

It 'makes you feel more like a person than a patient': patients' experiences receiving home-based primary care (HBPC) in Ontario, Canada

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What is known about this topic

- Home-based primary care (HBPC) is a widely recognised approach to provide comprehensive care to older adults with complex needs.
- HBPC can achieve multiple desired health outcomes, including reduced hospitalisations and emergency department visits.
- HBPC for homebound older adults is best provided by an interprofessional team of healthcare providers.

What this paper adds

- This paper is one of the first research studies to explore patients' perceptions of and experiences with HBPC.
- The HBPC team may be the only source of social support for the homebound older adult population, making the relational aspects of care fostered in HBPC vital.
- Despite the identified challenges associated with HBPC, patients expressed feeling a sense of security and peace of mind that they would receive appropriate care.

Abstract

The lack of effective systems to appropriately manage the health and social care of frail older adults – especially among those who become homebound – is becoming all the more apparent. Home-based primary care (HBPC) is increasingly being promoted as a promising model that takes into account the accessibility needs of frail older adults, ensuring that they receive more appropriate primary and community care. There remains a paucity of literature exploring patients' experiences with HBPC programmes. The purpose of this study was to explore the experiences of patients accessing HBPC delivered by interprofessional teams, and their perspectives on the facilitators and barriers to this model of care in Ontario, Canada. Using certain grounded theory principles, we conducted an inductive qualitative content analysis of in-depth patient interviews ($n = 26$) undertaken in the winter of 2013 across seven programme sites exploring the lived experiences and perspectives of participants receiving HBPC. Themes emerged in relation to patients' perceptions regarding the preference for and necessity of HBPC, the promotion of better patient care afforded by the model in comparison to office-based care, and the benefits of and barriers to HBPC service provision. Underlying patterns also surfaced related to patients' feelings and emotions about their quality of life and satisfaction with HBPC services. We argue that HBPC is well positioned to serve frail homebound older adults, ensuring that patients receive appropriate primary and community care – which the office-based alternative provides little guarantee – and that they will be cared for, pointing to a model that may not only lead to greater patient satisfaction but also likely contributes to bettering the quality of life of a highly vulnerable population.

Keywords: home visits, home-based primary care, interprofessional team care, Ontario, Canada, patient experience, patient satisfaction, quality of life

Introduction

The global implications of current demographic change include managing the growing complexity in the care needs of an ageing population. While today's older adults have a higher life expectancy and typically are in better health for longer periods than previous cohorts (Sinha 2011), many still will develop inter-related health and social issues, including multiple chronic conditions (MCCs) and functional disabilities (Barile *et al.* 2013). The lack of effective systems to appropriately manage those challenges for frail older adults – especially among those who are homebound (Qui *et al.* 2010, Wajenberg *et al.* 2010) – is becoming increasingly apparent (Boult *et al.* 2009). A promising alternative to office-based care, home-based primary care (HBPC) is now a widely recognised approach to provide comprehensive care to older adults with complex needs (Stall *et al.* 2013b). The purpose of this study was to explore the experiences of patients accessing HBPC delivered by interprofessional teams in Ontario, Canada, and to gain their perspectives on the facilitators of and barriers to this model of care.

Similar to Beales and Edes (2009) and Stall *et al.* (2013a), we define HBPC as being characterised by: (i) the provision of ongoing home-care services and primary medical care through a fully integrated interprofessional care team, led by a primary care provider; (ii) regular communication among team members to create care plans (based on multidimensional geriatric assessments at intake) that allow patients to remain in their homes with a high quality of life (QoL) by maximising their independence and function; (iii) after-hours availability for urgent issues; and (iv) a focus on reducing hospital admissions and emergency department (ED) visits. Substantial literature now documents the success of HBPC in achieving multiple desired outcomes, including identifying patients at risk of falls or suspected abuse; assessing medication adherence or the need for institutionalisation; supporting caregivers and families; and reducing caregiver burden (Smith *et al.* 2006), while reducing hospitalisations and ED visits and long-term care (LTC) admissions (Stall *et al.* 2014).

