McMaster University | HEALTH FORUM

Rapid Evidence Profile

Identifying what is known about the health-system arrangements that can support the delivery of innovative models of home care

21 February 2024

[MHF product code: REP 67]

Appendix 1: Methodological details

We use a standard protocol for preparing rapid evidence profiles (REP) to ensure that our approach to identifying research evidence is as systematic and transparent as possible in the time we were given to prepare the profile.

Identifying research evidence

In contrast to synthesis methods that provide an in-depth understanding of the evidence, this REP focuses on providing an overview and key insights from full evidence syntheses only (single studies were not included). We searched Health Systems Evidence (HSE) and PubMed for evidence syntheses within the last five years using the search terms "(home care OR home care)" in HSE and "home care" in PubMed. Links provide access to the full search strategy. We also conducted hand searches of all evidence syntheses completed by McMaster Health Forum on the topic of home care (using the advanced search filters for home and community care and long-term care on the products search page) to identify older syntheses that are relevant and of high-quality.

Each source for these documents is assigned to one team member who conducts hand searches (when a source contains a smaller number of documents) or keyword searches to identify potentially relevant documents. A final inclusion assessment is performed both by the person who did the initial screening and the lead author of the rapid evidence profile, with disagreements resolved by consensus or with the input of a third reviewer on the team. The team uses a dedicated virtual channel to discuss and iteratively refine inclusion/exclusion criteria throughout the process, which provides a running list of considerations that all members can consult during the first stages of assessment.

During this process we include published, pre-print and grey literature. We do not exclude documents based on the language of a document. However, we are not able to extract key findings from documents that are written in languages other than Chinese, English, French or Spanish. We provide any documents that do not have content available in these languages in an appendix containing documents excluded at the final stages of reviewing. We excluded documents that did not directly address the research questions and the relevant organizing framework.

Assessing relevance and quality of evidence

We assess the relevance of each included evidence document as being of high, moderate or low relevance to the question.

Two reviewers independently appraised the quality of the guidelines we identified as being highly relevant using AGREE II. We used three domains in the tool (stakeholder involvement, rigour of development and editorial independence) and classified guidelines as high quality if they were scored as 60% or higher across each of these domains.

Two reviewers independently appraise the methodological quality of evidence syntheses that are deemed to be highly relevant. Disagreements are resolved by consensus with a third reviewer if needed. AMSTAR rates overall methodological quality on a scale of 0 to 11, where 11/11 represents an evidence synthesis of the highest quality. High-quality evidence syntheses are those with scores of eight or higher out of a possible 11, medium-quality

evidence syntheses are those with scores between four and seven, and low-quality evidence syntheses are those with scores less than four. It is important to note that the AMSTAR tool was developed to assess evidence syntheses focused on clinical interventions, so not all criteria apply to those pertaining to health-system arrangements or to economic and social responses. Where the denominator is not 11, an aspect of the tool was considered not relevant by the raters. In comparing ratings, it is therefore important to keep both parts of the score (i.e., the numerator and denominator) in mind. For example, an evidence synthesis that scores 8/8 is generally of comparable quality to another scoring 11/11; both ratings are considered 'high scores.' A high score signals that readers of the evidence synthesis can have a high level of confidence in its findings. A low score, on the other hand, does not mean that the evidence synthesis should be discarded, merely that less confidence can be placed in its findings and that the evidence synthesis needs to be examined closely to identify its limitations. (Lewin S, Oxman AD, Lavis JN, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP): 8. Deciding how much confidence to place in a systematic review. *Health Research Policy and Systems* 2009; 7 (Suppl1): S8.)

Identifying experiences from other countries and from Canadian provinces and territories

For each REP, we work with the requestors to collectively decide on what countries (and/or states or provinces) to examine based on the question posed. For all countries and Canadian provinces and territories, we searched relevant government and stakeholder websites including national health and public health agency websites, international repositories for home- and community-care policies, and websites of organizations involved in leading home care initiatives. While we do not exclude content based on language. Where information is not available in English, Chinese, French or Spanish, we attempt to use site-specific translation functions or Google Translate. A full list of websites and organizations searched is available upon request.

Preparing the profile

Each included document is cited in the reference list at the end of the REP. For all included guidelines, evidence syntheses and single studies (when included), we prepare a small number of bullet points that provide a summary of the key findings, which are used to summarize key messages in the text. Protocols and titles/questions have their titles hyperlinked, given that findings are not yet available. For this profile, we only prepared bulleted summaries of key findings for documents deemed to be of high relevance. For those classified as medium or low relevance, we list the title with a link to the primary source for easy retrieval if needed.

We then draft a summary that highlights the key findings from all highly relevant documents (alongside their date of last search and methodological quality) as well as key findings from the jurisdictional scan.

Upon completion, the REP is sent to the requestor for their review.

