“A More Rounded Full Care Model”: Interprofessional Team Members’ Perceptions of Home-Based Primary Care in Ontario, Canada

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This study explores interprofessional team members’ perspectives and experiences providing home-based primary care (HBPC) in Ontario, Canada. Employing an inductive qualitative methodology using procedures informed by grounded theory, themes emerged in the data in relation to the benefits of the HBPC model, and the
barriers associated with its provision, as well as the key components that enable or hinder interprofessional collaboration in the HBPC environment. This research deepens our understanding of the key features and processes of interprofessional teams providing high-quality care in the home.

KEYWORDS community and home care, geriatrics, health services, integration staffing roles, staffing patterns, staffing responsibilities

INTRODUCTION

Canada’s health care system was not designed with the health care needs of an aging population in mind, and will need innovative solutions if it is to be sustainable into the future. Adults age 65 and older currently constitute only 14.9% of Canada’s population, yet they are responsible for nearly half of current health care expenditures (Marchildon & DiMatteo, 2011). With this population expected to double over the next two decades, our system is also grappling with an increasing number of individuals with complex and often interrelated issues such as polymorbidity, functional decline, and social frailty (Sinha, 2011), which can also render many of these individuals homebound.

Now estimated to be 100,000, but whose numbers are projected to rise dramatically in the coming decades (Stall, Nowaczynski, & Sinha, 2013a), homebound older adults require models of care that will allow them to comfortably and safely age in place. One such model gaining momentum in health care systems across the globe is home-based primary care (HBPC) (Stall et al., 2013a, 2013b). Given that the homebound patient is likely to experience considerable difficulty accessing care in a medical office, the benefits of being able to receive ongoing, timely, and quality primary care in their place of residence are clear (Smith, Ornstein, Soriano, Muller, & Boal, 2006; Smith-Carrier, Nowaczynski, Akhtar, Pham, & Sinha, 2012).

The HBPC Model

Over the past few decades, a number of systematic reviews, including meta-analyses, have been published to assess home visiting programs, albeit with equivocal results (e.g., Bouman, van Rossum, Nelemans, Kempen, & Knipschild, 2008). Recent research demonstrates, however, that many of the studies reporting less effective outcomes have been in fact those of British and European home visit outreach programs (Wajnberg, Wang, Aniff, & Kunins, 2010), which generally do not provide ongoing and comprehensive HBPC through an interprofessional team (IPT), but instead develop care plans based on home-based geriatric assessments that are then implemented
by an office-based care provider. These programs thereby fail to address the principal access to care issues that underlie the needs of homebound patients (Stall, Nowaczynski, & Sinha, 2014). Distinct from traditional house calls or other home visiting programs, an effective HBPC program should provide patients access to ongoing primary medical care; maximize their independence and function; reduce emergency department (ED) and hospital admissions; enhance patient safety and quality of life; and link patients to supportive home-care services (Stall et al., 2013a). These programs typically include a primary care provider-led IPT that meets regularly to support patients at home, and provides after hours availability for urgent issues (Beales & Edes, 2009).

Interprofessional Teams in HBPC

The benefits of IPTs in the provision of HBPC are well-documented in studies primarily from the USA (Beales & Edes, 2009; DeCherrie, Soriano, & Hayashi, 2012; Hughes et al., 2000). IPT care maximizes the knowledge and expertise of each team member in the care of the older patient and allows care to be effectively coordinated and integrated across the care continuum (Blewett, Johnson, McCarthy, Lackner, & Brandt, 2010). Teams offering HBPC services have also been shown to decrease service gaps (Desai, Smith, & Boal, 2008); reduce ED visits, hospital admissions and hospital days; generate fewer admissions to long-term care (Stall et al., 2014); contribute to fewer falls; improve physical functioning (Newbury & Marley, 2000); and increase home deaths relative to office-based care (Rosenberg, 2012), while reducing overall costs to the health care system (De Jonge et al., 2014).