Context

In 2011, nearly five million Canadians were 65 years of age or older. This number is expected to double in the next 25 years, reaching approximately 10.4 million older adults by the year 2036 (Statistics

Canada 2011a). Ninety-two per cent of the five million individuals over age 65 in 2011 lived in private households or dwellings, a proportion that has remained relatively stable since 2001. It is further estimated that approximately 90% of older Canadians would prefer to stay in their own place of residence (Statistics Canada 2011b) for as long as possible, and ultimately die at home (Stajduhar *et al.* 2008).

While many older adults report being healthy, 91% have one or more chronic conditions, 40% have a disability and roughly 23% are frail (Theou *et al.* 2012). Many of these adults, particularly those with chronic diseases (Roberge *et al.* 2008) or who may be homebound (Stall *et al.* 2013b), are struggling to access primary care in an office-based setting (Wajenberg *et al.* 2010), and are thus turning to less than ideal care alternatives, such as ED visits and hospitalisations (Stall *et al.* 2013b). These alternatives often exacerbate previous conditions and quicken functional deterioration, placing these older adults at an increased risk of admission to LTC facilities (Sinha 2011). Other systemic difficulties also make accessing office-based primary care difficult, i.e. multiple entry points, repetitive and redundant clinical assessments, a lack of standardised tools, protracted wait times for services and inadequate transmission of information (Hébert *et al.* 2003).

There have been a number of systematic reviews, some including meta-analyses, on house call programmes over the past few decades; the findings of these studies, however, have been equivocal (Elkan *et al.* 2001, Stuck *et al.* 2002, Bouman *et al.* 2008, Huss *et al.* 2008). Some researchers (e.g. Wajenberg *et al.* 2010) contend that a number of the studies reporting unfavourable outcomes have been in fact those of British and European home visiting outreach programmes. Such interventions typically do not provide ongoing and comprehensive interprofessional team-delivered HBPC, relying instead on home-based geriatric assessments to develop care plans that are implemented by office-based care providers. These programmes thus fail to address the principal access to care problems of the homebound population (Stall *et al.* 2014).

There remains a paucity of literature exploring patients' experiences with HBPC, particularly in relation to patient satisfaction and QoL (De Jonge *et al.* 2014). To improve our understanding of HBPC from the perspectives of patients, this study explores the experiences of patients accessing HBPC delivered by interprofessional teams, and their perspectives on the facilitators of and barriers to this model of care in Ontario, Canada.

Methods

We conducted a qualitative inductive content analysis of HBPC patient interviews, informed by certain grounded theory principles (Charmez 2006). Content analysis, as described by Elo and Kyngäs (2008), provides a systemic and objective method for describing phenomena. Applying an inductive approach, the researcher moves from the specific (discrete incidents observed in the data) to the general (emerging categories and themes). Informed by grounded theory guidelines, we included memo-writing (analytic notes made to compare and code the data) in our initial and focused coding procedures; used the constant comparative method, an iterative process whereby comparisons were made at each stage of the analysis (i.e. comparing incidents and categories, within and across the data); and engaged in concurrent data collection and analysis, allowing data collected from earlier interviews to inform and illuminate subsequent interviews (Charmaz 2006). A face-to-face interview format was employed to permit an in-depth exploration of the lived experiences and perspectives of participants (Padgett 1998) receiving HBPC. As advised by Charmaz (2006), we used an interview guide reflecting a series of open-ended questions (e.g. can you tell me about your experiences receiving HBPC? What is it about receiving HBPC care that you dis/like?). The study's ethics protocol was approved by multiple hospital, university and agency research ethics boards/committees prior to commencement.