Appendix 2: Key findings from evidence syntheses sorted by relevance

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
• Delivery arrangements ○ Planning, managing and supporting the health workforce required to deliver home care services	Home care workers face significant challenges in providing person-centred care for clients with dementia due to inadequate training, emphasizing a critical need for improved educational programs and the integration of peer support to enhance caregiver well-being and overall care quality (1)	High	No	3/9 (AMSTAR rating from McMaster Health Forum)	2023	No	Place of residence
• Delivery arrangements ○ Designing care to meet patients' home care needs	In addressing the risks that people with dementia experience when receiving home care services, the mitigating actions of home care workers – ranging from beneficial strategies such as use of assistive technologies to harmful interventions like non-consensual care – resulted in improved well-being for dementia patients but also unintended consequences, such as reduced care provision, loss of autonomy and emotional strains (2) • Creating second-order risks as an unintended consequence of interventions to mitigate risks experienced by people with dementia can cause more harm	High	No	5/9 (AMSTAR rating from McMaster Health Forum)	Published 2022	No	Place of residence
• Delivery arrangements ○ Monitoring, evaluating and reporting on the quality and safety of home care services	When compared to hospital care, home care services were found to be cost-saving and as cost-effective as in-hospital interventions for adults and older adults (3)	High	No	6/9 (AMSTAR rating from McMaster Health Forum)	2022	No	Place of residence

• Delivery arrangements
  ○ Designing care to meet patients' home care needs
  ○ Monitoring, evaluating and reporting on the quality and safety of home care services
	Current evidence suggests that the implementation of restorative home care or 'reablement' is an effective intervention for improving the functional ability and quality of life of patients, while decreasing the need for standard home care services; outcomes were sustained for patients at three months (4)	High	No	8/10 (AMSTAR rating from McMaster Health Forum)	2022	Yes	Place of residence

• Delivery arrangements
  ○ Designing care to meet patients' home care needs
  ○ Developing the infrastructure
	The implementation of telehealth in home care yielded no significant differences with respect to improving quality of life, psychological well-being, and physical function of patients; however, telehealth was favourably viewed among home care patients as it improved confidence, self-management, access to care, and active engagement with health professionals (although a	High	No	5/11 (AMSTAR rating from McMaster Health Forum)	Published 2021	No	Place of residence

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
required to provide home care	decrease in face-to-face contact with providers was noted as a disadvantage by some) (5)						
• Delivery arrangements o Planning and managing the health workforce required to deliver home care services	Task-and-time focused training for home care staff supporting individuals living with dementia and cancer are not reflective of best practices, and may contribute to the financial, recruitment and retention difficulties facing the sector; despite their varying effectiveness, active learning approaches (e.g., social support skills, multidisciplinary team learning, mentorship, and utilizing adaptive technology) that target staff needs, along with a strong organizational culture, are positive facilitators to training and education for this workforce (6)	High	No	4/9 (AMSTAR rating from McMaster Health Forum)	Published 2021	No	Place of residence Occupation
• Delivery arrangements o Planning and managing the health workforce required to deliver home care services	Palliative-focused home care volunteers provide valuable practical (e.g., helping with tasks around the house), social (e.g., going on walks and playing games) and emotional (e.g., serving as a conversation partner to confide in) support to patients and next of kin; current volunteer training opportunities are limited, and more formalized practices are needed to support them in managing their roles in these settings (7)	High	No	4/9 (AMSTAR rating from McMaster Health Forum)	2020	No	Place of residence
• Delivery arrangements o Designing care to meet patients' home care needs o Monitoring, evaluating and reporting on the quality and safety of home care services	End-of-life care that is home-based increased the likelihood of people dying at home when compared with usual care, and home-based end-of-life care was found to improve patient satisfaction at one-month follow-up but not at six-month follow-up (8) • The effect on the control of symptoms and patient outcomes as well as on caregivers, staff and health-service costs was found to be uncertain • The review defined end-of-life care at home as "the provision of a service that provides active treatment for continuous periods of time by healthcare professionals in the patient's home for patients who would otherwise require hospital or hospice inpatient end-of-life care"	High	No	10/11 (AMSTAR rating from McMaster Health Forum)	2020	Yes	Place of residence
• Delivery arrangements o Planning and managing the health workforce required to deliver home care services	Home care workers providing care for patients living with dementia up to the end of life often experience a lack of clarity in their job role, receive poor remuneration, and obtain limited client information; targeted efforts need to be placed on role clarification, validating staff efforts and providing essential education and training (e.g., training supports for workforce to prepare for and cope with the emotional labour of end-of-life care and improved dementia-specific education) (9)	High	No	3/8 (AMSTAR rating from McMaster Health Forum)	2016	No	Place of residence Occupation
• Delivery arrangements	The admission avoidance hospital-at-home model, which is an approach to care that provides time-limited treatment at home	High	No	9/10 (AMSTAR	2016	Yes	Place of residence

