Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: An Institutional Ethnography

by

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Abstract

Background: Over 90% of Canadians age 65 and over live at home or in community assisted living settings. Of this, 33% have two or more chronic conditions, with one in six of this population receiving home care services. Multi-morbidity is a predictor of decreased quality of life, premature mortality, and increased health care use. Home care case managers (HCCMs) strive to provide safe, quality, and integrated care for older adults with multiple chronic conditions (MCCs) in home settings. HCCMs' day-to-day experiences and work are socially organized by institutional discourses and processes of health systems and home care programs. How integrated care is known and organized in health and home care settings, contradicts and complicates HCCMs' work of providing actual integrated care for older adults with MCCs.

Purpose: The purpose of this dissertation was to explore the knowledge and practice of integrated care from the standpoint of HCCMs—and the authoritative institutional arrangements and discourse within which HCCMs' work is organized—to explicate how HCCMs provide, or not provide, integrated care for older adults with MCCs.

Methods: A scoping literature review was used to examine qualitative, quantitative, and mixed-methods research to explore how case management standards of practice correspond with functions of integrated care and identify facilitators and barriers to case management and integrated care delivery. Institutional ethnography was used for a qualitative inquiry that explored and explicated the social organization of HCCMs' work of providing integrated care to older adults with MCCs.

Findings: Findings demonstrated that HCCMs use case management standards and integrated care functions at the professional and clinical levels. Although case management standards and integrated care functions were found to be both facilitators and barriers, they were more likely to facilitate HCCMs' work. HCCMs' use of professional and clinical integrated care functions was inconsistent and varied based on use of standards. Findings showed that HCCMs' work was socially organized by institutional arrangements of health systems and home care programs that created points of tension for HCCMs. HCCMs' provision of integrated care was organized into three activities: documenting case management work, communicating with interdisciplinary team members external to home care, and creating "work-arounds" to provide integrated care. HCCMs' work, was seemingly guided by the philosophy and approaches of integrated care. However, health system ruling relations and discourses of business process management, cost containment, and efficiency, were organizing HCCMs' work in ways that were contradictory to the goals of integrated care. How these processes and texts operated together revealed a complex picture of how HCCMs' care of older adults with MCCs was organized to happen as it did.

Implications: The social organization of integrated care within the institutional arrangements of health systems and home care programs created work environments, by which HCCMs, who were nurses, experienced their knowledge and experience in contrast to the management processes that were applied to their work. Textual organization of nurses' work subordinates and renders nurses' actual knowledge and experiences invisible within health care, and in the creation of nursing knowledge. The privileging of dominant managerial discourses that undermine the principles of integrated care creates inequities in the delivery of nursing practice and integrated care for older adults with MCCs.

Preface

Ethics approval to conduct the study reported in Chapter 4 of this dissertation was received from the University of Alberta Research Ethics Board and the Prince Edward Island Research Ethics Board (Project Name: *Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: An Institutional Ethnography*, No. Pro00065467, March 9, 2017).

A version of Chapter 2 of this dissertation was accepted for publication in the journal *Home Healthcare Now* (Lippincott Williams and Wilkins Publications) and is currently in press as "L. Garland Baird and K. Fraser, *Conceptualization of the Chronic Care Model: Implications for Home Care Case Manager Practice*." I was responsible for study conceptualization, analysis, writing the manuscript, and responding to feedback from my co-author. K. Fraser supported study conceptualization, critically reviewed manuscript drafts, and provided substantive feedback. The copyright notice that appears in the Lippincott Williams and Wilkins publication is not yet available.

A version of Chapter 3 of this dissertation was accepted for publication in the journal *Professional Case Management* (Lippincott Williams and Wilkins Publications) and is published as "L. Garland Baird and K. Fraser, *Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: A Scoping Review.*" I was responsible for study conceptualization and design, completing the search and screening, data extraction, analysis, and writing the manuscript. K. Fraser contributed to and supported study conceptualization and design, analysis, and revision of manuscript drafts for important intellectual content. The copyright notice that appears in the Lippincott Williams and Wilkins publication is duplicated below:

A version of Chapter 4 of this dissertation is in preparation for publication (target journal *Qualitative Health Research*) as "L. Garland Baird, K. Fraser, S. Jakubec, S. Stahlke, & W. Duggleby, *Mapping the Social Organization of Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: An Institutional Ethnography."* I was responsible for study conceptualization and design, data collection, conducting all analysis, and drafting the manuscript. K. Fraser contributed to and supported study conceptualization and design; K. Fraser and S. Jakubec supported analysis; and K. Fraser, S. Jakubec, S. Stahlke, and W. Duggleby provided critical reviews of manuscript drafts and substantive feedback, contributing important intellectual content.

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Dedication

To my husband, forever love and life partner, Michael Baird; my children and heart, Emily and Owen Baird; my parents and North Stars, Pauline and Anthony Garland; my siblings and memory keepers, Lana MacIsaac, Andrea Garland, and Kyle Garland; and my dearest friends and soul sisters, Roberta Ward, Colleen Bannon, and Rosanne McQuaid.

You all believed in me. So, I believed in myself.
Thank you for your unconditional and unwavering love and support.
This dissertation is dedicated to you.

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List of Abbreviations

BPM – Business Process Management

CCM – chronic care model

HCCM/HCCMs – home care case manager/home care case managers

IE – institutional ethnography

MCC/MCCs – multiple chronic condition/multiple chronic conditions

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Chapter 1: Introduction of the Problem

It is anticipated that the proportion of older adults aged 65 and over in Canada will increase from 15% to 28% between the years 2013 and 2063, with variation between provinces and territories (Health Canada, 2015). This increase in the number of older adults will be most pronounced between 2013 and 2030, during a period when all members of the baby boomer generation will have reached the age of 65 and over (Canadian Home Care Association [CHCA], 2009, 2012; Canadian Institute for Health Information [CIHI], 2011; Cripps, 2011; Health Canada, 2015; Heckman, 2011).

Presently, it is estimated that over 90% of those age 65 and over live in the community and that older adults with multiple chronic conditions (MCCs) represent 33% of this group, with one in six of these individuals receiving home care services (CIHI, 2011). Multimorbidity is defined as living with two or more chronic diseases (McMaster Health Forum, 2013). Older adults with MCCs account for 30%–40% of reported health care use among seniors in Canada, and the intensity of health care use increases as the number of chronic conditions increases (Broemeling, Watson, & Prebtani, 2008; Chouinard et al., 2013; CIHI, 2011; Marengoni, 2009; Vogeli et al., 2007; World Health Organization [WHO], 2011).

Concerns have been raised that health care system resources will be unable to meet the growing needs of an aging population (Evidence Network, 2014). Yet, the increasing number of older adults itself will not threaten Canada's health care system (CIHI, 2011; Statistics Canada, 2015). Cost increases are driven by changes in the quantity and types of healthcare received by Canadians of all ages, not by demographic changes (Chappell & Hollander, 2011; CIHI, 2011; Evidence Network, 2014). However, the aging population highlights how Canada's health care system, with its emphasis on acute care, is not designed to best meet the population's need for chronic care, specifically care required to address multiple chronic conditions (Evidence Network, 2014). Effectively meeting the needs of older adults with MCCs is a Canadian public health issue that requires comprehensive, quality health care interventions, including access to integrated home care programs and services provided by home care case managers (HCCMs) (Markle-Reid, Browne, & Gafni, 2013; Public Health Agency of Canada [PHAC], 2014; Sinha, 2011).

In practice, HCCMs strive to provide safe, quality, holistic care across health and social systems to meet clients' biopsychosocial needs (National Case Management Network [NCMN], 2009). HCCMs of clients with MCCs apply principles of chronic disease prevention, rehabilitation, restoration of health, health protection, and health promotion, with the goal of managing existing chronic health problems and preventing exacerbations of illness (Chouinard et al., 2013; Jacelon, 2013). HCCMs play an important role in achieving and maintaining continuity of care between health care settings by supporting the client's ability to manage their care in the community and family caregivers' abilities to support the client.

There are calls for a national, integrated home care program to meet the needs of older adults with MCCs in the community (CHCA, 2012). However, at federal and provincial levels, institutional structures and organizational challenges to integration and implementation remain (Beland et al., 2006; CHCA, 2012). This has implications for both HCCMs' practice and health outcomes for older adults with MCCs. HCCMs are expected to anticipate, react, and plan for the complex biopsychosocial needs of this population (NCMN, 2009, 2012). However, HCCMs' approach to care happens within the fragmented arrangements of health systems and home care programs that create tensions, challenges, and barriers to their work. As a result, it is challenging for HCCMs to provide comprehensive, and holistic care for this population.

Despite the challenges, HCCMs are in a unique position to provide comprehensive care that promotes the health and independence of older adults with MCCs (Jacelon, 2013; Markle-Reid et al., 2013). There is a dearth of literature about how HCCMs provide integrated care or what factors influence their ability (or inability) to provide these services. My research questions were: a) how do HCCMs provide, or not provide, integrated care for older adults with MCCs? b) what documents organize/coordinate/mediate HCCMs' integrated care of older adults with MCCs? c) how is the work of HCCMs organized and directed by home care's institutional processes and practices? and d) how is HCCMs' integrated care of older adults influenced by social and institutional relations within health care?

In this introductory chapter, I will describe key terms I used such as *case management* and *integrated care*, as well as the conceptual frameworks that guided my approach to inquiry. I describe my worldview and inspiration for conducting this research and establish why I asked these research questions. Next, I provide a summary of my methods, which were a scoping review using Arksey and O'Malley's (2005) approach (Paper 2) and institutional ethnography (Papers 3 and 4). Finally, I present a brief synopsis of each of the four papers included in my dissertation, describing the objectives and essence of each paper, illustrating their linkage to each other.

Key Terms

Home Care: Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaption and integration, and support for family caregivers (CHCA, 2012).

Case Management: Case management is often described as a strategy, a process, and a role. Health care and social service agencies view case management as a potential means of improving client care and support. Those who provide case management use a collaborative, client-driven process for the provision of quality health and support services, promoting the effective and efficient use of resources. Case management providers support the client's achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment (NCMN, 2012).

Integrated Care: Integrated care refers to a process or strategy for improving the coordination and quality of health services to better meet the needs of patients and providers. Integrated models require flexibility and a focus on removing the barriers to integrated care, rather than being prescriptive. Common and congruent features of successful integrated care models include facilitated access to a range of health and social services, case management, multidisciplinary teams, active physician engagement, and system financing that promotes care integration and planning (Valentijn, Schepman, Opheij, & Bruijnzeels, 2013).

Older Adults with Multiple Chronic Conditions: Older adults with multiple chronic conditions are individuals over the age of 65 years who have been diagnosed with two or more chronic illnesses (Markle-Reid et al., 2013).

Researcher Worldview and Theoretical Positioning

My worldview and theoretical positioning includes the motives, presuppositions, and personal history that have led me toward, and ultimately shaped, my doctoral inquiry. The phenomenon of my interest is HCCMs' integrated care of older adults with MCCs. I became focused on this area of research for three reasons. First, my clinical nursing practice was within the home care setting in several roles, including direct care, case management, and policy and program development for older adults with MCCs. Second, my nursing education practice as a clinical nursing instructor included home care, where the majority of clients were older adults with MCCs. Third, as a doctoral candidate, I was a part of several research teams as a graduate research assistant and research trainee—work that predominantly focused on home care case manager work and workload intensity, as well as older adults', family caregivers', and health care professionals' perceptions of managing MCCs. My previous roles and practice have given me an in-depth knowledge of home care and case management and the broader health system organization and processes that influence them.

My worldview is situated within critical social theory (CST) and influences the nature of questions I ask as a researcher. Although my world view led me to my dissertation research question, it is also congruent with institutional ethnography. It was the approach of institutional ethnography that I used to answer my question, as CST did not guide my study.