Sample

Interviews were conducted with patients ($n = 26$) from seven programme sites delivering HBPC

services in the winter of 2013. This included five academic family health teams (FHT), one community-based (FHT) team and one fully mobile team operating out of a community support services agency; see Table 1 for a description of the programmes, and their patient caseloads. Through their enrolment at an HBPC site, patients receive ongoing primary and community care, and access to urgent care as needed, through an interprofessional team. Through an inter-organisational collaboration of home-care organisations, patients from all research sites are also privy to a variety of home and healthcare services, including assistance with activities of daily living (ADLs) (e.g. bathing, feeding, etc.) or instrumental ADLs (e.g. cleaning, shopping, etc.). Each site has a diverse compositional structure, with varying levels of organisational support, tenure in HBPC service provision and structures of team leadership. Table 2 outlines the criteria for HBPC programme eligibility and research participation.

Sampling and recruitment

We employed a professional referral strategy (Hogan *et al.* 2009) to recruit participants through their circle of care. Interprofessional team members from each site identified candidates meeting the inclusion criteria, and distributed the study information and informed consent letter to these patients. If patients were interested in hearing more about the study, they were asked for their permission to have their contact information forwarded to the research team. A member of the research team (with no connection to the teams or their patients) phoned interested candidates, and an interview was scheduled. In-depth semi-structured interviews were conducted at a time and place

Table 1 Description of HBPC teams and caseloads

Site	Team size	Roles on teams	Annual caseload
1	7	*Family Physician, Physician Assistant, *Nurse Practitioner, *Care Navigator, *Pharmacist, *Programme Co-ordinator, *Home Care Co-ordinator	60
2	13	†Occupational Therapist, Four Family Physicians, Nurse Practitioner, Social Worker, *Physiotherapist, *Rehabilitation Assistant, Team Co-ordinator, *Geriatrician, *Psychiatrist, Liaison Home Care Co-ordinator	400
3	9	*Registered Nurse, *Family Physician, *Administrative Assistant, *Geriatrician, *Dietician, *Pharmacist, *Care Navigator, *Occupational Therapist, *Home Care Co-ordinator	80
4	7	*Home Care Co-ordinator, *Family Physician, *Resident Physician, *Nurse Practitioner, *Team Co-ordinator, *Pharmacist, *Social Worker	40
5	3	*Family Physician, *Nurse Practitioner, *Home Care Co-ordinator	15
6	5	*Social Worker, Home Care Co-ordinator, *Family Physician, *Pharmacist, Physician Assistant	70
7	4	*Pharmacist, *Home Care Co-ordinator, *Family Physician, *Nurse Practitioner	30

*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.

Table 2 Eligibility criteria for HBPC programme and research study

Eligibility criteria	HBPC programme	HBPC research
Over age 65	✓	✓
Not living in a retirement or nursing home (where primary care is available)	✓	✓
Not requiring active palliative care at the time of enrolment	✓	✓
Residing in the team's catchment area	✓	✓
Demonstrates difficulty accessing office-based primary care	✓	✓
Willing to transfer responsibility for their primary care to the HBPC team	✓	✓
English speaking		✓
Have no known cognitive impairment, mental health issue or delirium		✓
Have no known physical impairments that would make participating in a 1-hour interview too onerous		✓

convenient for participants (generally in patients' homes). At the interview, the researcher reviewed the informed consent letter and asked participants to sign if they agreed to participate. Patients were given \$50 gift cards in recognition of their time and contributions to the study. All candidates approached for the study agreed to participate.

Data analysis

All interviews were audiotaped and transcribed verbatim, and memos were recorded and included in the coding. Written transcripts were read and re-read to ensure accuracy before being uploaded to NVivo (version 9) for analysis. We began by conducting a round of initial coding; a process described by Charmaz (2006) of comparing data with data, incident-by-incident, for conceptual fit and relevance. Following initial coding, we engaged in focused coding to clarify and refine identified categories and sub-categories (conceptually related phenomena). Finally, we identified overarching themes that cut across the data.