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
○ Designing care to meet patients' home care needs	from healthcare providers for a condition that would normally require hospital inpatient care, may be less expensive than admission to an acute hospital ward when the costs of informal care are excluded and may be effective for a select group of elderly patients at reducing the likelihood of living in residential care and improving patient satisfaction with healthcare; however, evidence is limited on the effect on caregivers (10)			rating from McMaster Health Forum)			
• Delivery arrangements ○ Designing care to meet patients' home care needs ○ Monitoring, evaluating and reporting on the quality and safety of home care services	Time-limited home-care reablement services that offer intensive (i.e., multiple visits), time-limited (typically six to 12 weeks), multidisciplinary, goal-directed and person-centred home care services to older adults (65+ years) may be slightly more effective than usual care in improving function of older adults at nine to 12 months, but reablement may make little or no difference to mortality after the first 12 months or to rates of unplanned hospital admission at 24 months (11) • Due to the limited and very low-quality evidence, the effectiveness of reablement services could not be adopted nor refuted; more evidence is needed to assess its effectiveness across different systems	High	No	11/11 (AMSTAR rating from McMaster Health Forum)	2015	Yes	Place of residence
• Delivery arrangements ○ Planning, managing and supporting the health workforce required to deliver home care services	Mobile technologies, when used by healthcare providers for consultations, reduced the time between presentation and management of health problems, increased the likelihood of specific examinations, and showed potential in reducing referrals, but also raised concerns about data-sharing (12) • There was lack of substantial evidence on provider satisfaction or costs • A mobile phone was the most commonly used mobile technology used by healthcare providers	Medium	No	10/11 (AMSTAR rating from McMaster Health Forum)	2019	Yes	Place of residence
• Delivery arrangements ○ Designing care to meet patients' home care needs	Evidence suggests that home palliative care relieved the symptom of burden for patients without having a negative impact on their caregivers, and that it is more cost-effective compared to usual care (13)	Medium	No	11/11 (AMSTAR rating from McMaster Health Forum)	2012	No	Place of residence
• Delivery arrangements ○ Designing care to meet patients' home care needs	Evidence from the included randomized controlled trials suggest that case-managed, integrated or consumer-directed home- and community-care services for older persons may improve function and appropriate use of medications, while increasing use of community services; however, studies were heterogeneous in methodological quality and results were inconsistent (14)	Medium	No	7/10 (AMSTAR rating from McMaster Health Forum)	2009	No	Place of residence

Appendix 3: Key findings from McMaster Health Forum evidence syntheses documents

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Last year literature searched

• Delivery arrangements
  ○ Designing care to meet patients' home care needs
  ○ Developing the infrastructure required to provide home care
  ○ Planning, managing and supporting the health workforce required to deliver home care services
	Identifying community-based models to enable older adults to live independently (15)
	• Three groups of models were described, namely place-based models, care-based models, and technology-based models, and the synthesis emphasized the importance of training and education for home care service providers, collaboration between housing-adaptation personnel throughout the home adaptation process, and older adults' own digital competencies to enhance the use of technology in home care
	  ○ Examples of home care models identified from the evidence in the synthesis included Naturally Occurring Retirement Communities (NORCs), cohousing, villages, the 'reablement' care model, and the 'Stay Active at Home' program in the Netherlands
	  ○ Examples of home care support models identified from the jurisdictional scan of all Canadian provinces and territories along with Australia and the U.K. included the Commonwealth Home Support Program in Australia, the Somerset Micro-enterprise programme in the U.K., and Canada's Home Opportunity People Empowerment (HOPE) Model
		High	30 September 2022

• Delivery arrangements
  ○ Designing care to meet patients' home care needs
  ○ Developing the infrastructure required to provide home care
	What is known from the evidence and experiences about challenges of aging with dignity and options to support aging with dignity in the community (16)
	• This evidence synthesis identified several options to support older adults living independently in communities and to ensure safety, including community-based housing models, multifactorial assessment and intervention programs, and eHealth technologies
		Medium	12 September 2022

• Delivery arrangements
  ○ Designing care to meet patients' home care needs
  ○ Developing the infrastructure required to provide home care
  ○ Planning, managing and supporting the health workforce required to deliver home care services
  ○ Monitoring, evaluating and reporting on the quality and safety of home care services
	Examining care coordination in the home- and community-care sector (17)
	• Key considerations highlighted in this evidence synthesis for implementing care coordination interventions in the home- and community-care sector were 1) carefully assessing and matching populations with the appropriate intervention, and 2) using competent healthcare providers throughout care coordination who have strong interpersonal skills, knowledge of the populations' needs, and knowledge of local service availability
	• The evidence synthesis also described 12 key components of care-coordination frameworks and additional supports for designing, adapting and implementing strategies that enable care coordination in different populations
		Medium	July 2022