CST includes feminist and emancipatory movements and belongs to the broader ontological and epistemological paradigm of postmodernism. The central tenets of CST include a) recognition that knowledge is created within a socio-political context and shaped by power dynamics, b) concern with valuing equality and subjugated ways of knowing and being, c) use of self-reflection, critique, emancipation, and unity of knowing and being, and d) shared power and authority, consciousness raising, and action are required components of knowledge development (Kagan, Smith, Cowling, & Chinn, 2009). In summary, CST is context-laden, anti-oppressive, and promotes praxis, empowerment, and critical analysis, leading to emancipation and transformation (Kagan et al., 2009; Meleis, 2012).

A distinctive feature of a CST approach to inquiry is the built-in relationship between social analysis and critique. This emphasis has an important place in the discipline of nursing (Campbell & Bunting, 1991; Forbes et al., 1999; Gortner, 1993) and the development of nursing knowledge by exposing health inequities; providing emancipation for individuals, groups, and communities; leading to greater understanding of the broad social, economic, and political factors that influence health (Ray, 1992; Mill, Allen, & Morrow, 2001; Sumner & Danielson, 2007; Wilson-Thomas, 1995).

Dissertation Methods

Scoping Literature Review

I completed a scoping literature review, according to Arksey and O'Malley's (2005) approach. A scoping review is a type of literature review that is similar, yet distinct from a systematic review. The main difference between systematic reviews and scoping reviews is that systematic reviews may focus on specific and well-defined questions where included research study designs can be identified in advance; while scoping reviews are more likely to address broad topics where a variety of research study designs, and grey literature, might be included (Arksey & O'Malley, 2005). In addition, systematic reviews aim to provide answers to questions from a relatively narrow range of quality assessed studies, while scoping reviews may not seek to address specific research questions and may not assess the quality of included studies. Overall, scoping reviews provide a rigorous and transparent method for mapping research and grey literature to identify gaps in existing literature and summarize and disseminate research findings (Arksey & O'Malley, 2005; Grant & Booth, 2009; Levac, Colquhoun, & O'Brien, 2010).

Institutional Ethnography

I report on an in-depth qualitative study conducted using the institutional ethnography approach. Institutional ethnography (IE) inquiry starts with a disjuncture or point of tension as the entry into the experiences and perspectives of people in their daily lives and work. These everyday experiences can be traced back to social relations that organize their activities within (often troublesome) ruling relations (Campbell & Gregor, 2002; Prodinger & Turner, 2013; Smith, 2005, 2006). Ruling relations are the socially organized exercises of power that shape people's actions and their lives. These practices of power are often experienced through abstracted or technical discourses that may bear little resemblance or connection to the everyday experiences of people (Campbell & Gregor, 2002; Prodinger & Turner, 2013; Smith, 2005, 2006). Institutional discourses represented by legislation, regulation, policies, or processes usually intended to support the practices and interests of people in the local setting, more often result in activities that lead to unintended events and processes that organize contradictory activities (Campbell & Gregor, 2002; Rankin, 2014).

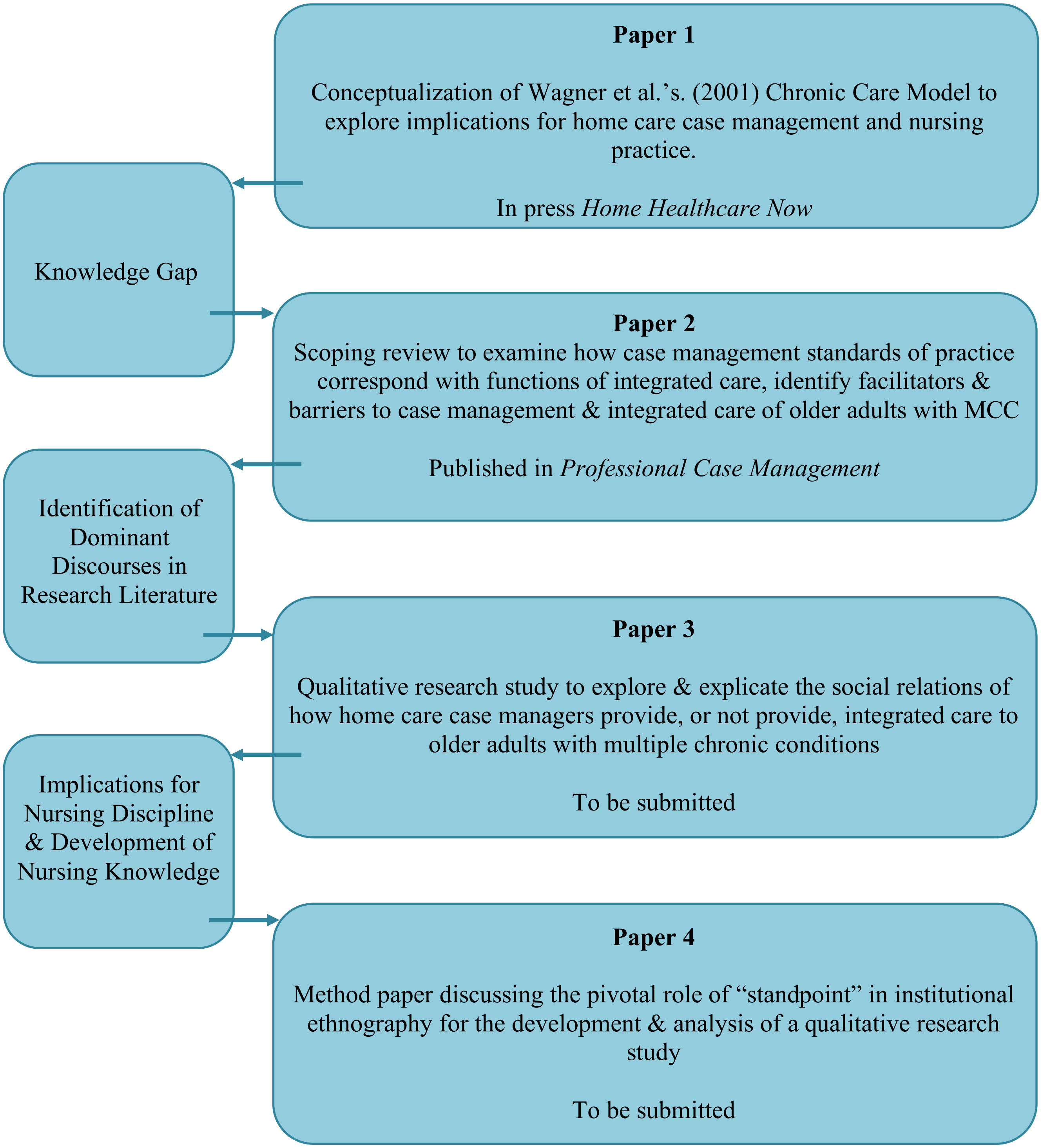
In IE, the term *text* is used to describe any material object or document (i.e., paper, electronic documents, videos, pictures) that can be distributed, transferred, copied, or stored. It is this physicality of texts that is fundamental to institutional organization because they represent institutional interests that are taken up and activated by people in local settings (Smith, 2005, 2006). People's reading and activation of texts are what organize and dominate both what goes on and what can be known authoritatively about the setting (Campbell & Gregor, 2002). In this way, texts are one example of a ruling relation, as they serve to organize and mediate people's activities (Campbell & Gregor, 2002; Smith, 2005). IE's goal is to explore these social and ruling relations with the aim of uncovering how people's activities and experiences are socially organized to occur as they do. By mapping this organization, the institutional ethnographer makes social relations visible so that those involved with an institution have a more complete view of how to either work within the institution or to change it (Devault, 2006; Smith, 2005, 2006).

Standpoint takes a central position in IE. Common use of the term *standpoint*, from an epistemological position, most often implies that knowledge of one group is privileged over another group (Mann & Kelley, 1997; Smith, 1987). In IE, however, standpoint refers to a starting place of inquiry—a point of entry—that is grounded in material, bodily experience, relevancies, problems, and concerns of a particular group of people (Smith, 2005, 2006). Standpoint in IE is necessary to understand the points of tension and impact of ruling relations on people's lives and experiences (Deveau, 2009; Ng et al., 2013; Tummons, 2018). Standpoint supports the researcher to explicate the everyday lives and experiences and work from where people are as knowledgeable participants, as their everyday world extends beyond individual experiences (Campbell & Manicom, 1995; Smith, 1987). The standpoint from which I undertook my research was that of the HCCM.

Overview of the Dissertation

My dissertation is comprised of four connected and successive papers. The first paper is a conceptual review of Wagner et al.'s (2001) Chronic Care Model and its concepts to consider the implications of its application for home care case management and nursing practice. The second is a scoping review (Arksey & O'Malley, 2005) that examines how case management standards of practice correspond with functions of integrated care. In this paper, I identified facilitators and barriers to case management and integrated care delivery and proposed a home care case management and integrated care framework. The third and fourth papers are composed of the results of my institutional ethnography inquiry. Paper 3 describes findings of the social organization of how home care case managers provide, or not provide, integrated care to older adults with MCCs. Paper 4 is an exploration of "standpoint" in institutional ethnography and its pivotal role in the development and analysis of my qualitative study. The linkage between each of the four papers is demonstrated in Figure 1-1.

Figure 1-1. Four papers that explore home care case managers' integrated care of older adults with multiple chronic conditions.



Paper 1

Conceptualization of Wagner et al.'s. (2001) Chronic Care Model to explore implications for home care case management and nursing practice.

In press *Home Healthcare Now*

Paper 2

Scoping review to examine how case management standards of practice correspond with functions of integrated care, identify facilitators & barriers to case management & integrated care of older adults with MCC

Published in *Professional Case Management*

Paper 3

Qualitative research study to explore & explicate the social relations of how home care case managers provide, or not provide, integrated care to older adults with multiple chronic conditions

To be submitted

Paper 4

Method paper discussing the pivotal role of "standpoint" in institutional ethnography for the development & analysis of a qualitative research study

To be submitted

Paper 1: Conceptualization of the Chronic Care Model: Implications for Home Care Case Manager Practice

Objective: This paper aimed to provide a conceptualization based on peer-reviewed literature relating to Wagner et al.'s (2001) Chronic Care Model and consider the implications for HCCMs and nursing practice.

Description: One of the most substantial challenges to health care systems is the management and prevention of chronic diseases. Within traditional models of care delivery, there are identified barriers to the effective prevention of chronic illness and provision of care to clients living with chronic diseases and their family caregivers. Wagner et al.'s (2001) Chronic Care Model (CCM) is an alternative model of care that aims to transform the daily care for clients with chronic illnesses from acute and reactive to proactive, planned, and population-based.

The literature for this conceptual paper was found in several databases using the key terms *Chronic Care Model*, *chronic illness*, *home care*, *home care case management*, and *home care nursing*. Search limitations included the following: within ten years of publication, peer-reviewed journals, English language, population of 65 years and older, and electronic availability. This preliminary search yielded 142 articles. I eliminated the articles in this sample that did not specifically address the CCM, home care nursing, or case management practice, leaving a total 54. Of these 54 articles, 36 were theoretical, and 18 were research. Theoretical papers were removed, leaving a final sample of 18 research papers. These included five qualitative studies and 13 quantitative studies, and, of these, only two examined the CCM within the context of HCCMs' practice (both qualitative). Therefore, with little available research literature that examined the combination of the CCM and HCCMs' practice, I decided that the literature review would instead focus on the CCM, and then consider implications for HCCMs' practice.