Scholarship capturing IPT members’ experiences and perspectives with HBPC is thin. This is an important void, not only because HBPC is just emerging in Canada and thus research in this country is limited, but also because researchers have tended to have a proclivity toward randomized controlled trials, which, as Clark (2001) cautions us, might not adequately capture the relational and process elements of HBPC programs. To help fill this gap, this qualitative study explores IPT members’ experiences providing HBPC vis-à-vis providing usual care, and their perspectives on the key characteristics that facilitate or hinder HBPC service provision.

METHODS

This research is part of a larger mixed methods study currently underway by the authors. In this study, we adopted an inductive qualitative methodology using procedures informed by grounded theory (Strauss & Corbin, 1998), the purpose of which was to garner insights to explain and conceptualize various dimensions of HPBC delivery by exploring the lived experiences of IPT members providing HBPC services. The study’s ethics protocol received approval
from all sites’ hospital, university, and agency ethics boards/committees prior to commencement.

Sample and Description of HBPC Programs

The sample involved seven research sites, including five urban academic family medicine teaching practices under the umbrella of their respective family health teams (FHTs), one non-academic FHT and an exclusively mobile primary care team operating out of a community support services agency. Each team is partnered with an embedded home care coordinator (HCC) from the regional home care organization (except the team with the largest caseload who has a liaison HCC that coordinates the work of multiple HCCs). Collectively, the teams seek to provide urgent and ongoing routine primary care to frail older adults within their delineated geographic boundaries, integrated with a comprehensive basket of home care and community support services (e.g., Meals on Wheels, nursing, adult day programs, respite care, and so forth) that would best meet the medical, cognitive, and social care needs of patients. Teams maintain constant communication through the use of smartphones, regularly scheduled meetings and/or rounds (at the clinic/agency site), and share access to patient electronic health records (EHRs). See Table 1 for the eligibility criteria for HBPC enrollment.

The size and composition of the teams varied, as did the patient caseloads at each site (see Table 2 for a description of the study teams). Most of the teams were relatively new; the oldest commenced in 2009, the next in 2010, another two formed in 2011, and the newest three launched in 2012. Though most team members (with the exception of two) had previous experience in primary care before joining their respective HBPC team (some within IPTs as part of a FHT), few (if any) had explicit training in interprofessional collaboration (IPC). Teams ranged in size from 4–9 members, with a variety of roles represented. For this study, a total of 17 team members participated in the research—including HCCs, social workers,

<table>
<thead>
<tr>
<th>TABLE 1 Patient Eligibility Criteria</th>
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<tr>
<td>To be eligible for HBPC services, patients must:</td>
</tr>
<tr>
<td>(1) Be greater than 65 years of age</td>
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<tr>
<td>(2) Not live in a retirement or nursing home where primary care is available</td>
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<tr>
<td>(3) Not require active palliative care at the time of enrollment</td>
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<tr>
<td>(4) Reside in the team’s catchment area</td>
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<tr>
<td>(5) Demonstrate difficulty accessing office-based primary care</td>
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<tr>
<td>(6) Be willing to transfer the responsibility for their primary care to the HBPC team</td>
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</table>
TABLE 2 Description of HBPC Study Teams

<table>
<thead>
<tr>
<th>Site</th>
<th># on team</th>
<th>Roles on teams</th>
<th>Annual caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>*FP, *PA, *NP, CN, P, PC, HCC</td>
<td>60</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>*RN, *FP, *AA, G, D, P, CN, OT, HCC</td>
<td>80</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>HCC, *FP, *RP, *NP, TC, P, SW</td>
<td>40</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>*FP, *NP, HCC</td>
<td>15</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>*SW, HCC, *FP, *P, *PA</td>
<td>70</td>
</tr>
</tbody>
</table>

*Note. Roles: NP = nurse practitioner; FP = family physician; HCC = home care coordinator; P = pharmacist; RN = registered nurse; AA = administrative assistant; G = geriatrician; D = dietician; CN = care navigator; OT = occupational therapist; PT = physiotherapist; RA = rehabilitation assistant; TC = team coordinator; PY = psychiatrist; PA = physician assistant; RP = resident physician; PC = program coordinator; LHCC = liaison home care coordinator.

