). Professional Identity Formation in Disorienting Times. *Medical Education*, *54*(8), 10.1111/medu.14202. https://doi.org/10.1111/medu.14202

Stevens, M., Rees, T., Coffee, P., Haslam, S. A., Steffens, N. K. & Polman, R. (2018). Leaders promote attendance in sport and exercise sessions by fostering social identity. *Scandinavian Journal of Medicine & Science in Sports*, *28*(9), 2100–2108. https://doi.org/10.1111/sms.13217

Stokes, J., Man, M.-S., Guthrie, B., Mercer, S. W., Salisbury, C. & Bower, P. (2017). The Foundations Framework for Developing and Reporting New Models of Care for Multimorbidity. *The Annals of Family Medicine*, *15*(6), 570–577. https://doi.org/10.1370/afm.2150

Stratil, J. M., Rieger, M. A. & Voelter-Mahlknecht, S. (2018). Image and perception of physicians as barriers to inter-disciplinary cooperation? – the example of German occupational health physicians in the rehabilitation process: a qualitative study. *BMC Health Services Research*, *18*(1), 769. https://doi.org/10.1186/s12913-018-3564-1

Stull, C. L. & Blue, C. M. (2016). Examining the influence of professional identity formation on the attitudes of students towards interprofessional collaboration. *Journal of Interprofessional Care*, *30*(1), 90–96. https://doi.org/10.3109/13561820.2015.1066318

Sturmberg, J. P., Getz, L. O., Stange, K. C., Upshur, R. E. G. & Mercer, S. W. (2021). Beyond multimorbidity: What can we learn from complexity science? *Journal of Evaluation in Clinical Practice*, *27*(5), 1187–1193. https://doi.org/10.1111/jep.13521

Szanton, S. L., Roberts, L., Leff, B., Walker, J. L., Seplaki, C. L., Soones, T., Thorpe, R. J. & Ornstein, K. A. (2016). Home but still engaged: participation in social activities among the homebound. *Quality of Life Research*, *25*(8), 1913–1920. https://doi.org/10.1007/s11136-016-1245-2

Tajfel, H., Billig, M. G., Bundy, R. P. & Flament, C. (1971). Social categorization and intergroup behaviour. *European Journal of Social Psychology*, *1*(2), 149–178. https://doi.org/10.1002/ejsp.2420010202

Temkin-Greener, H., Szydlowski, J., Intrator, O., Olsan, T., Karuza, J., Cai, X., Gao, S. & Gillespie, S. M. (2019). Perceived Effectiveness of Home-Based Primary Care Teams in Veterans Health Administration. *The Gerontologist*, *60*(3), 494–502. https://doi.org/10.1093/geront/gny174

Thomas, D. R. (2006). A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation*, *27*(2), 237–246. https://doi.org/10.1177/1098214005283748

Totten, A., White-Chu, E., Wasson, N., Morgan, E., Kansagara, D., O'Reilly, C. D.- & Goodlin, S. (2016). Home-based primary care interventions. *AHRQ Publication*, *15*(16), 561–565. https://doi.org/10.1097/nhh.0000000000000621

Valaitis, R., Cleghorn, L., Ploeg, J., Risdon, C., Mangin, D., Dolovich, L., Agarwal, G., Oliver, D., Gaber, J. & Chung, H. (2020). Disconnected relationships between primary care and community-based health and social services and system navigation for older adults: a qualitative descriptive study. *BMC Family Practice*, *21*(1), 69. https://doi.org/10.1186/s12875-020-01143-8

Valaitis, R. K., Wong, S. T., MacDonald, M., Martin-Misener, R., O'Mara, L., Meagher-Stewart, D., Isaacs, S., Murray, N., Baumann, A., Burge, F., Green, M., Kaczorowski, J. & Savage, R. (2020). Addressing quadruple aims through primary care and public health collaboration: ten Canadian case studies. *BMC Public Health*, *20*(1), 507. https://doi.org/10.1186/s12889-020-08610-y

Valentijn, P. P., Schepman, S. M., Opheij, W. & Bruijnzeels, M. A. (2012). Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. *International Journal of Integrated Care*, *13*(1), e010. https://doi.org/10.5334/ijic.886

Valluru, G., Yudin, J., Patterson, C. L., Kubisiak, J., Boling, P., Taler, G., Jonge, K. E. D., Touzell, S., Danish, A., Ornstein, K. & Kinosian, B. (2019). Integrated Home- and Community-Based Services Improve Community Survival Among Independence at Home Medicare Beneficiaries Without Increasing Medicaid Costs. *Journal of the American Geriatrics Society*, *67*(7), 1495–1501. https://doi.org/10.1111/jgs.15968

Vasunilashorn, S., Steinman, B. A., Liebig, P. S. & Pynoos, J. (2012). Aging in Place: Evolution of a Research Topic Whose Time Has Come. *Journal of Aging Research*, *2012*, 120952. https://doi.org/10.1155/2012/120952

Wagner, E. H., Austin, B. T., Davis, C., Hindmarsh, M., Schaefer, J. & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. *Health Affairs*, *20*(6), 64–78. https://doi.org/10.1377/hlthaff.20.6.64

Wajnberg, A., Ornstein, K., Zhang, M., Smith, K. L. & Soriano, T. (2013). Symptom Burden in Chronically Ill Homebound Individuals. *Journal of the American Geriatrics Society*, *61*(1), 126–131. https://doi.org/10.1111/jgs.12038