I used thematic content analysis to yield several findings. Available CCM research did not address the relevance and importance of HCCMs' practice in the prevention and maintenance of chronic illness, nor did it explore the complex elements of the multifaceted role of the home care nurse as a HCCM in the care of clients with chronic illness and their family caregivers. Clinical standards, evidence-based HCCM practice, and clinical competencies for chronic illness care of clients and family caregivers in the home were not discussed in the CCM literature reviewed. Surprisingly, the CCM literature did not address the need for a thorough understanding of clients', family caregivers', and HCCMs' actual experiences of managing chronic illness in the home setting. Finally, I found that CCM research did not explore the concept and impact of developing partnerships and reciprocal trust between HCCMs and clients living with chronic illness and their family caregivers.

Linkage: In Paper 1, I demonstrated that a gap existed in the knowledge of how Wagner et al.'s (2001) Chronic Care Model is used by home care nurses who are HCCMs when caring for, and building therapeutic relationships with, older adults with chronic illness and supporting their family caregivers. As I examined HCCM practice and the Chronic Care Model, Paper 1 did not address the broader understanding of integrated care. This research gap found in Paper 1 supported the rationale for Paper 2.

Paper 2: Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: A Scoping Review

Objective: This paper aimed to present my scoping review study that explored how HCCMs provide integrated care for older adults with multiple chronic conditions, explore how case management standards of practice correspond with functions of integrated care, and identify facilitators and barriers to case management and integrated care delivery. This paper resulted in a proposed framework, describing how HCCMs can use case management standards to provide integrated care to older adults with MCCs.

Description: HCCMs provide care to older adults with MCCs to promote health and to support their well-being, and, through a variety of home care models, HCCMs also use an integrated care approach. Current organizational health structures and strategies, such as chronic disease management and case management approaches, are frequently erroneously equated to integrated care. As a result, older adults with MCCs continue to experience decreased access, continuity, quality, and fragmentation of care in all health systems, including home care programs (van der Vlegel-Brouwer, 2013).

The literature for this scoping review was found through several databases using the key terms *home care*, *case management*, *integrated care*, *older adults*, and *multiple chronic conditions*. The total number of retrieved references was 2,074. After duplicates were removed, the number of references included was 926. Reference titles and abstracts were screened, resulting in 97 articles and reports for full-text review. A total of 14 articles met the criteria for final inclusion. A deductive content analysis approach to describe the phenomenon of how HCCMs provide, or not provide, integrated care to older adults with MCCs was used (Elo & Kyngas, 2008). I developed a structured categorization matrix using the Canadian Standards of Practice for Case Management (NCMN, 2009) and Valentijn et al.'s (2013) Conceptual Framework for Integrated Care. I identified the barriers and facilitators of case management practice and integrated care.

My findings demonstrated that HCCMs' work of providing case management (i.e., assessment, planning, evaluation) and integrated care functions (i.e., inter and intra-professional partnerships, shared accountability, client engagement, and participation for self-care, hands-on primary care delivery) closely correspond and was often interdependent. HCCMs most frequently use the case management standards of practice of assessment, planning, implementation, and evaluation to provide all professional integrated care (meso) and clinical integrated care (micro) functions in their care of older adults with MCCs in the home setting. Findings also revealed that although case management standards and professional and clinical integrated care functions are more frequently identified as facilitators for integrated care, different factors may influence whether they act as facilitators and barriers for HCCMs' provision of integrated care of older adults with MCCs.

Linkage: In Paper 2, I provided a view into how home care case management and integrated care was known in the broader health and home care discourses. My scoping review enabled me to see what was already "known" about HCCMs' work and integrated care to understand how that knowledge was organized and, subsequently, directing the actual work of HCCMs in practice. Through this work, I became more informed of how the decontextualized and managerial accounts of integrated care found in the literature eclipsed the actual accounts and experiences of HCCMs, home care clients and family caregivers to create points of tension. I wanted to understand how this occurred and make sense of how the discourse I observed in my scoping review, and the discourse experienced and known by HCCMs in everyday practice, intersected. Paper 2 led me to my institutional ethnography inquiry (Paper 3) which began in the experiences and standpoint of HCCMs. Paper 3 enabled me to explore and explicate the reality of how broader integrated care knowledge and discourses intersect with and socially organizes HCCMs' actual, material work experiences of caring for older adults with MCCs.

Paper 3: Mapping the Social Organization of Home Care Case Manager's Integrated Care of Older Adults with Multiple Chronic Conditions: An Institutional Ethnography

Objective: This paper aimed to describe the main findings of my IE inquiry, where I explored the points of tension between the actualities of HCCMs' work experiences and the goals of institutional health systems and home care programs. My inquiry identified and explained the social organization of HCCMs' work in a home care program to describe how HCCMs provide, or not provide, integrated care for older adults with MCCs.

Description: I used institutional ethnography (IE) to explore and uncover how HCCMs provide, or not provide, integrated care to older adults with MCCs. Data were collected in five rural and urban home care offices through semi-structured interviews with six HCCMs and three home care leaders, completing participant and site observations, and identification of paper and electronic texts. My findings demonstrated that HCCMs' work was organized within institutional health system and home care processes that created tensions, challenges, and barriers for HCCMs to provide actual integrated care for older adults with MCCs. Initial exploration demonstrated that the home care program's processes and related texts organized HCCMs' work into three key activities: documenting the work of case management, communicating with interdisciplinary team members external to home care, and creating "work-arounds" to provide integrated care. Further critical examination and analysis revealed that HCCMs' work was seemingly guided by the philosophy and approaches of integrated care. However, I found that the ruling relations of institutional health system and home care discourses of business process management, cost containment, and efficiency were operating to produce power over and organize HCCMs' integrated care work.

Health system and home care processes, practices, and texts that were concerned with increasing safety, quality, and consistency, led to unintended challenges and barriers to HCCMs' care of older adults with MCCs. This social organization created work environments, by which HCCMs who were nurses, experienced their integrated care knowledge and experience in contrast to the authoritative management processes that were applied to their day-to-day work. Concerns from these findings include the textual organization of nurses work that subordinates and renders nurses' actual knowledge and experiences of caring for older adults with MCCs invisible, or not acknowledged, within health care and the creation of new nursing knowledge. The privileging of dominant managerial discourses undermined the principles of integrated care and created inequities in the delivery of nursing practice and services for home care clients.

Linkage: In Paper 3, I used IE's philosophical tenet of standpoint to map the social relations, everyday embodied activities and actions of what HCCMs did when confronted with home care's institutional structures and practices as they strove to provide integrated care to older adults with MCCs within disintegrated health and home care systems. My Paper 3 provided the rationale for more in-depth examination of the use of standpoint for IE inquiries and the development of nursing knowledge in Paper 4.

Paper 4: Standpoint in Institutional Ethnography: A Critical Approach to Nursing Knowledge Development

Objective: This paper aimed to discuss the pivotal role of "standpoint" as a philosophical tenet of institutional ethnography in the development and analysis of my institutional ethnography inquiry and explore its congruency with the development of nursing knowledge.

Description: In this method paper, I demonstrated how standpoint guided the development of critical questions I used to explore the antecedents to HCCMs' organized work, identify the points of tension HCCMs encounter in their care of older adults with MCCs, and focus on and illuminate actual and poignant work experiences of HCCMs. The place of entry and standpoint that was taken in my inquiry led to critical questions, points of tension, data gathering, and analysis, all of which required reflexivity to hold attention to and mitigate the eclipsing of everyday knowledge by dominant discourse. Using the HCCMs' standpoint through the research process, I discovered new knowledge of HCCMs' integrated care for older adults with MCCs and the discipline of nursing. This kind of discovery enabled an alternative analysis of what is occurring in HCCMs' practice and what can be known about case management and integrated care from the standpoint of those who are organized and influenced by the management of home care programs.

Linkage: In Paper 4, I was able to complete a deeper examination and discussion of the philosophical tenet of standpoint in institutional ethnography in guiding the development and analysis in Paper 3. Paper 4 shows that standpoint in IE offers an alternative approach that is congruent with the development of nursing knowledge originating within nursing practice.

Dissertation Summary

My dissertation consists of four individual but connected and inter-related papers that explore and explicate the social organization of HCCMs' care of older adults with multiple chronic conditions within dominant institutional health system and home care discourses and ideologies (Chapters 2–5). In chapter 6, I present conclusions that are the result of my full dissertation. I offer a summary of my dissertation findings, provide strengths and limitations, present recommendations, discuss implications for future practice, policy, and research development, briefly describe reflective learnings gained from my research, and how I will build upon this work.

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Chapter 2: Paper 1

Conceptualization of the Chronic Care Model: Implications for Home Care Case Manager Practice

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Abstract

One of the most substantial challenges to health care systems is the management and prevention of chronic diseases. Within traditional models of care delivery, there are identified barriers to the effective prevention of chronic illness and provision of care to both clients living with chronic diseases and their family caregivers. Wagner's Chronic Care Model is a model of care that aims to transform the care for clients with chronic illnesses from an acute and reactive approach to a proactive, planned, and population-based approach. This paper aims to provide a review of the available research literature relating to the Chronic Care Model and consider the implications for home care case management practice. The review included 18 research studies in total, five qualitative and 13 quantitative. A thematic content analysis approach was used. The findings included three themes: Chronic Care Model and positive chronic illness health behaviours and outcomes, Chronic Care Model and delivery of quality chronic illness care, and the importance of the supportive role of the home care nurse in the role of home care case management. Gaps and limitations of the Chronic Care Model concerning home care case management were identified and discussed in relation to partnership building and reciprocal trust among clients, family caregivers, and the home care case manager. Finally, implications for the use of the Chronic Care Model in home care case management practice, policy development, and future research were presented.

Introduction

The World Health Organization (WHO) reports that chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases, and diabetes are, by far, the leading cause of mortality in the world, representing 63% of all deaths. Out of the 36 million people who died from chronic disease in 2008, 27 million were over 60 years of age, and 90% of these premature deaths occurred in low- and middle-income countries (WHO, 2011).

In comparison to many other countries, the overall health of Canada's population is considered very well (Public Health Agency of Canada [PHAC], 2007, 2013). However, the biggest challenge to our health care system is the management and prevention of chronic diseases. Canadians are at risk of heart disease, obesity, high blood pressure, osteoporosis, diabetes, cancer, and depression (PHAC, 2013). Within the traditional models of care delivery, there are identified barriers to the effective prevention of chronic illness and care to clients and families living with chronic disease. Therefore, alternative models of care that include a combination of multi-pronged strategies need to be considered (Barr et al., 2003; Larsen, 2013). One such model is the Chronic Care Model (Wagner et al., 2001).

This paper aims to provide a review of research literature relating to the topic of the Chronic Care Model and home care case management practice. A preliminary review of the research literature provided little available research combining these two concepts.

The Chronic Care Model

The Chronic Care Model (CCM) was developed in the early 1990s by Ed Wagner and the MacColl Institute for Healthcare Innovation as a broad vision and framework to guide the health system towards meeting chronic illness care needs (Moroz, 2007). The CCM aims to transform the daily care for clients with chronic illnesses from acute and reactive to proactive, planned, and population-based (Coleman, Austin, Brach, & Wagner, 2009; NurseOne, 2013).

The CCM describes chronic care as "the prevention and diagnosis, management, and palliation of chronic disease" (Wagner et al., 2001, pg.65) and is internationally accepted as the leading strategic response to the challenges of chronic disease. Of particular relevance to chronic care are continuous relationships with the health care team, individualization of the client's care according to their unique needs and values, services based on evidence, and interdisciplinary collaboration (Wagner et al., 2001).

The CCM identifies six essential elements of a health care system that encourage high-quality chronic disease care: community, health system, self-management support, delivery system design, decision support, and clinical information systems. The model was designed for application to a variety of chronic illnesses and health care settings (including home care), targeting populations for improved client health outcomes, increased satisfaction of health care providers, and system cost savings (Coleman, Austin, Brach, & Wagner, 2013; Hung et al., 2008; Moroz, 2007; Wagner, 1998). In 2003, five additional themes were incorporated into the CCM to reflect the advances in research and practice in the field of chronic illness care: patient safety, cultural competency, care coordination, community policies, and case management (Improving Chronic Illness Care, 2013).