• Governance arrangements
  ○ Policy and decision-making authority over home care
  ○ Oversight and rules governing how home care products and services are sold
• Delivery arrangements
	Examining intersections between Ontario health teams and home and community care (18)
	• While this evidence synthesis identified limited information that addressed the outcomes of different contracting arrangements for home and community care services, it did emphasize that effective implementation of contracts in home and community care requires access to legal supports, actuarial supports and clinical supports
	  ○ Factors that impact implementation occur at the provider level (provider engagement and collaboration), organization level (availability of shared information technology and supports, congruence in population coverage between purchaser and providers) and policy level (clarity of goals, stability of policies)
		Medium	February 2022

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Last year literature searched
○ Designing care to meet patients' home care needs ○ Developing the infrastructure required to provide home care			
• Delivery arrangements ○ Designing care to meet patients' home care needs ○ Developing the infrastructure required to provide home care	Identifying the effects of home care on improving health outcomes, client satisfaction and health system sustainability (19) • This evidence synthesis did not include specific findings on models of home care delivery, but the included evidence provided several examples of home care approaches, including home-based multidisciplinary rehabilitation (MHR), case management approach, preventive home visits and time-limited reablement services	Low	February 2018

Appendix 4: Detailed jurisdictional scan about what is known about innovative models of home care and the health-system arrangements that support their delivery

Jurisdiction	Model of care	Dimension of the organizing framework that is the focus of the model	Key features of the model

Canada	The Home Opportunity People Empowerment (H.O.P.E.) Model	• Governance arrangements
		  ○ Oversight and rules governing the health professionals providing home care services (e.g., training and licensure requirements, scope of practice, continuing competence, professional liability)
		• Delivery arrangements
		  ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)
			• AMS Healthcare and SE Health have partnered to pilot the H.O.P.E. model, which supports older adults through self-managing teams of nurses that provide home care services (nursing, personal support workers therapies, etc.), care coordination, and connections to formal and informal care services
			• Nurse-led, self-directed accountable teams work together through shared decision-making to organize their work
			• Funding to test emerging technologies to augment the H.O.P.E. model was provided by CanHealth Network, and EMR software and tablets for nurses and patients were funded by AlayaCare and Samsung, respectively
			• The H.O.P.E. model is based closely on the Netherlands' Buurtzorg model of care (see below), which also centres around home care via self-governing nursing teams and has shown relatively high patient-reported experiences while providing substantially fewer hours of care

	Naturally Occurring Retirement Communities with Social Service Program (NORC-SSP)	• Financial arrangements
		  ○ Financing home care (e.g., taxation, social/community-based/private insurance, health savings accounts, out-of-pocket payments)
		• Delivery arrangements
		  ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)
		  ○ Monitoring, evaluating and reporting on the quality and safety of home care services
			• Naturally Occurring Retirement Communities (NORCs) are defined as geographic designations in which 30–60% of adults are 60 years and older
			• NORC-SSP provides residents with health and home care workers (government services) that are publicly funded and leverage program coordinators to provide oversight about the coordination of services
			• In 2021, Oasis Senior Supportive Living Inc. received funding to expand implementation of a NORC model to 12 communities across Canada
			• During the same year, the Canadian Institute of Health Research (CIHR) funded an ongoing longitudinal evaluation of the Oasis Senior Supportive Living Inc. program from 2021 to 2025 to better understand the effectiveness of the program

	Home care services and home supports	• Financial arrangements
		  ○ Purchasing home care products and services (e.g., defining the scope and nature of insurance plans, changing the lists of covered/reimbursed organizations, providers and services and products)
		  ○ Incentivizing consumers of home care products and services (e.g., adjusting premiums, introducing cost-sharing, etc.)
		• Delivery arrangements
			• Across all 10 provinces, three territories, and at federal level, various home care supports are offered to older adults to support healthy aging in the community
			• Eligible older adults include those recently discharged from an acute care hospital, those requiring services to avoid hospital or long-term care admission, or those living with life-limiting illness
			• These programs support older adults living in the community, and often include caregiver services, personal care, home supports, rehabilitative care and nursing care (e.g., disease management, post-operative care)