Reflexivity contributes to the dependability and confirmability of qualitative research (Houghton *et al.* 2013). It is important then to discuss the locations of the authors, and the assumptions and biases they may have brought to this research endeavour. This study involved a team of both researchers (with qualitative research expertise) and healthcare practitioners

(with substantive content expertise). Having no direct experience with HBPC, and therefore, few a priori assumptions about it, the first author and two research assistants (RAs) collected and analysed these data. As the other authors, some also researchers, work in healthcare settings that either manage and/or provide HBPC services, safeguards were put in place to minimise opportunities for bias. To ensure that none of the authors had any knowledge of who participated in the study, the RAs recruited all the participants and collected the data. The first author and the two RAs then conducted the analysis and wrote up findings. To allow for peer scrutiny of the findings (Shenton 2004), the other authors provided feedback on the initial codes and coding framework. They later reviewed and edited drafts of the paper; their input into the analysis and report writing was limited. Having multiple (three) researchers conduct the coding contributed to analyst triangulation, bringing greater rigour to the research. Undertaking inter-rater reliability assessments (final coding round kappa = 0.92), and holding frequent peer debriefing sessions (Padgett 1998) also contributed to the rigour of the research.

Findings

A number of themes and categories emerged in the data, particularly in relation to patients' perceptions regarding the necessity of HBPC, the preference for this model in comparison to office-based care, how it promotes better patient care, as well as HBPC's challenges and suggested improvements. See Table 3 for an overview of the themes and categories identified.

HBPC is a fundamentally necessary service

HBPC is an essential service without which patients would be subject to inadequate access to primary and community care, and/or undesired institutionalisation. As such, HBPC is, as P1 describes, 'not a luxury, (but a) necessity'. This is particularly the case for those with difficulty ambulating. P1 explains, 'I cannot walk, you know, some people have a car and someone who can drive them [to the doctor's]. I have not this opportunity'. P3 similarly noted, 'It's not a question of like or dislike. It's a question of answering an extreme need, [I'm] not able to go out, not able to walk as far as my kitchen'. Social and psychological barriers can also make accessing office-based care taxing for patients. 'Well, I've had anxiety all my life ... agoraphobia ... so I don't go out of the house very much. I'm afraid to go away from the home you know', P4 explained. Moreover, for many on a fixed

Table 3 Themes and categories from patient data

Themes	Categories
HBPC is a fundamentally necessary service HBPC preferred over standard office-based care	Alternatives: institutionalisation, inadequate care Office care: Long waits, exposure to contagious illnesses, resort to emergency department visits HBPC: Comfort of home
HBPC promotes better patient care	More time, greater attention on patients Quality relationships
Improved satisfaction and perceptions of better quality of life among HBPC patients HBPC has its challenges	Improvements to quality of life Patient satisfaction Personal privacy Intrusion into personal space Trusting strangers Improvements in health status uncertain Difficulties within disorganised home and healthcare systems
HBPC must be expanded to meet growing demand	Expansion of HBPC, addition of new roles

income, the taxi drive to the doctor can be 'expensive' (P7, P8 and P9), cutting into already stretched personal resources.

HBPC preferred over standard office-based care

Patients experience a number of difficulties accessing care at the physician's office. Often there can be a long wait. 'In the office you always have to wait because (there are so) many people', stated P1, and echoed by P6,

You sit there in the lab and you've taken a number, which I can't read unless they tell me what it is, but then I sit there and they make ... some kind of noise and you're supposed to tell whether your number's being called, and I couldn't tell unless somebody was with me.

Rather than contend with these challenges, some patients simply resort to ED visits. 'Oh I'd just go to emergency. I never want to go there [the doctor's office] again to be honest', voiced P10. P11 similarly claimed, 'Before I used to go to emergency, now I would call (the team) because I know that they might send somebody and check first. . .'. Moreover, the risk of exposure to contagious illnesses either spread or contracted through the office-based setting can be a source of anxiety for home-bound patients. P12 commented,

...if you've got bronchitis, or as I had this last time, pneumonia, in (the) winter, it isn't good to be going outside and it isn't very good to be waiting in the waiting room infecting all the patients.