Wankah, P., Rai, A., Atkinson, G., Sim, M., Marshall, E., Reid, M., John, V. St., Lavergne, R., Embrett, M., Rayner, J., Beck, D., Wodchis, W. W. & Oelke, N. (2025). Understanding policy supports for Team-Based primary healthcare models. *International Journal of Integrated Care*, *25*(S2), 158. https://doi.org/10.5334/ijic.nacic24158

Wankah, Paul, Breton, Mylaine, Gray, S., Danielle, Shaw & James. (2022). *Enhancing inter-organisational partnerships in integrated care models for older adults: a multiple case study* |

Journal of Health Organization and Management | Emerald Publishing. J Health Organ Manag. https://www.emerald.com/jhom/article-media/224051/pdfviewer/1505750

Wiles, J. L., Leibing, A., Guberman, N., Reeve, J. & Allen, R. E. S. (2012). The Meaning of "Aging in Place" to Older People. *The Gerontologist*, *52*(3), 357–366. https://doi.org/10.1093/geront/gnr098

Williams, W. & Lewis, D. (2005). Convergent interviewing: a tool for strategic investigation. *Strategic Change*, *14*(4), 219–229. https://doi.org/10.1002/jsc.719

Winnipeg Regional Health Authority. (n.d.). *Priority Home Services:Client Services-Community Handbook*. Retrieved July 1, 2026, from https://professionals.wrha.mb.ca/files/priority-home-community-handbook-e.pdf

Woo, J., Yu, R., leung, G., chu, C., Hiu, A. & Hu, F. (2021). An Integrated Model of Community Care for Older Adults: Design, Feasibility and Evaluation of Impact and Sustainability. *Aging Medicine and Healthcare*. https://doi.org/10.33879/amh.xxx.2020.07067

World Health Organization. (n.d.). *Primary Health Care*. Retrieved July 1, 2026, from https://www.who.int/health-topics/primary-health-care#tab=tab_1

World Health Organization & United Nations Children's Fund. (2020). *Operational Framework for Primary Health Care*. https://iris.who.int/server/api/core/bitstreams/7b1dddf5-199f-4167-8667-98c1e6eaf50f/content

Xiang, X. & Brooks, J. (2017). Correlates of Depressive Symptoms among Homebound and Semi-Homebound Older Adults. *Journal of Gerontological Social Work*, *60*(3), 201–214. https://doi.org/10.1080/01634372.2017.1286625

Yutong, T., Yan, Z., Qingyun, C., Lixue, M., Mengke, G. & Shanshan, W. (2023). Information and Communication Technology Based Integrated Care for Older Adults: A Scoping Review. *International Journal of Integrated Care*, *23*(1), 2. https://doi.org/10.5334/ijic.6979

Zhao, Y. (Lucy), Alderden, J., Lind, B. & Stibrany, J. (2019). Risk factors for falls in homebound community-dwelling older adults. *Public Health Nursing*, *36*(6), 772–778. https://doi.org/10.1111/phn.12651

Zimbroff, R. M., Ornstein, K. A. & Sheehan, O. C. (2021). Home-based primary care: A systematic review of the literature, 2010–2020. *Journal of the American Geriatrics Society*, *69*(10), 2963–2972. https://doi.org/10.1111/jgs.17365

Appendix A

Demographic Survey Questions

Question	Response options
1. What is your professional role?	MD, NP, Nurse, SW, other allied health (please describe)
2. What best describes your current role?	Primary care provider Home care nurse Home care case coordinator
3. How long have you been in your current professional role/practice?	Less than 5 yrs, 5-10 years, 10-15 years. 15-20 years, more than 20 years
4. What community area do you work in?	(St James-Assiniboia/Charleswood, Fort Garry/ River Heights, St. Boniface/St. Vital, Downtown/Point Douglas, River East/ Transcona, Seven Oaks/Inkster, other (please describe)
5. Where did you attend training?	
6. What year did you complete your training?	
7. What is the funding model for your primary care work (if applicable_?	Alternately funded (contract) Alt funded (salary) Fee for service
8. Do you provide home visits as part of your current work?	No

	Yes (provide ranges – daily, weekly, monthly, rarely – annually or less)
9. Do you currently have homebound people in your practice/part of your work?	Yes/No/don't know
10. Have you previously had homebound people in your practice/part of your work?	Yes/No/don't know

Appendix B

Semi-Structured Interview Guide

Preamble – thank you for participating in this study. As a reminder, this interview will be audio recorded. You do not have to answer questions you do not feel comfortable answering. I also want to remind you that my role here today is to listen and learn from you. Do you have any questions before we get started?

I am going to share a link with you and ask you to complete this demographic survey. This additional information will be used during the data analysis of this project.

1) Tell me about your experience caring for homebound people/clients? (*general, stage-setting)*
2) Describe what an ideal situation/system in caring for homebound people/clients look like? (*appreciative inquiry prompt)*
    a. What aspects of your current work are in keeping with this ideal view? What are some of the barriers?
3) Who are your partners in caring for homebound people/clients? How do you work together? What helps make it easy? What would make it even better?
    a. When is working with partners challenging? (*convergent inquiry prompt – when is it not true?)*
4) How do you identify homebound people/clients? What makes this easy? What would make this even better?
    a. When is identifying homebound patients/clients challenging? (*convergent inquiry prompt)*
5) What additional information would you like to share about caring for homebound people/clients?

Thank you for your participation in this interview. If you have any colleagues you think may be interested in participating in this study, please share this contact/study information handout with them.