		○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Home and Community Care office coordinators from the respective health authorities are responsible for arranging service delivery and can help guide older adults through the process • Responsible Ministries of Health subsidize a portion of the program, and services can be free of charge, offered at a reduced rate based on income, or offered at low cost
	AlayaCare	• Delivery arrangements ○ Developing the infrastructure required to provide home care (e.g., buildings, transportation and other equipment)	• Alayacare and its partners have developed AI-based optimization software to make home care scheduling, time reporting, clinical documentation and patient monitoring more efficient
	The New Brunswick model of home care	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• The New Brunswick model of home care leverages interprofessional teams of nurses, respiratory therapists, physiotherapists, occupational therapists, dieticians and social workers • A nurse is assigned as a primary care provider and service coordinator for most new clients and families and provides on-call services 24/7, while other professionals provide services based on assessed needs • The model's stated goal is to help clients remain in their homes
Australia	Consumer-directed care	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• This model allows consumers to choose their care providers, services and schedules based on their specific needs • Consumer-directed care approach provides choice, flexibility and control over: ○ Types of services received ○ How services are provided ○ Who provides the services ○ When services are provided • Responsibilities include: ○ Collaborating to create home care agreement, care plan and individualized budget ○ Allowing individuals to determine their level of involvement in managing services ○ Conducting ongoing care discussions to ensure services meet their needs ○ Assisting in accessing information for informed decision-making ○ Transparency about funding allocation and expenditures ○ Informing and explaining fees and charges associated with the home care agreement • Home Care Packages Program ○ Aids older individuals with complex care needs for independent living in their homes ○ Utilizes a consumer-directed care approach to tailor support according to individual needs and goals

			○ Support is delivered through a Home Care Package, comprising a coordinated mix of services: ▪ Assistance with household tasks ▪ Provision of equipment like walking frames ▪ Minor home modifications ▪ Personal care ▪ Clinical care, including nursing, allied health, and physiotherapy services
	Commonwealth Home Support Programme (CHSP)	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Commonwealth Home Support Programme (CHSP) is an entry-level home support program aiding older individuals in independent living, offering respite services for carers • Program goals: ○ Foster independence ○ Collaborate with individuals, focusing on working with them rather than doing things for them ○ Provide minimal assistance to a large number of people • Target audience includes frail older Australians aged 65 or over (50 or over for Aboriginal or Torres Strait Islander peoples) with functional limitations, as well as those prematurely aged (50 years or older; 45 years or older for Aboriginal and Torres Strait Islander peoples) on a low income, facing housing challenges or living in adverse conditions • CHSP extends support to carers through planned respite services, enabling them to take breaks from caregiving duties • The program can fund services for individuals under the Disability Support for Older Australians Program
	Residential aged care	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Residential aged care is designed for senior Australians unable to live in their own homes, offering 24-hour accommodation, personal care and access to health services • Aged care homes are subsidized to provide residential care to eligible individuals; approval by an Aged Care Assessment Team (ACAT) is required before entry • Residential aged care homes assist with day-to-day tasks, personal care, health services, clinical care, therapies, social and emotional support, and entertainment • All government-funded aged care homes must be approved providers and adhere to quality standards
	Queensland Community Support Scheme	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Queensland Community Support Scheme (QCSS) offers low-intensity support to promote independent living, community engagement, and reduce social isolation • Designed for those impacted by circumstances affecting independent living or community participation • QCSS aims to:

			○ Enhance self-management and independence at home ○ Alleviate social isolation through community connections ○ Connect individuals with formal and informal supports to address specific needs • Eligibility: ○ Under 65 years old (or under 50 for Aboriginal or Torres Strait Islander people) ○ Not eligible for the National Disability Insurance Scheme (NDIS) ○ Support services include community outings (e.g., shopping, banks, post office, recreational activities), linking to community supports and assistance with home-related tasks (e.g., meal planning, household chores, personal care, yard maintenance for safety)
	Home Assist Secure	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Home Assist Secure is a service in Queensland for individuals aged 60 and over or those with a disability who cannot manage critical home maintenance independently or financially • The service offers safety-related information, referrals, and subsidized assistance, covering home maintenance, repairs, minor modifications, safety and security upgrades, and other Queensland Government–provided aid • Local Home Assist Secure services can assist in hiring tradespeople for repairs or modifications and planning future work • Eligibility criteria include being at least 60 years old or having a disability, holding a Pensioner Concession Card, inability to perform the work due to technical expertise or health risks, and no alternative assistance through programs like the Commonwealth Home Support Program, Department of Veterans' Affairs, or family and friends
New Zealand	Enabling Good Lives	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Innovative approach supporting disabled individuals • Emphasis on greater choice and control over received supports • Enables planning for the lives individuals desire • For individuals and families, this approach provides: ○ Increased control over lives ○ One unified plan based on strengths, preferences and aspirations ○ All government funding consolidated into a single pool ○ Initial contact with an Independent Facilitator for envisioning a good life ○ Increased choice in managing resources and connecting with networks ○ Input into designing, governing and monitoring systems and services • For service providers, this approach provides: ○ Capacity to operate with clear principles and expected outcomes ○ Negotiating work on an individual or family basis, aligned with the person's plan ○ Experiencing a developmental monitoring and evaluation process