The office is not seen as a desirable place to receive care, nor is the hospital. P13 remarked, 'So I was here because I don't want to be in hospital. I have many times been in hospital and it's depressing'. As such, P3 describes where decision-makers should focus their efforts:

...to help people put it (money) where the best work is being done that has the best results. And I think that is going to people in their home. And not trying to have that horrible adjustment calling an ambulance to get to the hospital. You're never gonna (sic) have a private room, having the constant noise, no privacy, sharing a bathroom, nothing actually related to your life, to get some kind of care. I mean that is a setback immediately, all of those things, are immediate setbacks that the patient has to deal with.

As a result, patients affirmed the importance of ageing in place, with home the preferred place to both live and die.

To be at home, it's wonderful. And I want to die here. I don't want to go anywhere to ... some public institution because I ... think here at home ... you are more comfortable and it can prolong your life. (P1)

HBPC promotes better patient care

As opposed to typically brief office-based visits, patients felt the team of HBPC healthcare providers gave them more time and attention at home. 'I never have the feeling that [the provider] is rushed or that I'm being short changed where time is concerned', remarked P14. Similarly, P16 expressed, 'They paid attention to anything I said, and they listened'. HBPC also provides the context in which the immediate needs of the patient can be met. P11 explained, '[The healthcare provider] came one evening. She was wonderful, even went to the pharmacy to get my antibiotics and brought them back [to me]'.

Given the regularity of home visits and added time spent with patients, many participants felt that HBPC team members knew them well, and were thus able to intervene quickly should they become ill. 'If something would happen, if I would call, I would see someone probably within 24 hours', noted P3. Within

this more 'intimate' (P17) context, participants feel they can more freely ask questions. 'Now I can get information ... and if something's not clear I ask to have it clarified because I know now that I can do that', P3 remarked. As a result, many patients discussed that home visits felt more 'personal' – as described by P18, 'Well, it's more personal isn't it? They come to the house, have a coffee or tea or some fruit or something' – fostering relational aspects of care. Such relationships cannot be overstated for patients who are homebound. P8 expressed, 'I like everything ... because, when I call they're very, very generous with me, talk nice, spend time to talk to me'. Indeed, for some patients, the HBPC team may not only be vital in meeting their primary care needs but also their social needs as well, possibly being one of their only sources of social support. P16 noted,

Well it's nice to know that you've got a support system, and I have one of my own [the team], which is pretty good, and we have a lot of fun.

Improved satisfaction and perceptions of better QoL among HBPC patients

Understandings of participants' QoL were imbricated in expressions of sadness surrounding the limitations they face as a result of their challenging chronic health conditions. This was demonstrated by P11,

My life is not bad. The problem is I can't go out ... I have a walker; I think I used it once outside, and I just went around the corner, I couldn't go further ... I think it would help my heart to walk.

For P14, with age comes 'moments of depression and anxiety'.

When you grow older and your life becomes more and more limited, naturally you have moments of depression and anxiety, and anxiety about the future for your children, and the problems that they have. Not that I can do that much, but I'm still here...

However, receiving HBPC gave patients a sense that they would be cared for, and this knowledge gave them comfort. P3 acknowledged,

Well it's different because before I knew I had to try and manage on my own. Now I don't have to do that, you know, I have someone who will help me.

P9 similarly commented,

Well, knowing that somebody cares, knowing that there is a doctor, that there are services that I can access ... makes me feel comfortable.

Despite the tensions in the articulation of patients' perceived QoL outlined earlier, receipt of HBPC

fostered constructive emotional experiences for participants. HBPC provided participants with 'more confidence' (P20) and 'took the fear away' (P4), giving participants a 'feeling of security' (P14) that they would receive appropriate care. P4 expressed,

Because they call and follow up and provide mechanisms that I can be in touch. If I feel afraid about something I can be in touch with a nurse or someone ... It took the fear away of how you were feeling, knowing full well that someone was looking after [you].

P14 described experiencing 'peace of mind' as a result of receiving HBPC. She explains,

... knowing that somebody cares, that there are services that I can access ... makes me feel comfortable ... there have been cases in these two buildings where ladies have died and nobody's known that they're dead for a few days...