Summary of the Chronic Care Model Research Literature

Relevant literature for this review was located by searching the following computerized databases: CINAHL, PubMed, and Google Scholar. The key words for searching were *Chronic Care Model*, *chronic illness*, *home care*, *home care case management*, *home care nursing*, and various combinations of these terms. The search limitations for the articles included the following: within ten years of publication, peer-reviewed journals, English language, population of 65 years and older, and electronic availability. This preliminary search yielded 142 articles. The articles in this sample that did not specifically address the CCM, home care nursing, or case management practice were then eliminated, leaving a total of 54. Of these 54 articles, 36 were theoretical, and 18 were research. As the goal of this review was to focus on the research literature, the 36 theoretical articles were eliminated, leaving a final sample of 18 research articles. The 18 research articles included five qualitative studies and 13 quantitative studies; of these, only two examined the CCM within the context of home care case management practice (both qualitative). Therefore, with little available research literature that examined the combination of CCM and home care case management practice, it was decided that the literature review would instead focus on the CCM, and then consider implications for home care case management practice.

Qualitative Research Literature

The various methods used in the five qualitative studies included hermeneutic phenomenology, narrative inquiry, comparative case study, and program evaluation. Data was collected through semi-structured interviews, and document review. The populations studied included clients living with chronic illness, family caregivers, district home care nurses, disease management project leaders, primary care clinics, and chronic care collaborative organizations. Of these qualitative research studies, only two had the same purpose. The various purposes of these research studies included a) increasing understanding about how to best design and implement disease management models based on the CCM in primary care settings, b) measuring health care organizations' implementation of CCM interventions for chronic care quality improvement, c) exploring the experiences of informal caregivers providing care in the home for a family member with chronic obstructive pulmonary disease, and d) explaining the meaning of district nurses' experiences of encounters with clients with chronic illness and their close relatives in their homes.

Quantitative Research Literature

The 13 quantitative studies included randomized control trials, pre- and post-intervention design, and pre- and post-evaluation design. Data were collected using assessment tools, organizational evaluations, and surveys and questionnaires. The sample populations studied were selected both randomly and purposively and included clients with one or more chronic illnesses (i.e., diabetes type 1 and 2), cardiovascular disease, hyperlipidemia), interdisciplinary health care professionals and teams (i.e., home care nurses, home care case managers, physicians), primary care settings, and health care organizations. The purposes of these research studies included exploring the feasibility and effects of the implementation of the CCM on quality care in public and private primary care settings; examining relationships between the CCM and patient health measures (including general health status and health-related quality of life); examining self-assessed and perceived team effectiveness for changes to improve care for clients with chronic illness; and determining the impact of the CCM on diabetes education and self-management programs, health providers' diabetic care, and clinical and behavioural outcomes for clients with diabetes who are at risk for cardiovascular disease.

Research Contributions to Chronic Care Model Knowledge

Three themes emerged after grouping the 18 qualitative and quantitative research studies and analyzing their content for contributions made to understanding about the CCM a) CCM and positive chronic illness health behaviours and outcomes, b) CCM and delivery of quality chronic illness care, and c) the importance of the supportive role of the home care nurse in the role of home care case manager.

Chronic Care Model and Positive Chronic Illness Health Behaviours and Outcomes

Eight research articles contributed to this theme. Seven of the studies focused on type 1 diabetes. Two articles also explored the reduction of risk of cardiovascular disease for clients with diabetes. One article explored the relationship between health status and health-related quality of life. In all of the studies, it was found that there was a) a positive correlation between the implementation of the CCM in urban and rural primary care clinics and health care organizations and the control of hemoglobin A1C and lipids for diabetic clients (Glasgow et al., 2002; Nutting et al., 2007; Piatt et al., 2006; Siminerio, Piatt, & Zgibor, 2005; Siminerio et al., 2006; Stuckey et al., 2009; Vargas et al., 2007), b) effectiveness of diabetes education and self-management programs for clients, reducing the risk of cardiovascular disease for clients with diabetes (Glasgow et al., 2002; Vargas et al., 2007), and c) improvement of general health status and health-related quality of life for a client with chronic illness (Hung et al., 2008).

Chronic Care Model and Delivery of Quality Chronic Illness Care

Eight research articles contributed to this theme. Seven of the studies explored the feasibility and effects of the implementation of the CCM on quality care in public and private primary care settings, as well as in large health care organizations. One study explored how to best design and implement disease management models based on the CCM in primary care settings. One study examined health care professionals' self-assessment and perceived team effectiveness for changes to improve care for clients with chronic illness using the CCM. One study explored the increase in adherence of diabetic care providers to best practice guidelines for the delivery of diabetic care. In all but two studies, there was a positive correlation between the implementation of the CCM and an increase in the quality of chronic illness care and use of best practice methods of health providers’ diabetic care (Pearson et al., 2005;

Shortell et al., 2004; Siminerio, Zgibor, & Solano, 2004; Stroebel et al., 2005; Szecsenyi et al., 2008; Walters, Adams, Nieboer, & Bal, 2012). Hroscikoski et al. (2006) concluded that a more specific plan for organizational change is needed to overcome the barriers to implementing the CCM in broader health care organizations, and Solberg et al. (2006) demonstrated few correlations between the implementation of the CCM in a primary practice setting and improvements in quality measures for three chronic diseases.

Importance of the Supportive Role of the Home Care Case Manager

Two research articles contributed to this theme. Öhman and Soderburg (2004) found that district nurses working as home care case managers, who were able to share an understanding of the illness experience in the home, were better able to develop a close relationship with the client and family members. This close relationship allowed the home care case managers to be available to the client's and family members' needs and alleviate the suffering and loneliness associated with the client's illness. The significance and impact of the role of the home care nurse as a home care case manager is also demonstrated in the study by Hynes, Stokes, and McCarron (2012). These researchers determined that when home care case managers did not actively engage with family caregivers while caring for a chronically ill client, care and illness burden may be increased for family caregivers.

Chronic Care Model Research and Home Care Case Management Practice

The previous summary and discussion of CCM research literature and knowledge contributions have established that few research studies have been completed with a focus on the CCM and home care nurse in the home care case manager role. The lack of available CCM research informing home care case management practice could potentially be misinterpreted as an indication that home care case managers do not have an essential role to play in the care of the chronically ill client and family members in the community. The relevance of home care case management practice to the CCM and identified gaps in CCM research require examination.

Relevance of Home Care Nurse Case Management Practice to the Chronic Care Model

Through a variety of care delivery models, home care nurses have the highest proportion of direct interaction with Canadians of any health care providers (Canadian Nurses Association [CNA], 2011). Home care nurses promote health and prevent and manage chronic illnesses to support the health and well-being of individuals, families, groups, communities, and populations (CNA 2011). Often, home care nurses work in formal or informal case management roles to carry out a variety of home care case management functions (Community Health Nurses of Canada [CHNC], 2011; National Case Management Network [NCMN], 2009). These home care case management functions enhance the traditional nursing process through individual or community participation, multiple ways of knowing, and awareness of the influence of the broader environment on the individual, group, or community as the focus of their care (CHNC, 2011).

Both the practice of home care nurses and home care case managers encompasses chronic disease prevention, rehabilitation, restoration of health, health protection, and health promotion, with the goal of managing existing chronic health problems and preventing exacerbations of illness. Their activities include teaching, curative interventions, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for family caregivers (Canadian Home Care Association [CHCA], 2008; NCMN, 2009). These various activities involve initiating, coordinating, managing, and evaluating the resources needed to promote the patient's maximum level of health and function in their homes (American Nurses Association, 2008; NCMN, 2009). Furthermore, home care nurses and home care case managers incorporate excellence in communication and motivation skills, applying critical thinking and clinical decision making in the application of the nursing process and working collaboratively with clients and their families and caregivers, and as productive members within inter-professional teams (CHNC, 2010).

Coleman, Austin, Brach, and Wagner (2009) state that most chronically ill, dependent persons have their needs met in home or through community-based care arrangements. Furthermore, clients and families struggling with chronic illness have needs that require regular interaction with their caregivers and necessitate interventions that emphasize empowerment and acquisition of self-management skills (Wagner et al., 2001). Home care nurses and home care case managers provide continuity of care that considers both the client's ability to self-manage and the family's ability to support the self-management. Therefore, it stands to reason that home care nurses working in home care case management practice are in unique positions to apply frameworks for nursing and case management practice, such as the CCM, that promote the independence of clients and families living with chronic illness (Jacelon, 2013).

Caregiving: Partnership and Reciprocal Trust

Approximately two-thirds of dependent persons in the community rely solely on informal caregivers (Mittleman, 2003). Mittleman (2003) describes informal caregivers as family members, friends, and neighbours who provide unpaid care for an individual or family. Public policy has been shaped by a combination of financial constraints and presumptions that families are mostly responsible for the care of their chronically ill family member (Montgomery & Kosloski, 2009). Home-based care is cost-effective for the health system; however, it creates multiple challenges and stressors for the family. To have positive health outcomes for chronically ill clients living at home, it is essential that home care case managers provide support for family members as they play a central role in the long-term care of the client in need. This supportive care can be accomplished by the development of partnerships and reciprocal trust that includes the processes of mutual decision making and goal setting with the client living with chronic illness and their family caregivers.

Partnership

Partnership is a guiding principle of both home care nursing and case management practices. Both the CHNC Standards of Practice (2011) and the NCMN Standards of Practice (2009) describe partnerships and building client capacity as core principles in the development of a therapeutic relationship with clients, families, communities, and populations. The Home Health Nursing Competencies (CHNC, 2010) and Canadian Core Competencies for Case Manager Providers (NCMN, 2012) detail the specific roles of home care nurses and home care case managers in developing partnerships with clients and family caregivers. These include a) mobilizing client and family members to take action to address health needs, b) assisting clients and families to recognize their capacity for self-management according to available resources, c) assisting colleagues, partners, and clients to build on capacities in order to influence policy change, d) demonstrating cultural competency when addressing client care issues, e) and adapting and being flexible to the changing health needs and perspectives of the client and family. It is interesting to note that although three of the CCM elements include community, self-management, and decision support, the available CCM research does not explore the concept of partnerships with clients living with chronic illness and their family caregivers. This is an identified gap in CCM research, viewing it through both the home care nurse and home care case management practice lenses.

Reciprocal Trust

Thorne and Robison (1988) state that trust is an ingredient of successful health care relationships. In particular, home care nurses and home care case managers are active in the role of encouraging clients to develop trust in their health care professionals. They recommend that the Guarded Alliance Model of Health Care Relationships provide a framework to achieve mutual decision making and information sharing between the client and the health care professional (Thorne & Robison, 1988). This model views trust development from the perspective of the client and family members and includes three stages: naïve trust, disenchantment, and guarded alliance. The researchers state that it is necessary for the health care professional to develop a variety of skills, such as listening with intent, curbing preconceptions, soliciting patients' perspectives, and validating conclusions to incorporate reciprocal trust in effective relationships with client and family members (Thorne & Robison, 1988).

Again, the CCM model's research and structural elements fall short of incorporating this intimate level of relationship and trust building with clients and family members living with chronic illness in their homes. According to Thorne and Robison (1988), this is also a gap in CCM research.

Gaps and Limitations Related to the CCM and Home Care Case Manager Practice

There are several gaps and limitations in the knowledge related to CCM research and home care case management practice. CCM literature does not address the relevance and importance of home care case management practice in preventing and maintaining chronic illness, nor does it explore the complex elements of the multifaceted role of the home care case manager in the care of clients with chronic illness and their family caregivers.