			○ Facilitation-based approach to tailor supports, prioritizing generic community options
Sweden	Subsidized elderly care	• Governance arrangements ○ Policy and decision-making authority over home care (e.g., centralization/decentralization of decision-making about home care) • Financial arrangements ○ Financing home care (e.g., taxation, social/community-based/private insurance, health savings accounts, out-of-pocket payments) ○ Purchasing home care products and services (e.g., defining the scope and nature of insurance plans, changing the lists of covered/reimbursed organizations, providers and services and products) ○ Incentivizing consumers of home care products and services (e.g., adjusting premiums, introducing cost-sharing, etc.) • Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models) ○ Developing the infrastructure required to provide home care (e.g., buildings, transportation and other equipment) ○ Planning, managing and supporting the health workforce required to deliver home care services (e.g., estimating workforce need, demand, supply and required skill mix, implementing plans for recruiting new and retaining existing health workers, optimizing working conditions, supporting training and other supports)	• In Sweden, the elderly care system is regulated by the Social Services Act and implemented by municipalities ○ Recipients of elderly care can choose if they want home care services to be provided by public or private operators ○ More municipalities are choosing to allow private care providers to run their operations • Elderly care in Sweden is mostly funded by government grants and municipal taxes, and healthcare costs paid directly by the elderly are subsidized • Each municipality sets its own rates for elderly care and has an establish maximum charge for home assistance, daytime activities and other types of care ○ Cost of elderly care depends on the level or type of care provided and the recipient's income • Transportation services for the elderly or disabled in Sweden are partially tax-funded and significantly cheaper than regular private transport • Municipalities offer a number of services for the elderly at home: ○ Communal meals are provided for the elderly by municipalities at special day centres ○ Daytime activities are offered to those in need of rehabilitation and stimulation, and mainly target those with dementia and mental disabilities ○ Transportation services are provided for the elderly who are unable to travel by regular public transport at a more affordable cost than a regular taxi • Volunteers also provide support to older adults at home through organizations such as the Swedish Red Cross
Netherlands	Buurtzorg model of care	• Governance arrangements ○ Oversight and rules governing the health professionals providing home care services (e.g., training and licensure requirements, scope of practice, continuing competence, professional liability) • Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-	• Buurtzorg Nederland, a non-profit Dutch home care organization, gained international attention for providing high-quality care at lower cost than most competing organizations by using self-governing nurse teams ○ The self-governing nurse teams consist of a maximum of 12 nurses who take responsibility for all aspects of care for 50–60 patients ○ It aims to be a sustainable and holistic model of community care that maintains or regains patient independence, trains patients and families in self care, and creates networks of neighbourhood resources ○ The teams rely on IT systems for online scheduling, documentation of nursing assessments and services, as well as for billing

		based models within and across sectors, technology-based models) ○ Monitoring, evaluating and reporting on the quality and safety of home care services	○ Coaches provide problem-solving support for each team, and a small back office handles administration • Buurtzorg's nurses provide medical services as well as support services, and the approach has consistently demonstrated high patient satisfaction and that Buurtzorg has the most satisfied workforce of any Dutch company with more than 1,000 employees • The model appears to provide some savings, with teams of nurses using fewer hours to meet patients' needs than other organizations ○ The Dutch Ministry of Health, Welfare, and Sport commissioned KPMG to compare Buurtzorg to other home care providers, controlling for patient characteristics, and found that although Buurtzorg is a low-cost and effective provider of home care services, total per-patient costs were closer to average when including other services (e.g., physician and hospital costs)
Norway	Scandinavian or Nordic model of care	• Governance arrangements ○ Policy and decision-making authority over home care (e.g., centralization/decentralization of decision-making about home care) • Financial arrangements ○ Financing home care (e.g., taxation, social/community-based/private insurance, health savings accounts, out-of-pocket payments) ○ Incentivizing consumers of home care products and services (e.g., adjusting premiums, introducing cost-sharing, etc.) • Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models) ○ Planning, managing and supporting the health workforce required to deliver home care services (e.g., estimating workforce need, demand, supply and required skill mix, implementing plans for recruiting new and retaining existing health workers, optimizing working conditions, supporting training and other supports)	• The Health and Care Services Act legislates that Norwegian residents have a legal right to home care services • Norway has implemented the Scandinavian or Nordic model of healthcare where municipalities are responsible for providing home care services ○ Service eligibility is needs-based as per criteria set by the municipality • Costs for home-based care for older or disabled people are shared between the municipality and the recipient, and cost-sharing can be up to 85% based on personal income • Home health nurses provide a comprehensive set of services to people who require home care, including rehabilitation and assistive nursing services ○ Nurses typically use IPLOS, a standardized assessment form, to collect information on the level of support that a home care recipient would need during home visits • Support contacts assist individuals who require personal assistance at home and their families with engaging in meaningful activities in order to avoid isolation and remain socially active
United Kingdom (U.K.)	Emergent home care models: uberization, managed live-in, community-based,	• Governance arrangements ○ Oversight and rules governing home care organizations (e.g., ownership rules, management approaches, accreditation requirements, networks/multi-institutional arrangements)	• The typical 'time and task' model of home care, whereby services are delivered through care packages in short time slots and focus on completing personal care tasks, can create unhelpful inflexibilities that can limit the quality of care delivered • In response, the following models have emerged:

	and preventative models	○ Oversight and rules governing how home care products and services are sold (e.g., licensure and registration requirements, patents and profits, pricing) ○ Oversight and rules governing the health professionals providing home care services (e.g., training and licensure requirements, scope of practice, continuing competence, professional liability) • Financial arrangements ○ Paying health professionals who provide home care services (e.g., fee-for-service, capitation, salary, episode-based payment, fund holding) • Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models) ○ Planning, managing and supporting the health workforce required to deliver home care services (e.g., estimating workforce need, demand, supply and required skill mix, implementing plans for recruiting new and retaining existing health workers, optimizing working conditions, supporting training and other supports)	○ The 'uberization model' involves gig economy care platforms and agency-type providers that have a database of self-employed home care workers to match providers with service users ○ Managed live-in models leverage independent organizations that provide home care services through a pool of skilled staff that they vet, employ, train and supervise its home care workers directly • These organizations are regulated and assessed according to national minimum standards and regulations (e.g., for training and record keeping) ○ Community-based models include self-managed teams (see West Suffolk Buurtzorg test and learn 2017–18 below) that deliver home care services in a community, enabling continuity and relationship-based care while creating efficiencies such as reduced travel times ○ The preventative model uses tools such as predictive analytics, machine learning and digital monitoring systems to make risk assessments that shape care plans to help predict and prevent complex care (e.g., hospital admissions) in the future
	West Suffolk Buurtzorg test and learn 2017–18	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models) ○ Monitoring, evaluating and reporting on the quality and safety of home care services	• The nursing teams based on the Buurtzorg model made some notable changes in terms of team make-up and working patterns: ○ Whereas the Buurtzorg model consists of 8–12 nurses and nursing assistants, the West Suffolk Neighbourhood Nursing and Care Team (NNCT) approach leveraged two to six nurses and assistant practitioners at any given time, with temporary input from two additional nurses ○ Teams in the Buurtzorg model had flexible work patterns aligned with client needs, while NNCT working patterns were influenced by availability of staff, with a local admission prevention service and the Early Intervention Team covered any clinical care that had to be delivered outside of these times • In the Netherlands, new Buurtzorg teams inherit already-established information management systems, expert back-office support, a Buurtzorg coach to provide expert organizational development support, and a strong online peer network ○ In West Suffolk, the frontline nursing team was given agency to make decisions throughout the process, including about the test location, IT systems, and referral criteria

			• An independent report commissioned by the East of England Local Government Association found that patients/clients reported that the holistic care provided was outstanding and allowed people and their unpaid caregivers to make improvements to their health, well-being and independence
			  ○ The teams were beginning to build relationships with care agencies and the hospital to share information and coordinate care for specific individuals
			  ○ Senior partners across health and social care in West Suffolk demonstrated a strong commitment to the key elements of the Buurtzorg vision
			  ○ Key challenges of the project included: 1) the amount of highly skilled management, leadership and organizational development work to initiate the model, 2) NNCT members receiving minimal initial information about the Buurtzorg principles and how it was to be adapted for the U.K. context, and 3) difficulties encountered by NNCT members with self-management, leading to more directive (rather than coaching) support from other actors

	Personal budgets and direct payments	• Financial arrangements
		  ○ Financing home care (e.g., taxation, social/community-based/private insurance, health savings accounts, out-of-pocket payments)
		  ○ Purchasing home care products and services (e.g., defining the scope and nature of insurance plans, changing the lists of covered/reimbursed organizations, providers and services and products)
		  ○ Delivery arrangements
		  ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)
			• This initiative is for those with health concerns that significantly impact their wellbeing and ability to perform daily tasks, and includes social care services delivered in-home
			• The initiative is generally financed through one of the following options: 1) the council can manage one's personal budget; 2) the council can make payments to a third-party organization that is providing care for the client; or 3) the council can provide funding to the client directly or to a designated contact (i.e., direct payments)
			• An initial assessment and onboarding process is undertaken by the social services department of local councils
			• Different types of personal health budgets that also include medical care services are available for palliative and end-of-life care, adults eligible for NHS Continuing Healthcare (CHC) funding, children, young people and their families, people with a learning disability and/or autism, and for mental health aftercare and recovery services
			  ○ Personal health budgets can be used flexibly, and can include home care services