*Percentage of a role that is less than 1.0 full time equivalent (FTE). **Percentage of a role that is greater than 1.0 FTE.

physicians, occupational therapists, physician assistants, nurse practitioners, nurses, and pharmacists.

Sampling and Recruitment

We adopted a purposive sampling approach, the intentional selection of subjects for inclusion in the study, coupled with maximum variation sampling, ensuring a breadth of perspectives from a range of participants. In this case, we purposefully sampled by team role to establish a heterogeneous sample that would uncover variations in the lived experiences of participants, while seeking common themes that cut across these variations (Patton, 2002). Sampling therefore involved the recruitment of 1–2 team member(s) from each site that occupied a different role (e.g., a nurse from Site 1, a pharmacist from Site 2, etc.).

Two research assistants (RAs), who had no attachment to any of the teams, held in-person semi-structured interviews with team members in the fall and winter of 2012. An RA contacted team members via email (with the informed consent letter attached) to request their participation in the study. Interested candidates were asked to respond to the email to schedule an interview. All candidates invited to participate responded favorably to schedule an interview. Interviews were held at the clinic/agency site at the participants' convenience. At the interview, the RA reviewed the informed consent letter and requested the participant sign if they agreed to participate. No compensation was provided. Data from the roughly one-hour interviews were transcribed and analyzed using NVivo Version 10 (QSR International, Doncaster, Australia). Although a topic guide was followed, interview questions were open-ended, allowing researchers to further explore and elucidate
**TABLE 3 Sample Questions From Topic Guide**

1. Can you tell me about your experience delivering primary care with (the site)?
   Probes: Can you tell me about your role? The level of care you believe patients received? Relationships? Social aspects of care?

2. Did you deliver primary care before coming on board with (the site)? If so, can you tell me about your experience delivering primary care before working with (the site)?
   Probes: Similar to Question 1.

3. What would you say are the facilitators of (the site)—the things that make (the site) work well?

4. What are the best practices of (the site)?

5. What would you say are the barriers for (the site)?

6. What would you say could be improved with (the site)?

7. As HBPC sites are composed of a number of interprofessional team members working together, what factors do you think lead to better team functioning?

8. What factors do you think lead to poorer team functioning?

Participants’ responses. Table 3 provides a sample of questions included in the topic guide.

Interviews were transcribed verbatim, and memos were kept during the analysis of the data. The first author and two RAs read and re-read the interview transcripts for accuracy before commencing the first round of open coding. The researchers employed the constant comparison method to make comparisons at each stage of the analysis, comparing similarities and differences within and across interviews (Charmaz, 2006). Open coding procedures were engaged to identify categories (concepts that represent phenomenon emerging in the data; e.g., any mention of instances or processes related to “team characteristics”), followed by axial coding procedures to elucidate and refine identified categories, with their associated properties (i.e., general or specific characteristics; e.g., types of communication) and dimensions (i.e., frequency; e.g., the repeated use of the word “rewarding” to describe participants’ perception of their work). The coding was iterative, meaning the process was not linear and sequential, but required going back and forth between interview transcripts, codes, and memos (Strauss & Corbin, 1998).

Processes engaged to enhance the trustworthiness of the research involved three key elements. Regular peer debriefing sessions were scheduled between the first author and the two RAs throughout the study. As we had multiple (three) coders analyze the data, we conducted checks on inter-rater reliability (kappa = .84) to ensure consistency in the coding process. Finally, we presented our findings to a research advisory committee (that, in addition to the authors, included two RAs and two HCC administrators).
to obtain their feedback, allowing for peer scrutiny of the findings. This discussion helped to clarify and confirm the themes identified in the analysis, ensuring that these derived from the research, limiting potential bias of the researchers (see Shenton, 2004).