Consequently, the word 'grateful' came up repeatedly (nine times) in the data referring to how participants felt being able to receive care in the 'comfort of their own home' (P21).

While many participants expressed they did not have specific expectations entering the HBPC programme, for example, P10 commented, 'Well really, to be honest, I didn't have any expectations', there were no patients in the sample that indicated they were not satisfied with the care they received, and as P18 and P22 admitted, many felt 'lucky to get it'. Several participants felt that the treatment they received through HBPC made them feel special. P24 expressed,

Sometimes I think I'm the Queen ... the Queen don't do (sic) better than me ... that they come to my house ... that they treat me good. I have everything I need ... They treat me like I have money ... They treat me like a I am a lady.

While it is unclear how much the power differential between the researcher and the participants may have influenced these findings, patients' views on HBPC appeared overwhelmingly positive, pointing to a perception that the model has the potential to provide high-quality care. 'I'm very pleased with it; I praise it all the time. I should be a salesperson for them', pronounced P9. Accordingly, responses generally reflected how 'happy' (P18, P25) they were with HBPC, how 'wonderful' (P26), 'marvellous' it was to receive care in the comfort of their own homes, and how 'grateful' (P18) and 'pleased' (P9) they were with their HBPC care providers.

HBPC has its challenges

Participants raised a number of challenges associated with the receipt of HBPC. Personal privacy can be a concern.

The only thing I have to criticise about the programme is you lose ... and this happens when you're ill I've found out ... you lose any privacy you ever had ... so that can be very stressful. (P10)

The intrusion into personal space can also be problematic. P10 remarked,

People come in off the street and they don't wipe their feet and the dirt that comes in here ... this is my bedroom and they walk right in and I can't stand up and clean it myself.

Moreover, being in a position of vulnerability, needing to trust others, without that trust necessarily being earned, can be challenging. P11 expressed, 'I learned to trust people and to put myself in their hands because you have no choice and to accept that totally'.

HBPC introduces patients to a range of interprofessional care providers and services to which they might not otherwise be connected. Yet, it is difficult to ascertain whether HBPC yields vast improvements in patients' health trajectories. Thus, when asked if his health has improved as a result of receiving HBPC, P11 stated, 'No, my health cannot improve much because I know they cannot do anything for that [the condition]'. While some felt they were improving, others felt their health has 'remained the same' (P11) since they began receiving HBPC services.

Some discussion surrounded the home-care services that patients are privy to being part of the HBPC programme, but that are distinct from it. For example, publicly funded home-care workers are employees of a variety of home-care agencies whose services are contracted through the Ontario government's regional home-care organisations. In our model, the regional home-care organisation provided a dedicated or liaison home-care co-ordinator to work with each HBPC team to initiate and/or re-evaluate access to publicly funded home-care and nursing home services. For a few participants, the experiences with publicly funded personal support workers were positive; many however raised a number of concerns about how these services were provided and articulated the need for better organisation. P16 describes her experience with a contracted home-care provider.

...I knew of it (the home-care organisation), but I didn't know that it had been hived off into these little sections, which is pretty stupid, I think ... but now you've got these layers. You've got the top person and the supervisor, then you have another supervisor ... So, at first I was told I would have a personal care person to come and give me shower ... I would have trouble getting in and out of that bathtub ... Somebody phoned me ... I would be getting two sessions a week ... Nobody told me who was coming

or what time ... I just thought this was a little not very well organised...

The recognition that greater organisation is needed is particularly salient as the demand for services grows, and resources are increasingly limited. P10 expressed, 'The (family health) team worked very hard to get me help every day. I get an hour a day and that is very good according to what I've heard...'

HBPC must be expanded

Suggested improvements for the model largely had to do with the need for enlarging HBPC provision. Patients recognised that as it currently stands HBPC is insufficient to meet the demand, and will need to expand to serve more people. 'I can tell you it must be much larger than it is, much larger (P13)', and meet different patient needs, 'I think there could be more doctors available of a different nature. I think there should be some mental health (providers) available' (P3). More contact directly with the physician would also be helpful, as P17 suggested, 'But if you ask me how it (HBPC) could be improved that would be ... if more often, not every time, more often I could talk directly with the doctor'. Greater access to HBPC was limited due to funding as patients hypothesised, and as P3 notes, 'They're just not getting enough'.