Although the CCM was developed as a system or population health approach to address chronic illness, its objectives also include assisting health care professionals to support clients and family caregivers living with chronic illness at the point of care (Coleman, Austin, Brach, & Wagner, 2009; Hung et al., 2008; Moroz, 2007; Wagner, 1998). Health care professionals, such as home care case managers, achieve this by employing care coordination and case management functions to support and guide clients and family caregivers with decisions and chronic illness self-management in the home care or community-based setting where the majority of clients with chronic illness have their needs met (Coleman, Austin, Brach, & Wagner, 2009; Improving Chronic Illness Care, 2013).

The CCM literature does not explore evidence-based home care case management's standards or clinical competencies for chronic illness care of clients and family caregivers in the home. Nor does the CCM literature address the need for a thorough understanding of clients' and family caregivers' experiences of managing chronic illness or home care case managers' experiences of supporting clients and family caregivers in the home setting. Most concerning is that the CCM literature fails to explore the impact of developing partnerships and reciprocal trust between home care case managers and clients living with chronic illness and their family caregivers, a key component of case management practice.

Additional gaps in CCM research include a lack of available CCM research from a Canadian health system perspective, little recent (within five years) work on the CCM, and available cost analysis or feasibility studies associated with the implementation of CCM to the broader health system. Furthermore, there is a dearth of literature on the use of the CCM and its long-term impact on the prevention and maintenance of chronic illness rates.

Implications for Research, Practice, and Policy Development

The findings of this literature review have important implications for the use of the CCM in home care case management practice, policy development, and future research.

Practice

Implications for CCM practice include encouraging home care case managers to be aware of, and present to, complex needs of clients and family caregivers in any given caregiving situation. When home care case managers increase their understanding of their own, the client's, and family caregivers' illness experience, there is potential for home care case managers to alleviate the client's feelings of loneliness and isolation. Furthermore, home care case managers may affect the impact of family caregiver burden through understanding the shared illness experience of clients, caregivers, and home care case managers (Hynes, Stokes, & McCarron, 2012). Also, home care case management practice can enhance reciprocal trust and partnership development by providing education and guidance for the client and family caregivers to be able to reflect and communicate their illness trajectory and care experiences to the home care case manager (Öhman & Soderburg, 2004).

Policy Development

Implications for policy development include encouraging home care case managers who work in smaller health care settings to seek opportunities to share CCM resources with more extensive health care organizations to increase capacity for this complex care (Siminerio et al., 2004). In addition, to ensure the success of chronic illness initiatives, it is crucial that health care organizations with a central organization and coordinating structure consider and include all elements of the CCM and home care case management practice when planning health strategies to address the prevention, treatment, and maintenance of chronic illness from a population health perspective (Siminerio et al., 2004, 2006).

Research

Additional research is needed to identify which specific CCM care interventions matter most and how best home care case managers can implement these. As Solberg et al. (2006) suggest, the use of more sensitive, reliable, and valid tools for measuring the presence and function of specific care delivery processes and systems would be helpful. Stroebel et al. (2005) also concur with Solberg et al.'s findings and suggest the use of randomized, controlled trials to further strengthen widespread implementation of the CCM in primary care settings (Hroscikoski et al., 2006; Nutting et al., 2007; Solberg et al., 2006).

Additional implications for research exist when planning the development of effective interdisciplinary teams to improve the quality of care for clients with chronic illness—longitudinal studies are needed to measure changes in team culture, quality improvement practice, and related variables over time (Shortell et al., 2004). As well, it is recommended that future large-scale research studies be required to demonstrate the effectiveness of implementing the CCM approach with home care case managers in community settings to improve clinical and behavioural outcomes for clients with chronic illness (Piatt et al., 2006).

Conclusion

This paper presented a review of the Chronic Care Model (CCM) research literature concerning home care nurses' and home care case managers' practice. The CCM model was defined, selected research articles were summarized and explored for common themes, and contributions to CCM knowledge were identified. These contributions were applied to the context of home care nursing and case management practice in an attempt to critique existing CCM research.

This review resulted in a number of findings. Available and current CCM research does not address the relevance and importance of home care case management practice in the prevention and maintenance of chronic illness, nor does it explore the complex elements of the multifaceted role of the home care nurse as a home care case manager in the care of clients with chronic illness and their family caregivers. Clinical standards, evidence-based home care case management practice and clinical competencies for chronic illness care of clients and family caregivers in the home were not discussed in the CCM literature reviewed.

Surprisingly, CCM literature did not address the need for a thorough understanding of clients’, family caregivers’, and home care case managers’ lived experiences of managing chronic illness in the home setting. Finally, CCM research does not explore the concept and impact of developing partnerships and reciprocal trust between the home care case manager and clients living with chronic illness and their family caregivers. Caregiving in conjunction with partnerships and reciprocal trust between clients and family caregivers and home care nurses in the role of home care case manager was also explored and used to critique the available CCM research further. Finally, implications for future CCM research, practice, and policy development were identified and addressed.

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Chapter 3: Paper 2

Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: A Scoping Review

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Abstract

Integrated care is a multi-level strategy to improve coordination and quality of health services to meet client needs. A characteristic feature of successful integrated care models includes access to case management. Currently, there is no clear description of how home care case managers (HCCMs) provide integrated care. A scoping review using Arksey & O'Malley's (2005) approach was used to explore availability of peer-reviewed research and grey literature to a) describe how HCCMs provide, or not provide, integrated care for older adults with multiple chronic conditions (MCCs), b) identify elements of integrated care and how they correspond with case management standards, c) identify facilitators and barriers to integrated care delivery, and d) propose a framework to describe how HCCMs provide integrated care. Fourteen studies were deductively analyzed using National Case Management Network's Canadian Standards for Practice (2009) and Valentijn et al.'s (2013) Conceptual Framework for Integrated Care. Analysis identified and categorized integrated care practice functions according to corresponding case management standards, and facilitators and barriers. Findings demonstrated HCCMs provide integrated care at clinical and professional levels. All case management standards and integrated care functions acted as facilitators and barriers and were more likely to facilitate HCCMs' work. A framework describing HCCMs' provision of integrated care for this population was developed to assist with practice, policy and research recommendations for home care case management and integrated care of older adults with MCCs.

Background

In Canada, the number of older adults aged 65 and over is estimated to increase from 15% to 28% between the years 2013 and 2063. According to Statistics Canada's (2015) projection scenarios, between 2013 and 2045, the population aged 80 and over will increase from 1.4 million to 4.9 million, representing about 10% of the total Canadian population (Canadian Institute of Health Information [CIHI], 2011; Statistics Canada, 2015). Chronic illness, and particularly multi-morbidity, has become a key driver of our Canadian health system, with the intensity and increase of health care use reciprocal to the increasing number of chronic conditions (Broemeling, Watson, & Prebtani, 2008; Chouinard et al., 2013; CIHI, 2011; Vogeli et al., 2007; World Health Organization [WHO], 2011). Multi-morbidity, or multiple chronic conditions (MCCs) is defined as living with two or more chronic diseases (Aging, Community & Health Research Unit, 2013; McMaster Health Forum, 2013) and can be experienced by individuals of all age groups. It is estimated that over 90% of those age 65 and over live in the community, with older adults with MCCs representing 33% of this group (Canadian Institutes of Health Research, 2014).

Older adults with MCCs report lower health status, take five or more prescription medications, have higher rates of health care utilization and costs, and are at higher risk for adverse events (i.e., falls, hospitalization, death). These factors are typically related to decreased cognition, physical and functional limitations, depression, lack of social support, financial limitations, and reduced access to health and community services (Gilmour & Park, 2006; Markle-Reid et al., 2011). Currently, older adults with MCCs account for 30%–40% of reported health care use among seniors in Canada (Canadian Home Care Association [CHCA], 2006). To address this, interventions such as chronic illness education and self-management programs have been implemented to improve the management of chronic disease in a variety of community settings (Bodenheimer, Lorig, Holman, & Grumbach, 2002; Jordan & Osborne, 2007).

However, current organizational health structures and strategies, such as chronic disease management and case management approaches, are frequently erroneously equated to integrated care. Also, many chronic illness management programs are developed for populations with one specific disease, such as diabetes or chronic obstructive pulmonary disease. These disease-specific programs do not consider the perspectives, or the varying complex needs, of older adults with MCCs and are often provided from the perspective of the health care professional (van der Vlegel-Brouwer, 2013). As a result of these barriers, older adults with MCCs continue to experience decreased access, continuity, quality, and fragmentation of care in all health systems, including home care programs (van der Vlegel-Brouwer, 2013).

Continued strategies to address the current and growing rates of chronic disease are required to enhance the quality of care, address health and social challenges, improve health outcomes of older adults with MCCs, and reduce pressures on health care services, including home care (CHCA, 2013; Health PEI, 2013; Markle-Reid, Browne, & Gafni, 2013).

Home Care

Internationally, there has been a shift in the provision of care from institutional to home and community. Several reasons for this shift include preference for receiving care at home (Beswick, Gooberman-Hill, Smith, Wylde, & Ebrahim, 2010), an aging population with increasing rates of chronic illness (Wilhelmson et al., 2011), more sophisticated technology (Matthew Maich et al., 2016), and, most notably, efforts to contain health care budgets (Landers, Madigan, & Leff, 2016). Home care is generally perceived to be lower in cost to deliver than acute and long-term care services (Spoorenberg et al., 2013). Therefore, available home care services within a high-functioning health care system has the potential to support cost containment, and more importantly, to improve the care and quality of life of individuals who may otherwise be cared for in an institutional setting (Health Canada, 2015; Spoorenberg et al., 2013).

In Canada and other developed countries, home care is vital to health care systems. In 2012, over two million Canadians from all subsets of the population relied on home care services. The largest of these populations receiving home care is older adults with MCCs (Accreditation Canada & CHCA, 2015; Statistics Canada, 2015). Not surprisingly, the demand for home care is outpacing the available funding and resources within our current fragmented system structures. This inhibits quality care for older adults with MCCs and directly affects the scope and quality of care that home care case managers (HCCMs) can provide for older adults with MCCs (Accreditation Canada & CHCA, 2015; Chappell & Hollander, 2011; CHCA, 2012, 2013; Cripps, 2011; Dubuc et al., 2013; Henningsen & McAlister, 2011; National Case Management Network [NCMN], 2009, 2012; Sinah, 2011; Røsstad, Garåsen, Steinsbekk, Sletvold, & Grimsmo, 2013; Wilhelmson et al., 2011).

Home Care Case Management and Integrated Care

According to the NCMN (2009), case management is a client-driven, collaborative process that ensures effective and efficient use of resources for the provision of quality health and social support services in a variety of care settings, including home care. The Canadian Standards of Practice for Case Management include client identification and eligibility for case management services, assessment, planning, implementation, evaluation, and transition (NCMN, 2009). HCCMs use these case management standards to work collaboratively with clients and their family caregivers to identify goals of care and include them as partners with the inter-professional team (Comunity Health Nurses of Canada, 2011; Fraser & Strang, 2004).

HCCMs provide care to older adults with MCCs to promote health and to support their wellbeing, and, through a variety of home care models, they also use an integrated care approach. Integrated care refers to a process or strategy for improving the coordination and quality of health services to meet the needs of patients and providers better. There is no single definition or best practice model for integrated care. It can mean different things in different contexts, and it can take many forms. Integrated care models require flexibility and a focus on removing the barriers to integrated care, rather than being prescriptive (CHCA, 2006, 2009, 2013; Kodner & Spreeuwenberg, 2002).

A standard and congruent feature of successful integrated care includes facilitated case management (Johri, Beland, & Bergman, 2003; McAdam, 2011). The benefits for older adults with MCCs receiving integrated care through case management interventions include increased engagement and capacity building in making decisions about their care, and support in enabling self-management (CHCA, 2012). The benefits for HCCMs working within an integrated care model or approach include the ability to define vulnerable populations in order to support relationships between health care teams and the vulnerable population or community to provide a more coordinated approach to the management of their care (Carrier, 2012; Lukersmith, Millington, & Salvador-Carulla, 2016).