RESULTS

The results are summarized across two main areas. These broad areas correspond to the research questions posed in the study (as reflected on the topic guide; see Table 3). The first of our research questions aimed to explore team members’ experiences with HBPC vis-à-vis usual care. What surfaced in these data were themes related to the benefits of and barriers to HBPC service provision in comparison to office-based care. In response to our second research question, specific characteristics emerged on what facilitates, and hinders, IPC in HBPC (see Table 4 for the key themes that surfaced in the analysis).

Interprofessional Collaboration

Team members discussed a number of key components that help facilitate IPC in HBPC—including having a shared vision for the patient, leadership, mechanisms for communication, and team learning. Central to teamwork was having a shared vision for the patient, as expressed in the following quote:

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**TABLE 4** Themes From HBPC Data

<table>
<thead>
<tr>
<th>Home-based primary care (HBPC)</th>
<th>Interprofessional collaboration (IPC)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits of HBPC</strong></td>
<td><strong>Facilitators of IPC</strong></td>
</tr>
<tr>
<td>Provider satisfaction</td>
<td>Positive relationships built on trust and respect</td>
</tr>
<tr>
<td>Enhanced care planning</td>
<td>Mechanisms for communication</td>
</tr>
<tr>
<td>Smooth access to services</td>
<td>Shared vision</td>
</tr>
<tr>
<td>Perception of deferred hospital visits</td>
<td>Leadership</td>
</tr>
<tr>
<td>Perceived effectiveness in improving patients’ health outcomes</td>
<td>Flexibility and creativity</td>
</tr>
<tr>
<td>Improved medication management</td>
<td>Organizational supports</td>
</tr>
<tr>
<td>Perceived patient satisfaction</td>
<td>Continual team learning</td>
</tr>
<tr>
<td><strong>Barriers to HBPC</strong></td>
<td><strong>Hindrances to IPC</strong></td>
</tr>
<tr>
<td>Demands on time and energy</td>
<td>Unresolved conflict</td>
</tr>
<tr>
<td>Lack of resources and equipment</td>
<td>Competing values</td>
</tr>
<tr>
<td>Provider reluctance to engage in home visits</td>
<td>Hierarchical leadership</td>
</tr>
<tr>
<td>Perception of deferred hospital visits</td>
<td>Power dynamics and turf issues</td>
</tr>
<tr>
<td>Perceived effectiveness in improving patients’ health outcomes</td>
<td>Unclear roles</td>
</tr>
</tbody>
</table>
I think it’s a common vision that the patients are at the center of what we do, and the patients’ wishes and goals are number one . . . (MD-3)

With common goals that take into account the patient’s wishes, teams are able to garner “richer ideas” to contend with complex issues. MD-3 explains:

[It’s] a collaborative discussion; we all have to listen to each other, the patient; if the patient is not capable, a family member, but taking into account the patient’s wishes. But when you have a team approach, you get much richer ideas in terms of strategies because different team members bring their different perspectives, training and creativity.

Equipped with a multiple mechanisms for communication (i.e., smartphones, email and telephone, shared EHRs and communication folders), team members were able to communicate with each other quickly and easily. SW-2 commented:

Whereas before in the community, if I needed to consult with the Occupational Therapist (OT) I would have to find out who is involved, play telephone tag. . . . Now because we work as an interdisciplinary team, communication is very easy and quick.

S/he went on to say:

Using our computers and our Blackberries, everything goes into the client’s file . . . We are not missing anything using the interdisciplinary approach.

In-person meetings were also central to the team’s care planning processes:

We meet in rounds weekly and discuss mutual clients and we can present new ones that we feel stuck with and how to help. The regular rounds are basically how we work best. (HCC-1)

Participants concurred that being part of a team, in an environment that promotes learning, allows for better client care:

I think I’ve learned a lot just from the interprofessional aspect, and the fact that as a team we discuss the care plans, so obviously you learn from one another. So, very multidisciplinary, we all learn from each other. (NP-5)

This learning must include an appreciation of the different roles of team members, and their contributions to the team. OT-4 described the need:
to make sure that everyone coming on the team understands everybody's roles... I rely... on other team members to let me know when they might need me, therefore I have to make sure those team members know what I do so they can identify when (the appropriate) goal is needed.