	Somerset Micro-enterprise programme	• Governance arrangements
		  ○ Oversight and rules governing home care organizations (e.g., ownership rules, management approaches, accreditation requirements, networks/multi-institutional arrangements)
		  ○ Oversight and rules governing how home care products and services are sold (e.g., licensure and registration requirements, patents and profits, pricing)
			• This initiative consists of 867 micro-providers offering over 26,000 hours of home care to more than 6,000 individuals who require support to age in place
			• The initiative allows individuals to launch and operate small businesses that offer services such as personal care and social visits to support local older adults and help them live independently
			• The initiative was funded through an initial investment of £75,000 per year and pooled through the Somerset council and NHS funds

		○ Oversight and rules governing the health professionals providing home care services (e.g., training and licensure requirements, scope of practice, continuing competence, professional liability) • Financial arrangements ○ Financing home care (e.g., taxation, social/community-based/private insurance, health savings accounts, out-of-pocket payments) ○ Purchasing home care products and services (e.g., defining the scope and nature of insurance plans, changing the lists of covered/reimbursed organizations, providers and services and products) • Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models) ○ Monitoring, evaluating and reporting on the quality and safety of home care services	• The model of micro-providers is thought to have resulted in an estimated £2.9 million in savings when compared to traditional commissioned home care services while demonstrating positive outcomes among users ○ A service quality feedback form is available to clients to describe their experiences and suggest improvements to the program
United States (U.S.)	Home Health (Medicaid)	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Health Homes is an optional Medicaid State Plan benefit to help coordinate care for people who have chronic conditions • Health home providers aimed to operate with a 'whole person' philosophy, that integrates primary, acute, behavioural and long-term services delivered by health professionals such as doctors and nurses • States receive a 90% enhanced Federal Medical Assistance Percentage when they provide specific health home services
	Home Care, Homemaker Services, Home and Environmental Accessibility Modifications (Medicaid)	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Home care provides assistance to individuals in performing daily activities such as bathing, grooming, dressing, eating and mobility • These types of services are covered through regular Medicaid or a waiver • Homemaker services include assistance with household chores like housekeeping, laundry and shopping for essentials • Home modifications include adjustments to the environment to increase or maintain independence (e.g., wheelchair ramps, walk-in bathtubs, stairlifts)
	Home health services (Medicare)	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Medicare Part A and/or Part B can cover eligible home health services such as nursing care, physical therapy, occupational therapy, speech-language pathology services, medical social services and intermittent home health aid care • The Medicare agency will notify the recipient about how much they will pay for services

		○ Monitoring, evaluating and reporting on the quality and safety of home care services	
	Kaiser Permanente	• Delivery arrangements ○ Designing care to meet patients' home care needs (e.g., place-based models including Naturally Occurring Retirement Communities (NORCs), care-based models within and across sectors, technology-based models)	• Home health care could include nursing care, physical therapy, blood tests and education, where the health provider prescribes home health care by connecting their patients with a home health agency • Nurses and other professionals will come to the home to provide care and also teach their caregivers • Kaiser Permanente can also provide 24/7 patient care through home visits, virtual visits, and remote monitoring overseen by physician-led teams • They also connect clients to their Thrive Local directory to community-based services and programs for food, medical equipment and transportation assistance
	California Home Care Services Branch (HCSB)	• Governance arrangements ○ Oversight and rules governing home care organizations (e.g., ownership rules, management approaches, accreditation requirements, networks/multi-institutional arrangements)	• California has the Home Care Services Branch, which is responsible for licensing home care organizations (e.g., processing applications, receiving and responding to complaints, compliance visits), and maintains the Home Care Aid Registry • Required by law, home care organizations must be licensed and be subjected to background checks • Home care services include non-medical services and assistance provided to clients who have difficulties performing everyday activities such as bathing, dressing, feeding, personal hygiene, transferring and transporting to different locations, toileting, making phone calls, meal planning, housekeeping and grocery shopping • Home care aides are not allowed to provide medical services to clients unless provided authorization

Appendix 5: Documents excluded at the final stages of reviewing

Document type	Hyperlinked title
Systematic review	Community-based case management does not reduce hospital admissions for older people: a systematic review and meta-analysis
Systematic review	Learning and use of eHealth among older adults living at home in rural and nonrural settings: Systematic review
Systematic review	Unmet care needs of community-dwelling stroke survivors: A systematic review of quantitative studies
Systematic review	Home-based primary care: A systematic review of the literature, 2010-2020
Systematic review	Implementing advance care planning with community-dwelling frail elders requires a system-wide approach: An integrative review applying a behaviour change model
Systematic review	Can aging in place be cost effective: A systematic review
Systematic review	Elements of integrated care approaches for older people: A review of reviews
Meta-analysis	A meta-analysis of "hospital in the home"
Scoping review	Examining community-based housing models to support aging in place: A scoping review
MHF synthesis	Identifying pharmacist remuneration models for the provision of clinical services
MHF synthesis	Empowering caregivers to deliver home-based restorative care
MHF synthesis	Using non-medical home services to support older adults

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