Several models of integrated care within home care programs, such as PRISMA and PACE, include case management. These models have been implemented in several programs, both nationally and internationally, as a means to provide quality and cost-effective care for older adults with MCCs (Carrier, 2012; de Stampa et al., 2013; Dubuc et al., 2013; Hammar, Rissanen, & Perälä, 2009; MacAdam, 2008; Nuño, Coleman, Bengoa, & Sauto, 2012;

Petrakou, 2009; Proctor, Wilson, Brooks, & Kendall, 2013; Røsstad et al., 2013; Valentijn, Sanneke, Opheij, & Bruijnzeels, 2013; Veras et al., 2014; Watkins, Hall, & Kring, 2012; Wilhelmson et al., 2011). However, there are knowledge gaps related to HCCMs and the integrated care of older adults with MCCs. These include a lack of understanding of the complex elements of the multifaceted role of the HCCM in the care of older adults with MCCs and the clinical standards and evidence-based case management competencies required for the care of older adults with MCCs. There is also a need to increase knowledge and understanding of how HCCMs plan, coordinate, and deliver care for older adults with MCCs within an integrated care approach with inter-professional teams that span a variety of care settings, health care institutions, and systems (Glasgow et al., 2002; Nutting et al., 2007; Pearson et al., 2005; Piatt et al., 2006; Shortell et al., 2004; Siminerio, Piatt, & Zgibor, 2005; Siminerio, Zgibor, & Solano, 2004; Siminerio et al., 2006; Stroebel et al., 2005; Stuckey et al., 2009; Szecsenyi, Rosemann, Joos, Peters-Klimm, & Miksch, 2008; Vargas, Mangione, Asch, Keesey, & Rosen, 2007; Walters, Adams, Nieboer, & Bal, 2012).

HCCMs are in a unique position to provide integrated care to promote the health and independence of older adults with MCCs and their family caregivers (Jacelon, 2013). The impact of case management and integrated care approaches on delaying institutionalization, reducing acute care stays, and improving the quality of life for older adults with MCCs is reasonably well described in the literature (Carrier, 2012; Lukersmith et al., 2016; Reilly, Hughes, & Challis, 2010; Veras et al., 2014). However, we were unable to find reviews that explore case management and integrated care as complementary functions in the care of older adults with MCCs in the home care setting. An exploration of available research literature related to HCCMs' ability to provide integrated care to older adults with MCCs could add to the knowledge base in this area. Because the literature on older adults with MCCs, home care, case management, and integrated care is vast and somewhat disparate, a scoping review is appropriate for understanding the current state of knowledge.

Method

Study Aim and Design

After completing a preliminary search of the literature and considering the broad nature of the research question, it was determined that a scoping review would be the best approach to meet aims of our review. A scoping review is a type of literature review that addresses broader topics where many different study designs might be applicable (Arksey & O'Malley, 2005). A scoping review may be employed for a variety of reasons, to determine the value of undertaking a systematic review, provide a rigorous and transparent method for mapping research to identify gaps in existing literature, and to summarize and disseminate research findings (Arksey & O'Malley, 2005; Colquhoun et al., 2014; Grant & Booth, 2009; Levac, Colquhoun, & O'Brien, 2010).

Arskey and O'Malley's (2005) scoping review method was used to answer our research question, "How do home care case managers provide, or not provide, integrated care to older adults with multiple chronic conditions?" The aim of our scoping review was to a) explore peer-reviewed research and grey literature, such as unpublished government reports, in order to examine the extent, range, and nature of available research that describes how HCCMs provide integrated care for older adults with multiple chronic conditions, b) identify how case management standards of practice correspond with functions of integrated care, c) identify facilitators and barriers to case management and integrated care delivery, and d) propose a framework to describe how HCCMs can use case management standards to provide integrated care to older adults with MCCs.

The scoping review process is an iterative, non-linear, and evolving process where researchers reflexively engage with the steps of the scoping review and often repeat review steps to ensure the comprehensiveness of literature (Arksey & O'Malley, 2005). We used Arksey and O'Malley's (2005) five-step approach for our scoping review. The steps include 1) identifying the research question, 2) identifying relevant studies, 3) completing the study selection, 4) charting the data, and 5) collating, summarizing, and reporting the results (Arksey & O’Malley, 2005). Arksey and O’Malley (2005) also recommend an optional sixth step of consultation, which, due to resource constraints, was not used in this review. Because scoping reviews are used to provide an overview of available evidence rather than assess the quality of the evidence, the methodological rigor of the included studies was not evaluated.

Identifying the Research Question

There is a lack of consensus in the research and health policy literature on home care practice and how HCCMs use case management to provide integrated care for older adults with MCCs. This knowledge informed the development of our research questions, as well as the first author’s previous practice experience and research on case management and integrated care for older people with MCCs.

Identifying Relevant Studies

The preliminary electronic search was completed in collaboration with a health science librarian on OVID and yielded 236 references. The first author also searched additional electronic databases, including CINAHL Plus, PubMed, Cochrane Library, EMBASE, Scopus, Web of Science, Google, and Google Scholar, yielding 1478 references. Keyword searches, use of MeSH terms, and explosion of terms produced a wide variety of search terms and combination of terms. Additional search strategies included checking reference lists and hand searching of key journals. Existing networks of organizations were also searched to retrieve grey literature generated from health, policy, and government websites, yielding an additional

360 references. The total number of retrieved references was 2074. After duplicates were removed, this number dropped to 926. Reference titles and abstracts were screened by the first author, resulting in 97 articles and reports for full-text review. Consensus on final included articles was achieved through discussion between the first and second authors. A total of 14 articles met the criteria for inclusion (Table 3-1).

We used RefWorks and Mendeley to store and organize retrieved studies. Folders and subfolders were created to differentiate between studies retrieved from various databases and to manage studies that were included or excluded from the final review. Microsoft Word documents and Excel spreadsheets were used to organize the retrieved literature, and a PRISMA diagram (Moher, Liberati, Tetzlaff, & Altman, 2009) was developed to track the flow of research and grey literature (Figure 3-1).

Study Selection

Our inclusion criteria for research studies were a) quantitative, qualitative, and mixed-method research studies, b) studies conducted in home care settings, c) studies focused on older adults aged 65 and over with MCCs (more than two diagnosed chronic illnesses and not limited to specific chronic diseases), and d) studies that used case management and integrated care approaches. Grey literature was included to capture government or conference reports, frameworks, and policies that specifically targeted integrated care and case management of older adults with MCCs in the home care setting (Centre for Reviews & Dissemination, 2008). Our exclusion criteria included a) studies conducted in acute care, long-term care, or rehabilitative clinical settings, b) studies involving pediatric, adolescent, young- or middle-aged adult populations, and c) studies that focused on participants with a diagnosis of only one chronic illness.

Charting the Data

Data were extracted and then organized using a data extraction tool adapted from Peters et al. (2015). This tool applied to all methodological research article types and was used to collate, summarize, and share data for review and decision making (Arksey & O'Malley, 2005 Armstrong, Hall, Doyle, & Waters, 2010; Levac et al., 2010). Extracted data included journal, title, first author/year, study location, method/design, sample/population, aim, and findings.

Full review articles were imported into NVivo 11 to assist with data management and organization to facilitate analysis. We used a deductive content analysis approach to describe the phenomenon of how HCCMs provide, or not provide, integrated care to older adults with MCCs (Elo & Kyngas, 2008). This approach is useful when the aim is to test concepts, frameworks, or hypotheses (Marshall & Rossman, 1995). A structured categorization matrix was developed using the Canadian Standards of Practice for Case Management (NCMN, 2009) and Valentijn et al.'s (2013) Conceptual Framework for Integrated Care (Figure 3-2). We also captured barriers and facilitators of case management practice of integrated care through our analysis. Our unit of analysis was the included papers. Graneheim and Lundman (2004) advise that whole texts are the most suitable unit of analysis, as they are large enough to be considered as a whole and small enough not to lose context and meaning during the analysis process.

The six case management standards of practice (NCMN, 2009) were used to identify the core competencies, practice expectations, and processes of how case management was provided to older adults with MCCs. The standards include client identification and eligibility for case management services, assessment, planning, implementation, evaluation, and transition.

To identify the work of how HCCMs provided integrated care to older adults with MCCs, the three levels of integrated care (macro, meso, micro) that were initially reported by Valentijn et al. (2013) were used. We then examined each of these levels to identify the integrated care functions within the context of home care case management practice for older adults with MCCs (Valentijn et al., 2013). We found that two of the three levels of integrated care correspond with case management practice: the meso and micro levels. Valentijn et al. (2013) identified the meso level as professional integrated care and the micro level as clinical integrated care. They further explained that both professional and clinical integrated care reflect a bio-psychosocial perspective of health and are used to achieve person-focused care within the conceptual framework (Valentijn et al., 2013).

We determined that it was appropriate to exclude Valentijn et al.'s (2013) macro level, which focuses on system level integrated care, and the aspect of the meso level that focused on organizational level integrated care from our analysis. Within their conceptual framework, both the meso and macro levels are directed at population-based outcomes, and, therefore, describe the broader system and organizational foci and are beyond the scope of our review.

Using Valentijn et al.'s (2013) Conceptual Framework for Integrated Care, seven functions of professional integration (meso) and five functions of clinical integration (micro) were identified that could be used within home care case management. Professional integrated care functions are carried out through partnerships between health care professionals, both within (intra) and between (inter) organizations and are based on shared competencies, roles, and responsibilities to deliver care to a population (Valentijn et al., 2013). These functions include a collective responsibility to provide a continuum of care, shared accountability for integration of services, shared problem-solving, shared decision making, commissioning services, inter-professional partnerships, and intra-professional partnerships.

Clinical integrated care functions refer to the coherence in the primary process of care delivery to individual patients. Clinical integration refers to the extent that health care professionals coordinate patient care services across various professional, institutional, and sectoral boundaries in a system (Valentijn et al., 2013). These functions include fostering client engagement and participation for self-care management and decision making, coordination of care for clients, person-centred care versus disease-centred care, matching services to meet client need, and hands-on primary care delivery. We used this framework, as well as the categories of facilitators and barriers, to analyze and present HCCM case management standards of practice and their corresponding functions of professional integrated care and clinical integrated care.

Collating, Summarizing, and Reporting the Results

Descriptive findings.

Of the 14 studies included in the review (Table 3-1), six were qualitative, five were quantitative, and three were mixed methods. Grey literature was not included as none of the resources met the scoping review inclusion criteria. Four studies were from Canada, three were from Sweden, two were from the USA, one study occurred in both Canada and France, one was from Ireland, one was from Italy, one was from the Netherlands, and one was from a combination of eleven European countries (Czech Republic, Denmark, Finland, France, Germany, Iceland, Italy, Netherlands, Norway, Sweden, United Kingdom). All 14 studies were conducted in community home care settings.

Two studies were randomized control trials, one study was a cluster randomized control trial, two studies used grounded theory, and two were focused ethnographies. Also, two were descriptive designs, one study was a two-phase exploratory design, one was an experimental study, one was a literature review, one was a retrospective cohort study, and one was an intervention design and evaluation study.

Ten studies focused on older adults over 65 years of age with two or more chronic conditions who were receiving home care services in the community setting. Two studies' samples included case managers and family caregivers, as well as older adults with MCCs in the home care setting. One study's sample included primary care physicians, case managers, and geriatricians who care for older adults with MCCs in the home care setting. One study focused only on case managers who care for older adults with MCCs in the home care setting.

All 14 studies focused on case management as a care intervention within a model of care to provide integrated care for older adults with multiple chronic conditions in home care settings. There were a variety of aims. Seven studies focused on evaluating the impacts of integrated home care case management for older adults with MCCs on many outcomes. These included institutional admission rates and length of stay, health and social system costs, quality and effective care, frailty and functional decline, quality of life, the ability for self-management, and older adults', family caregivers', and health care professionals' level of interaction, collaboration, and satisfaction.