Some teams were small and had only a few roles represented, others were larger, and had more diverse health and social care professionals on board. Thus teams not only had different compositions, but also varied in leadership and power structures. For some, the physician was “at the top” (Nurse-14), for other teams, another member of the team took the lead. Nurse-14 commented:

But there has to be somebody in charge... because if we all had control it would be not doable [sic] for anybody. So whatever gets put into place, there's the MD at the top then right.

In contrast, Pharmacist-13 remarked:

(I)t's all through our physician assistant. So she's sort of the quarterback and she gathers all of us together and whoever she needs help with, and then she helps carry out the plan.

Irrespective of the leadership model of the team, power dynamics still appear to be at play. Power differentials were particularly evident in relation to the physician on the team. This doctor explains:

I guess one of the other challenges... was that some of our physicians are not as embracing of a nurse going out to see their patients... there's this protectionism of “my practice” attitude, and we really have to move away from that. We need to remember it's the patient that's at the center of what we do, not the physician or the physician's views... It's a challenge I have had in complex continuing care, it's a challenge being out here. (MD-3)

As with any group working together regularly, conflict and “personality quirks” do emerge, and must be appropriately handled:

We are a functional-dysfunctional family, which I guess any sort of team are (is). I think when they hired, everybody was a very strong practitioner and came with their own ideas, which was an excellent thing so we can be very autonomous. But you also get a lot of personality quirks... So it's just trying to get all of these people, who are used to working on their own, none of us really came from teams... (OT-4)
HBPC Benefits and Barriers

Team members identified numerous ways in which the model has promoted better patient care. Caring for patients in the home is different than providing care in an office-based setting because, as NP-5 explains:

"You can visually understand what their needs are. You can tell if they are taking their medications, you can tell if they have safety issues, the extent of their dementia becomes more rapidly obvious to you. . . . So you can address multiple issues quickly, so from that respect I find it easier to create a care plan that works for the patient."

Indeed, the provision of care in the home allows team members to “dig deeper” into the client's context and environment, including their access to and use of medications:

"I have the opportunity to dig deeper . . . you open up the cupboards and then there's all this other stuff that comes out. And you get a better sense of how they're taking things and what they're doing with the medications."

(Pharmacist-13)

Although we cannot yet empirically verify whether the teams in this study are effective in deferring hospital visits, there is a sense among team members that this is indeed the case, particularly given that patients “. . . can actually manage their care through us now without having to access emergency department services on every occasion” (NP-5). SW-2 also explains:

"It is more effective, less time consuming, we can get in there quickly, help the person, stabilize them, prevent hospitalization, prevent prematurely moving to a nursing home, and we can prevent a crisis often."

Participants believed that HBPC facilitates a holistic bio-psycho-social model of care that is “preventative work” (MD-6), and promotes a “more rounded, full care model,” as PA-7 asserts:

"I think that in office care, they are more focused on treating the disease. And I find that the perspectives of . . . [those] providing home care are much more focused on the entire bio-psycho-social model, and their access to food, their social and mental stimulation is just as important as their labs and their blood work. So I think that it's actually a more rounded, full care model."

The need to have a “full care model” is vitally important; as one HBPC team noted almost half of the patients in their program have dementia, and as
such, it can be difficult to determine their goals and wishes, and to involve the patient in care planning. MD-15 explains:

I’m really guessing here but I’m thinking at least 40% of our patients, if not 50% suffer with dementia. So it often does involve caregivers and family members and figuring out what the goals are of care, of that particular person. I think that’s one of the most important places to start, and then looking at all the different things that feed into their health status, like all those different determinants of health.