Discussion

Patient-centred care, as outlined by the Institute of Medicine (IOM), is defined as being 'respectful of and responsive to individual patient preferences, needs and values, and ensur(es) that patient values guide all clinical decisions' (Institute of Medicine 2001, p. 3). Other dimensions identified by the IOM include co-ordination and integration of care; information, communication and education; physical comfort; emotional support; and involvement of family and friends (Institute of Medicine 2001). Arguably, HBPC provides the context in which patient-centred care can be optimised, ensuring that patients' preferences and need for integrated primary, home and community care services are provided at home, where many are most comfortable. Moreover, it is clear from our study data that being known as an individual – a marker of patient-centred care (Hanyok *et al.* 2012) – is clearly a key characteristic of HBPC service provision. Many patients highlighted the relational aspects promoted through the model, or as one participant put it, '(receiving

HBPC) makes you feel more like a person, than a patient'.

Patients with complex care needs prefer – and need – HBPC. Despite the intrusions into personal space and lack of privacy noted in our study, the majority of patients, in our study and others, are highly satisfied with team-based HBPC care (Cooper *et al.* 2007, Beck *et al.* 2009, Hanyok *et al.* 2012). Our study revealed how patients described the 'peace of mind', 'sense of security' and 'relief' associated with receiving HBPC; findings that are also reflected in Muramatsu *et al.*'s (2004) qualitative study in which patients also expressed feeling a sense of security that they would be cared for. Not only do patients have greater 'peace of mind' that by receiving HBPC they can remain in their homes for as long as possible, where they prefer to live (Shepperd *et al.* 2011) but also HBPC can, more so than the alternatives, facilitate a death at home (Rosenberg 2012), where most prefer to die (Stajduhar *et al.* 2008).

Another thread that emerged in our data centred around patients' perceptions of fragmentation and disorganisation of the publicly funded home-care system, characterised by Aronson (2006) as a poorly co-ordinated patchwork of services, marked by a thinning of provisions such that services are insufficient to meet growing demand (Aronson & Neysmith 2006). While recent funding announcements have introduced increased support for publicly funded home and community care services in Ontario (Smith-Carrier *et al.* 2012), provincial deliberations that would support an integrated delivery system would likely not only help with cost containment but also begin the much needed discussion on how to better align primary, home and community care services to support patients living at home.

While a host of scholarship now documents the positive effects of HBPC in improving medication management (Ornstein *et al.* 2013) and reducing hospital admissions, hospital bed days, ED visits and LTC admissions (Stall *et al.* 2014), findings on the health outcomes for HBPC patients at the individual level have been equivocal (e.g. Hughes *et al.* 2000). The high burden of illness associated with this population (North *et al.* 2008, Olsan *et al.* 2009) makes the achievement of significant long-term improvements in patient health uncertain (Mayo-Wilson *et al.* 2014). Our study confirms that patients are well aware of the advanced stages of their health conditions and the limited improvements to be expected, making innovations that improve QoL immensely important.

QoL is typically conceived of either as a global (i.e. perceived assessment of life satisfaction or well-being [Hellstrom & Hallber 2001]) or health-related

measure (health-related quality of life [HRQoL]) assessing physical and mental health status (Barile *et al.* 2013). Chen *et al.*'s (2011) study in the United States found that respondents with MCCs reported worse HRQoL than those with one or no chronic conditions, and as the number of MCCs grew, so too did frequent physical distress (outpacing frequent mental distress). In relation to QoL, Borg *et al.* (2006) found that life satisfaction among older adults with reduced self-care capacity was determined by social, physical, mental and financial aspects; specifically, self-reported health status, having sufficient funds to meet one's needs, limitations in performing ADLs, and feeling worried and/or lonely. To address diminished QoL engendered by loneliness, Borg *et al.* (2006) suggest that home visits may be particularly helpful in meeting the social needs of this population (Borg *et al.* 2006); a recommendation echoed in Theeke and Mallow's (2013) study on loneliness with chronically ill older adults in rural settings.