Two of the studies explored the scope of peer-reviewed national and international research literature on the roles and outcomes for nurse-led case management for older adults with MCCs in the home setting. One study focused on older adults with MCC experiences of case management, while one study focused on case managers' everyday work experiences in providing care for older adults with MCCs. Three studies aimed to identify the factors that influenced case managers' and health professionals' facilitators and challenges of case management practice and collaboration, and choice of case management models when providing care for older adults with MCCs in the home care setting.

Case management standards. All six case management standards were identified in the review data (Table 3-2). The standards of assessment and evaluation had the highest representation in the data and were identified in all 14 papers. The case management standard of planning was identified in 12 papers, implementation in ten papers, and client identification and eligibility for case management were identified in nine papers. Transition was the least identified standard, appearing in only three papers.

Professional integrated care functions. All seven professional integrated care functions were identified in the review data (Table 3-3). Collective responsibility to provide a continuous, comprehensive and coordinated continuum of care was the most represented function being identified in all 14 papers. Shared accountability for integration of services was identified in 13 review papers, followed by inter-professional partnerships in 13 papers. Commissioning services was identified in 12 papers, intra-professional partnerships were identified in 10 articles, and shared decision making was identified in seven papers. Finally, shared problem solving was the least identified professional integrated care function, appearing in only four articles.

Clinical integrated care functions. All five clinical integrated care functions were identified in the review data (Table 3-4). The clinical integrated care functions of coordination of care for clients was identified in all 14 papers. Person-centred versus disease-centred care was identified in 11 papers, as was client engagement and partnership in self-management, and matching services to meet client need. Finally, primary process of care delivery to clients was identified in nine papers.

Facilitators. All six case management standards were identified as facilitators in the data (Table 3-5). Assessment was identified as a facilitator in nine papers, implementation in seven papers, client identification and eligibility for case management in five papers, evaluation a facilitator in five papers, planning in four papers, and transition in one paper.

All professional integrated care functions were identified as facilitators in the data (Table 3-6). Interprofessional partnerships was identified as a facilitator in eight papers, collective responsibility to provide continuous, comprehensive, and coordinated continuum of care in eight papers, intra-professional partnerships in seven papers, shared accountability for integration of services in seven papers, commissioning services in seven papers, shared decision making in five papers, and shared problem solving was identified in four papers.

All clinical integrated care functions were identified as facilitators in the data (Table 3-7). Primary process of care delivery was identified as a facilitator in five papers, person-centred verses disease-centred care in five papers, matching services to meet client need in six papers, coordination of care for clients in seven papers, and ensuring client engagement and partnership in self-management in nine papers.

Barriers. Four case management standards were also identified as barriers in the data (Table 3-5). Client identification and eligibility for case management services were identified as a barrier in three papers, assessment in three papers, planning in two papers, and evaluation in one paper. The case management standards of implementation and transition were not identified as barriers in any of the review papers.

All professional integrated care functions were also identified as barriers in the data (Table 3-6). Inter-professional partnerships, collective responsibility to provide a continuous, comprehensive, and coordinated continuum of care, and shared accountability for integration of services were each identified as barriers in five papers. As well, intra-professional partnerships, commissioning services, shared problem-solving, and shared decision making were each identified as barriers in one paper.

Four clinical integrated care functions were also identified as barriers in the data (Table 3-7). Ensuring client engagement and partnership in self-management was identified as a barrier in two papers, whereas person-centred versus disease-centred care, matching services to meet client need, and coordination of care for clients was each identified as barriers in one paper. The clinical integrated care function of primary process of care delivery was not identified as a barrier in any of the review papers.

Analytic findings.

Case management standards and integrated care functions. We found that all six case management standards of practice were reflected through the HCCMs' provision of integrated care. HCCMs used seven professional integrated care (meso) functions (Table 3-8) and five clinical integrated care (micro) functions (Table 3-9) for older adults with MCCs in the home setting. However, on closer examination, only five professional integrated care functions were represented in all six case management standards. Shared problem-solving and shared decision making were not represented in the two case management standards of client identification and eligibility for case management and transition. Also, four of the clinical integrated care functions were represented in all six case management standards. However, primary care delivery was not represented in the case management standards of client identification and eligibility for case management and transition.

HCCMs were able to provide all identified functions of professional and clinical integrated care to older adults with MCCs while carrying out the case management standards of assessing, planning, implementing, and evaluating their clients and their care. However, not all professional and clinical integrated care functions were represented in the standards of client identification and eligibility for case management or transition.

The representation of professional integrated care and clinical integrated care functions with corresponding case management standards revealed that relationships exist among case management standards and all integrated care functions. Overall, the professional and clinical integrated care functions were most represented in the assessment component of case management standards. These included the professional integrated care functions of inter-professional partnerships, and commissioning services and clinical integrated care functions of coordination of care for clients, client engagement, and participation in self-management. Person-centred versus disease-centred care were also represented within case management assessment.

Professional and clinical integrated care functions were equally represented in the standards planning, implementation, and evaluation. However, the clinical integrated care function of coordination of care was the most represented of all integrated care functions in these three standards. Client engagement and participation in self-management, and person-centred care verses disease-centred care were most represented in the standard implementation, and person-centred care verses disease-centred care was most represented in evaluation.

Professional integrated care functions of shared problem solving, shared decision making, and clinical integrated care functions of primary care delivery were the least represented in the standards of identification of client and eligibility for case management, and transition. These findings align with the identification that only five of the seven professional integrated care functions, and four of the five clinical integrated care functions were associated with all six case management standards.

Facilitators and barriers. Deductive analysis demonstrated that all case management standards, professional integrated care functions, and clinical integrated care functions were identified as a facilitator, a barrier, or both in the review data. All case management standards, professional integrated care, and clinical integrated care functions were more likely to be identified as facilitators rather than barriers to HCCMs' care of older adults with MCCs. Indeed, two case management standards (implementation and transition), and one clinical integrated care function (primary process of care delivery), were solely identified as facilitators in the data.

We found variations when case management standards, professional integrated care, and clinical integrated care functions were identified as a facilitator or a barrier. The case management standards most frequently identified as a facilitator included assessment, planning, and implementation. Within professional integrated care functions, intra-professional partnerships, inter-professional partnerships, collective responsibility to provide a continuum of care, and shared accountability for integration of services were most frequently identified as a facilitator. Finally, within clinical integrated care functions, person-centred versus disease-centred care, coordination of care for clients, and ensuring engagement and partnership in self-management were most frequently identified as a facilitator.

Other than implementation, transition, and primary process of care delivery, all case management standards and professional integrated care and clinical integrated care functions were identified as barriers in the data. Specifically, the professional integrated care functions of inter-professional partnerships and shared accountability for integration of services were most frequently identified as a barrier. Although, as previously stated, both of these functions were more likely to be identified as a facilitator for the HCCM integrated care of older adults with MCCs in the home setting.

Discussion

The Case Management Standards of Practice (NCMN, 2009) and the Conceptual Framework for Integrated Care (Valentijn et al., 2013) were useful frameworks to examine how HCCMs provide integrated care to older adults with MCCs, and three salient issues came to light. These included HCCMs' ability to provide professional and clinical integrated care to older adults with MCCs, an understanding that case management standards and integrated care functions—according to the Conceptual Framework for Integrated Care (Valentijn et al., 2013)—may be either a facilitator or barrier to HCCM delivery of care, and the need for a new conceptual framework to guide HCCMs and integrated care practice.

Home Care Case Managers' Provision of Integrated Care

Our findings demonstrated many ways that HCCMs' case management practice corresponded with Valentijn et al.'s (2013) professional and clinical integrated care functions. Although HCCMs' work includes integrated care functions at both the professional and clinical level, there was more of an emphasis on clinical integrated care functions. For example, HCCMs' coordination of client care, client engagement activities, and provision of person-centred care were more likely to occur when the HCCM was carrying out the case management standards of planning, implementing, and evaluating client care. This demonstrates that when HCCMs carry out professional and clinical integrated care functions, these may vary depending on the specific case management activity they are performing.

Another interesting finding was that the case management standards of identification of client and eligibility for case management, and transition were the least discussed and described in the data. An examination of the role of the HCCM in identifying the client and screening them for eligibility for case management services demonstrates that this is the first step in establishing an appropriate case management service relationship. An assessment determines the initial needs of the client, and the needs are matched against the eligibility criteria of the case management service provided (NCMN, 2009). In their literature review, Reilly, Hughes, and Challis (2010) reported considerable variation in how HCCMs carried out the standards of client identification and eligibility for case management services and transition for their clients. They reported that to identify clients, HCCMs used data such as recent hospitalization or history of previous admissions, and functional impairment assessments to identify frail adults at risk for extended hospitalization or long-term care admission, and direct referrals for case management. HCCMs adopted these inconsistent identification methods based on the available information systems of health services, although fragmented, rather than on client need.

With transitions in care, the role of the HCCM is to either lead a process that supports a shift in the interventions to meet clients' goals of care or discharge them. This can often mean a move to an alternate care setting. When or if this occurs, there is an adjustment of the therapeutic relationship between the client and HCCMs; the relationship may conclude with client goals achieved or with goals unfulfilled (NCMN, 2009). Reilly, Hughes, and Challis (2010) also found case management transition procedures to be inconsistent, with a lack of standardization between case management programs and services. They found that case management duration in the study ranged from no time limitation for services to a span of six months to a year and was based on the availability of funding or if the client's health improved to the point that case management would no longer be needed.

Facilitators and Barriers of HCCMs' Provision of Integrated Care

Our findings demonstrated that case management standards and professional and clinical integrated care functions were often identified as both facilitators and barriers for HCCMs' care of older adults with MCCs but were more likely to be identified as facilitators. Threapleton et al. (2017) identified that facilitators for integrated care practice with older populations included shared values and understanding between health care professionals, time for communication and building relationships and professional partnerships within and between organizations, shared problem solving and decision making, health care professional and client engagement, and clear, open communication with clients about their integrated care goals. These facilitators are consistent with our findings. Professional and clinical integrated care functions, such as intra-professional partnerships, inter-professional partnerships, collective responsibility to provide a continuum of care, shared accountability for integration of services, person-centred versus disease-centred care, and ensuring engagement and partnership in self-management were identified as facilitators for case management and integrated care practice in our review. These facilitators can be described as essential mechanisms to achieve normative integration (Valetijn et al., 2013). Normative integration is significant, as it supports strategies for coordination of client care through health care professionals' shared values and common goals of collaboration and partnership development to achieve patient-centred care (Valentijn et al. 2013).

Barriers to integrated care for older populations were reported as lack of shared values or disagreements over the goals or benefits of integrated care interventions between interdisciplinary staff, and lack of clarity in health care professionals’ roles and responsibilities (Threapleton et al., 2017). These barriers are also consistent with our findings, whereby inter-professional partnerships and shared accountability for integration of services were the professional integrated care functions most likely to be identified as barriers. This is problematic as the development of intra- and inter-professional partnerships and collaboration are critical normative integration mechanisms to effectively coordinate client care within and across care settings (Valetijn et al. 2013).

Integrated Care and Case Management Framework

Our findings demonstrate a need for the development of a theoretical framework to support HCCMs’ ability to provide integrated care of older adults with MCCs. A promising start could be working with the concepts of the Case Management Standards of Practice (NCMN, 2009) and Valentijn et al.'s (2013) Conceptual Framework of Integrated Care. Our initial review of Valentijn et al.'s framework revealed that case management standards of practice (NCMN, 2009) was not represented within system integrated care (macro) or the organizational integrated care (meso) levels. This is reasonable to expect, given the vast majority of HCCMs' work occurs at the professional and clinical integrated care levels, where the HCCM, client, and intra- and interdisciplinary professionals interact to provide person-centred care.