All HBPC teams were assigned one specific HCC (or liaison HCC), and this addition to the team was deemed to be highly valuable in streamlining and integrating care. Physician Assistant (PA)-6 expressed:

The introduction of (name of home and community care “agency”) in house has streamlined the process, which is amazing. Now I don’t have to fax and wait for (agency) to book someone to draw blood, I just hand it off to her and she just calls the nurse and it gets it done much faster.

Given the relative ease of connecting patients to services within these programs, participants suggested HBPC allows for more seamless access, and potentially a less frustrating experience for patients:

It’s made things smoother and they’re not as frustrated, they don’t have to tell their story to six different people. (Nurse-12)

HBPC also allows for the deepening of patient-provider relationships that might not be typical within an office-based context:

I think it opens patient communication and it makes the health care provider’s role a lot more rich and in-depth . . . the relationship is . . . richer. . . . (Social Worker [SW]-16)

Team members believed that this relational approach contributes to patients’ sense of being safe and cared for in the home. As noted by NP-11:

The fact that somebody stops by their house and looks after their needs for a half hour, an hour once every two months, the impact it has is terrific. It gives them a feeling of safety and it gives them a feeling of being cared for and that they have somebody that they can call if need be.
There was a clear perception among participants that clients appear more satisfied with HBPC services relative to office-based care, as discussed by Nurse-14:

It's essentially (a) one-stop shopping . . . where the providers come to them. So I would be very surprised if patients didn't find it a better experience.

Not only did team members perceive clients to be more satisfied with HBPC, but they appeared to be as well. MD-15 remarked:

I think it's [HBPC] a really satisfying way to practice . . . I feel really lucky . . . I . . . do really feel like we're making a difference.

Moreover, the notion that the work was rewarding came up frequently (seven times in fact) in the data. Many participants felt they were less stressed caring for clients with complex care needs, and that HBPC “hugely lighten(s) my workload . . . without so much strain” (MD-3).

Team members also noted a number of barriers that inhibit the effectiveness of HBPC delivery. Practitioners providing HBPC frequently do not have access to all of the equipment typically found within a care facility, or if they do, these resources might not always be optimal. MD-3 notes:

The labs that go into the home are not always reliable. Blood can sit in a car and it can throw my electrolytes off. There is a time delay in getting the results. I guess access to diagnostics and timeliness of access to diagnostics and results are the biggest barriers to home-based care.

Time came up repeatedly as a barrier to providing HBPC, particularly given the significant administrative load associated with the model:

After seeing the patient there's a lot of kind of paper work and stuff that needs to be attended to, you know, you're not seeing people with colds, you know. (MD-12)

Furthermore, the travel associated with HBPC clearly emerged as an obstacle, specifically in regions that are expansive. “One of the biggest barriers would be how far away . . . the person has to drive,” commented Nurse-14.

Wielding technology, which emerged earlier in relation to having mechanisms for communication to facilitate IPC, also has its disadvantages. Some participants felt that increased accessibility also meant that clients perceived them as being too available, resulting in a “drain(s) into your personal life” (OT-4). Moreover, the cost of delivering HBPC to the practitioner was also
raised as a barrier. Seeing patients at home translates into less money for physicians than seeing patients in the office, as noted by NP-11:

They are not getting paid much to do home visits. I don't know if that has changed . . . they are not getting paid a lot so home visits are not a priority as they can make more money seeing patients at the office.