For a number of patients in our study, the HBPC team was ultimately their only source of social support; being isolated, typically without adequate social interaction, can be detrimental (Vanderhorst & McLaren 2005). For a homebound population already more prone to depression (Choi & McDougall 2007), the relational aspects of care are all the more vital. Mistry *et al.*'s (2001) study, for example, showed that social isolation was a significant predictor of re-hospitalisation for socially isolated older American veterans. On the other hand, strong patient-physician relationships are associated with greater medication adherence (Wroth & Pathman 2006), and patients with high trust in their healthcare providers have shown improved health outcomes, particularly in the area of chronic disease management (Murray & McCrone 2014). Care provided within a community context in particular has been shown to be more person-focused, which is congruent with patient-reported quality and satisfaction with care (Flocke *et al.* 2002).

Relatively little is known about patient satisfaction within the context of interprofessional team service provision. Wen and Schulman's (2014) systematic review and meta-analysis of randomised control trials examining patient satisfaction within a team environment found some evidence of higher patient satisfaction vis-à-vis usual care; however, given suboptimal trial quality, many studies were excluded, and from those included, only studies using a dichotomous outcome showed favourable results. More research is thus needed to more fully understand patient satisfaction within the context of team-delivered care. We do know that what patients expect from their healthcare providers, juxtaposed to their actual experiences

of care, can influence their satisfaction with the healthcare services they receive. However, how these expectations are defined and the ways that they are measured vary across programmes and settings (Bowling *et al.* 2012). Interestingly, patient satisfaction in our study data was not linked to a priori expectations. Patients did not have explicit expectations about the kind of care they would receive from the HBPC team prior to programme enrolment. Expectations were fulfilled, and satisfaction was thus amplified, as patients experienced HBPC by a team of specialists trained in medical and social care (highlighting team-delivered service provision as an attribute of patient-centred care [Davis *et al.* 2005]); in an ongoing (emphasising connected and coherent continuity of care [Haggerty *et al.* 2003]), timely (where wait times have traditionally impeded satisfaction [Anderson *et al.* 2007]) and relationship-centred manner (Flocke *et al.* 2002).

Measuring the multiple dimensions of patient satisfaction and QoL can be problematic, particularly for patients with MCCs and inter-related co-morbidities (Zulman *et al.* 2014) who receive care from a variety of healthcare professionals (DuGoff *et al.* 2013). Consequently, we argue, as others have done before (Marcinowicz *et al.* 2009), that patient surveys (and other quantitative measures to assess quality) may be insufficient to appropriately measure the complexity of what satisfaction is and what it is not. Qualitative analysis, when coupled with quantitative data, may be more useful in deciphering not only whether patients are satisfied but also how and why.

By providing rich and detailed descriptions of a phenomenon, qualitative research can be both powerful and compelling (Anderson 2010). However, while these findings in support of HBPC show promise, and may potentially be transferable to other settings, these data do not render generalisable results. Further rigorous research is needed to substantiate the benefits of HBPC.

The HBPC model, which draws on multiple team and organisational healthcare providers in managing the care of the frail older adult, is reliant on effective interprofessional collaboration (Stall *et al.* 2013b) and inter-organisational integration (Leff *et al.* 2015). Such integration not only reduces silos of care for the patient, and within the healthcare system broadly but also results in more effective resource utilisation (De Jonge *et al.* 2014, Edes *et al.* 2014) and ultimately, as captured here, greater well-being for patients. HBPC is thus well positioned to serve frail homebound older adults, ensuring that patients receive appropriate primary and community care – which the office-based alternative provides little guarantee – and that

they will be cared for, pointing to a model that may not only lead to greater patient satisfaction but also likely contributes to bettering the QoL of a highly vulnerable population.

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