Finally, the environment in which HBPC is offered yields unique challenges, including all of the issues that the setting of home might contain:

Uh, bed bugs. Cockroaches. . . . Yeah, it's a big issue here, a big, big issue. . . . But I've only been in one home without them, so it's a big issue that get our patients. (MD-17)

For likely one or more of the reasons cited, team members felt that other health care providers are disinclined to take on HBPC:

There seems to be some physicians who are extremely willing to take these clients on and others who do not want them whatsoever, and do not want to make home visits. And they don't talk about it, so I don't know how to partner with them and help them make that shift. (HCC-1)

DISCUSSION

Collaboration is essential for health and social care practitioners to provide efficient and effective health care services (Hammick, Freeth, Copperman, & Goodsmen, 2009). Within the HBPC context, the importance of a high-functioning team—one that embraces IPC—is perhaps even more imperative. Although some have suggested that understanding IPC requires setting- and population-specific team models (Lemieux-Charles & McGuire, 2006), the components of IPC that emerged from our data support existing literature on what contributes to IPC. Specifically, collaboration is enhanced when teams have a shared vision and common goals for client care, systems for communication (San Martín-Rodríguez, Beaulieu, D’Amour, & Ferrada-Videla, 2005), positive working relationships built on trust and respect (Ayoko, Callan, & Hartel, 2008), effective leadership (Greenfield, 2007), and constructive avenues for handling conflict (D’Amour, Ferrada-Videla, San Martín-Rodríguez, & Beaulieu, 2005). These essential ingredients might be salient for a variety of teams (and, in reality, many groups posing as “teams”); for this distinction, see Giddings & Williamson, 2007), but appear particularly germane in the HBPC context, where team members must learn to trust each other, and often improvise, in the unfamiliar
and highly ambiguous environment of the community and patients’ homes (Smith-Carrier & Neysmith, 2014).

Interprofessional learning (IPL) necessitates that team members learn to ward off profession-centrism (Pecukonis, Doyle, & Bliss, 2008) and understand the roles and contributions of each team member (D’Amour & Oandasan, 2005). For HBPC teams endeavoring to adopt the “interprofessional” label, we are reminded that processes of IPL (with, from, and about each other; Centre for the Advancement of Interprofessional Education [CAIPE], 2002) must be ongoing and planned. Working and learning together is what distinguishes IPTs from other interdisciplinary/multidisciplinary care teams (Hammick et al., 2009); therefore, team members must have built-in team processes for IPL; formal and informal learning interactions that allow team members to confront stereotypical views; expand their understanding of a multiplicity of perspectives; and develop the knowledge and skills to effectively engage in teamwork (Sargeant, Loney, & Murphy, 2008).

While many of our participants described the informal IPL they experienced as being part of an HBPC team, there was little in the data to suggest that these teams had established formal IPL activities. In fact, as previously noted, none of the participants indicated receiving specific training in IPC before or during their tenure on their HBPC team. Given that IPC involves these structured interactive learning opportunities (Begley, 2009), these teams have room to grow in the future. Indeed, while not wishing to get mired in the “terminological quagmire” of team labels (Reeves, Goldman, & Zwarenstein, 2009), it is critically important that HBPC teams shift away from an interdisciplinary team orientation and fully embrace interprofessional practice. As others have noted, “contact is not enough” to develop IPC (Sargeant et al., 2008); all team members must be able to identify the key principles and processes that lead to high team performance (D’Amour & Oandasan, 2005). This knowledge, combined with ongoing reflective practice and self-awareness (to listen and appreciate the contributions of the other professionals, as well as recognize the value of one’s own disciplinary perspective), equips team members with the interprofessional attitudes, beliefs, and skills (Margolis, Rosenberg, Umble, & Chewning, 2015) to provide effective care.

Unequivocally, team leadership is a pivotal dimension of team effectiveness (Greenfield, 2007). Our research reflected a number of different practitioners holding the position of “team lead.” While this perhaps might reflect an orientation toward clinical democracy (Lingard et al., 2012), power dynamics were still clearly at play. Traditional health care structures continue to reflect differences in hierarchical authority and divisions of labor (Pecukonis et al., 2008), elevating certain medical professionals at the apex of power and decision making. Nugus, Greenfield, Travaglia, Westbrook, and Braithwaite (2010) describe the need to negotiate and develop collaborative
power, not competitive power. Openly acknowledging and confronting these issues might prove helpful in curbing their adverse influence (Lingard et al., 2012).

While health care teams are being urged to adopt a philosophy of shared leadership, health care institutional, regulatory, and funding structures continue to reify professional hierarchies (Lingard et al., 2012). Perhaps in consequence, the notion of shared leadership, as promoted by the Canadian Interprofessional Health Collaboration’s (2010) Interprofessional Competency Framework, was unclearly articulated in our data. These teams were not immune to the tensions in leadership discussed by Lingard et al. (2012). Some participants described team processes involving the sharing of expertise to arrive at decisions collectively; however, many were also quick to identify one team member as the “team lead,” with potentially more sway in decision making. Consequently, it would appear that some teams embraced, perhaps more so than others, a model of collaborative leadership, whereby decision making is situational (Lingard et al., 2012), rotating case-by-case, governed by the needs of the patient (and her/his family and/or caregivers), and the relevant expertise of the team member(s) to respond to these at any given moment (Giddings & Williamson, 2007). It is important then, as Bleakley (2013) appropriately argues, to move beyond traditional notions of the “hierarchical and personality-bound” (p. 23) sole team lead, putting the patient at the center—not a central team leader.

Notwithstanding some of the challenges associated with team-delivered care, our study participants identified numerous benefits of the HBPC model. When compared to office-based care, participants clearly believed that providing care in the home facilitates smoother access to services and care planning processes, defers hospital admissions, is associated with better medication management, and improves patients’ overall health and social outcomes (see Table 4). In the home, providers are able to garner new insights about the health status, needs, and care processes of their patients; producing a care plan that is tailored to the individual’s preferences, capacities, and constraints. The sharing of expertise and continual negotiation among multiple professionals, together with the patient and his/her caregivers, helps to produce an integrated care plan; one that is holistic and considers, as our team members maintain, all of the bio-psycho-social aspects of care. Prevailing power dynamics are altered, and trust actively fostered, as patients and their care providers/families are met on their own turf (Boling & Yudin, 2015). In this more relational environment, and through the pooling of specialized knowledge accrued through IPC, “better options” (noted by Pharmacist-4) are identified, and effectively implemented.

The tremendous satisfaction team members experience providing HBPC services is noteworthy. Research documents a high rate of satisfaction among HBPC patients (Edes et al., 2014) and caregivers (Hughes et al., 2000). Provider satisfaction, less commonly taken into account, is often linked to
the knowledge that one is providing vital services to an underserved population. HBPC allows providers to develop more meaningful relationships with their patients and their families (Olsan, Shore, & Coleman, 2009), which also increases satisfaction (Lynn-McHale & Deatrick, 2000). Similar to Olsan et al.’s (2009) findings, our participants talked about the rewarding work they do to assist a highly frail population; the easing of their stress in caring for patients with complex care needs; and the greater commitment to patient-centred care afforded by the model. Evidence is mounting that with increased importance placed on primary care, particularly within the context of improved quality of care initiatives, patients achieve better health outcomes and providers are more satisfied in their work (Reid et al., 2010).

Within the context of HBPC, these outcomes also appear evident.

Table 4 outlines a number of challenges that may affect the day-to-day processes of HBPC teams. As cited in the literature, and clearly reflected in our study data, these challenges involve considerable demands on time (Pereles, 2000) and energy; a lack of resources, including a shortage of diagnostic equipment (Eaton, 2000); travel challenges (Stall et al., 2013b); administrative load; and issues related to negotiating the home environment, including concern for environmental contamination (Eaton, 2000). Despite the difficulties that come with providing health and social care in the home, providers in our study believed that the merits of HBPC outweigh its challenges, and remain committed to growing this model of care in the future.

HBPC is increasingly being understood as essential for patients with complex care needs (including the frail and homebound populations), an approach requiring the specialized expertise of an IPT. Being one of the first to explore team members’ perspectives on HBPC and their IPC in this environment, this study deepens our understanding of the key features, processes, and barriers confronting teams endeavoring to provide high-quality care in the home.

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REFERENCES