The system (macro) and organizational (meso) levels in Valentijn et al.'s (2013) framework focus on functions of integrated care that support broader health systems and organizations to achieve population health. These higher levels of integrated care are vital in creating and maintaining health systems and organizational environments that support and promote HCCMs' provision of integrated care. Combined, all levels of Valentijn et al.'s (2013) framework (micro, meso, and macro) impact person-centred and population health approaches to integrated care.

Recommendations for the development and application of a framework for integrated care by HCCMs should include the case management standards of practice, professional integrated care (meso), and clinical integrated care (micro) levels, where HCCMs are most likely to function (Figure 3-3). The framework should include accompanying evidence-based practice guidelines to address practice and policy issues, as well as provide direction for policies that promote functional and normative integration in the development of case management and integrated care programs. We propose that these framework elements will assist HCCMs in the provision of person-focused integrated care to promote consistency across all case management standards. This would promote role clarity of HCCMs with interdisciplinary health professionals and foster shared values for collaboration and sustainability of partnerships across sectors and between HCCMs, interdisciplinary health care professionals, and clients.

Implications for Home Care Case Manager Practice, Policy, and Research

Practice

Questions arise from our findings about whether the work of HCCMs in the case management standards of identification of client and eligibility for case management, and transition are simply not consistently described in the literature, or if there are variations in HCCMs' practice that impacts the delivery of case management standards when caring for older adults with MCCs. If it is the latter, this has implications for the comprehensiveness and consistency of HCCM practice, as well as both interdisciplinary health professionals' and clients' awareness of the HCCM role when providing integrated care to older adults with MCCs within home settings.

The lack of consistency in HCCMs' practice could be mitigated with the development of evidence-based practice guidelines for HCCM integrated care in the provision of case management for older adults with MCCs. The design of HCCM practice guidelines requires participation and input from HCCMs and would need to combine case management standards with functions of integrated care to provide a foundation for and assist in, standardizing HCCM practice (Joo & Huber, 2017). These guidelines could also add to role clarity and increased awareness of the HCCM scope of practice for clients, family caregivers, and interdisciplinary health care professionals within the home care setting and broader health system (Reilly, Hughes, & Challis, 2010).

Policy

Our findings suggest that the greatest facilitators and barriers to integrated care are those case management standards and clinical and professional integrated care functions that focus on partnerships, collective and shared responsibility and accountability, coordinated person-centred care for clients, and ensuring engagement and partnership in self-management. This indicates the need for the development of case management policies and programs that support the work of HCCMs in the delivery of seamless and collaborative case management and integrated care functions that foster collaboration and partnership building efforts (Kodner & Spreeuwenberg, 2002).

Early policies that targeted integrated care program efforts narrowly focused on the functional redesign of health care structures between inter-sectoral settings, central administration, and implementation strategies, such as shared electronic medical records. These policies targeted system and organizational changes and were often imposed upon interdisciplinary health care professionals in a top-down approach. These failed to demonstrate improved integrated care outcomes (Burns et al., 2001; Goodwin, 2016), reinforcing that functional integration, which includes how health systems are formally organized and structured, alone are insufficient for integrating services and client care (Janse, Huijsman, de Kuyper, & Fabbricotti, 2016; Valentijn et al., 2013; Wollscheid et al., 2013).

In addition to functional integration, current integrated care research is exploring the mechanisms and impacts of normative integration (Valentijn et al., 2013). Normative integration is less tangible than functional integration and includes coordination mechanisms based on shared values, culture, and goals across and between interdisciplinary health care professionals and organizations towards patient-centred care, teamwork, and communication efforts. Normative integration is an essential ingredient to foster interdisciplinary and inter-sectoral collaboration to promote consistency between all the levels of an integrated system (Valentijn et al., 2013).

We posit that the development and implementation of case management and health care policies inclusive of functional and normative integration strategies and mechanisms would foster collaboration and the sustainability of partnerships among HCCMs, clients, and other health care professionals. This will achieve shared responsibility and accountability for the integrated care of clients that focus on coordinated patient-centred care. As well, the client will be engaged in developing their knowledge and capacity for self-management and care when working across a variety of care settings.

Research

Research implications for these findings include the need to test and evaluate this framework to ensure reliability and validity for advanced intervention research and development to measure and advance case management and integrated care practice by HCCMs and in a variety of care settings. Joo and Huber (2017) explained that well designed research studies are required to inform the development of appropriate and effective frameworks by exploring the components of case management and integrated care interventions, alongside estimating clinical effectiveness in a variety of settings and populations.

Strandberg-Larsen and Krasnik (2009) completed a systematic review to identify the different types of methods used to measure integrated health care delivery in health systems with emphasis on structural, cultural, and process aspects. They found that only five of the 24 measurement methods shared a theoretical framework, leading to a large variety of concepts being measured. They concluded that without a guiding theoretical framework, conceptual diversity occurred, leading to the majority of methods lacking in validity and reliability for measuring integrated care.

Janse et al. (2016) engaged health care professionals in primary care practices and home-care organizations to implement an integrated care intervention, explicitly targeting frail, elderly patients. The study measured integration processes in the delivery of integrated care as perceived by professionals. They adopted Donabedian's model of quality assessments as their theoretical framework, as it had been proven to be useful in previous evaluations of integration. Their instrument included existing measures of key integration indicators similar to Valentijn et al.'s (2013) functional and normative integration. This proved to be a reliable measure of integration from the professional perspective, consisting of empirically and theoretically consistent scales, and may contribute to the development and refinement of integrated care frameworks (Janse et al., 2016).

Developing a reliable and valid framework using Case Management Standards of Practice (NCMN, 2009) and Valentijn et al.'s (2013) Conceptual Model of Integrated Care would assist in the development, implementation, and evaluation of HCCM practice, policies, and future research. This will aid in the exploration of case management and integrated care models that can better support HCCMs in the provision of case management and integrated care to older adults with MCCs in the home setting.

Limitations

There are some limitations to our scoping review. In keeping with current standard practices of scoping reviews (Arksey & O'Malley, 2005), the quality of research evidence included in our review was not appraised. This could potentially increase bias in our results, as the research literature is limited in its rigor. Also, our scoping review did not address the issue of "synthesis," or the weight of evidence in favour of the effectiveness of case management standards and integrated care functions. While these limitations are present, our scoping review provided a descriptive and analytic account of the available research in our area of study and supported our ability to suggest important practice, policy, and research recommendations for HCCMs and integrated care of older adults with MCCs in the home care setting.

Conclusion

This study is the first scoping review that broadly examined both case management and integrated care to determine how HCCMs provide, or not provide, integrated care to older adults with MCCs in home care. Case management standards of practice and integrated care are each complex phenomena. Through our scoping review, we have shown that HCCMs' work of providing case management and integrated care functions closely correspond and are often interdependent.

We have also identified that HCCMs most frequently use the case management standards of practice of assessment, planning, implementation, and evaluation to provide all professional integrated care (meso) and clinical integrated care (micro) functions in their care of older adults with MCCs in the home setting. We posit that the development of evidence-based HCCMs' practice guidelines, combining case management standards and professional integrated care and clinical integrated care functions, would be foundational to provide consistent, integrated care functions across all case management standards.

Our review also demonstrated that although case management standards and professional and clinical integrated care functions are more frequently identified as facilitators for integrated care, different factors may influence whether they act as facilitators and barriers for the HCCM provision of integrated care of older adults with MCCs. Policies and programs inclusive of both functional and normative integration strategies should be developed to foster collaboration and the sustainability of partnerships among HCCMs, clients, and other health care professionals to achieve shared responsibility and accountability for integrated care for older adults with MCCs across care settings.

Finally, the development and testing of a theoretical framework inclusive of case management standards of practice (NCMC, 2009) and their corresponding professional (meso) and clinical integrated care (micro) functions of the Conceptual Model of Integrated Care (Valentijn et al., 2013) would enhance HCCM practice, policy development, and future research in this area. Understanding how HCCMs provide integrated care could potentially reduce fragmented care, improve care quality, introduce cost savings, and enhance the delivery of person-focused care to older adults with MCCs in the home setting.

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Table 3-1. Description of Articles Included in Scoping Review

First Author/ Year	Journal	Paper Title	Location	Method/ Design	Sample	Aim
McWilliam et al. (2000)	Healthcare Management Forum	Case management approaches for in home care	Canada	Quantitative: Two phased exploratory, descriptive design	Seniors > 65 yrs n=148 Case Managers n=40 Caregivers n=73	Determine what factors differentiated case manager selection of one of the three generic approaches to case management for care of in-home clients over 65 years of age
Landi et al. (2001)	Journal of Clinical Epidemiology	A new model of integrated home care for the elderly: Impact on hospital use	Italy	Quantitative: RCT	Seniors > 65 yrs > 2 chronic conditions n=1204	Examine effect of an integrated social & medical home care program based on comprehensive geriatric assessment (Minimum Data Set for Home Care) & case management on hospital use & cost of frail elderly individuals

First Author/ Year	Journal	Paper Title	Location	Method/ Design	Sample	Aim
Hallberg et al. (2004)	Journal of Clinical Nursing	Preventive home care of frail older people: A review of recent case management studies	Sweden	Qualitative: Literature Review	Seniors > 65 yrs > 2 chronic conditions	Explore & summarize the empirical literature on recent studies of case/care management interventions for community-dwelling frail older adults with regard to the content of the interventions & the nurse's role & outcome
Beland et al. (2006)	Canadian Journal on Aging	Integrated services for frail elders (SIPA): A trial of a model for Canada	Canada	Quantitative: Experimental study	Frail elderly > 65 yrs > 2 multiple chronic conditions n=1230	Compare differences in utilization & costs of health & social services as between the seniors admitted to SIPA & those receiving the services usually available to frail elderly persons within the Quebec health & social system

First Author/ Year	Journal	Paper Title	Location	Method/ Design	Sample	Aim
Onder et al. (2007)	Journal of the American Geriatrics Society	Case management and risk of nursing home admission for older adults in home care: Result of the AgeD in Home care study	Czech Republic Denmark Finland, France, Germany Iceland, Italy, Netherlands, Norway, Sweden, United Kingdom	Mixed Method: Retrospective Cohort Study	Seniors > 65 yrs > 2 chronic conditions n=3292	Explore the relationship between a case management approach & the risk of institutionalization in a large European population of frail, older people in home care
Golden et al. (2010)	The Gerontologist	Care management's challenges and opportunities to reduce the rapid rehospitalization of frail community-dwelling older adults	USA	Qualitative	Frail older adults with multiple chronic conditions	Identify challenges facing care managers, discuss the current limitations of care management, & specify opportunities to improve the effectiveness of transitional care of community dwelling frail older adults

First Author/ Year	Journal	Paper Title	Location	Method/ Design	Sample	Aim
Lupari et al. (2011)	Journal of Clinical Nursing	We're just not getting it right: How should we provide care to the older person with multi-morbid chronic conditions?	Ireland	Mixed Method: Systematic Review	Seniors > 65 yrs >2 Study 1 n=7759 Study 2 n=1112 Study 3 n=11 Study 4 n=228 Study 5 n=597 Study 6 n=27 Study 7 n=19 Study 8 n=74 Total n=9827	Appraise available research & service evaluation evidence on nurse-led case management services targeting older people with multiple chronic conditions in their own homes
DeStampa et al. (2013)	The Gerontologist	Opening the black box of clinical collaboration in integrated care models for frail, elderly patients	Canada & France	Qualitative: Grounded Theory	Primary care Physicians n=35 Care managers n=7 Geriatricians n=4 who care for older adults > 65 yrs with multiple chronic conditions	Understand the clinical collaboration process among primary care physicians (PCPs), case managers (CMs), & geriatricians in integrated models of care for frail older adults

First Author/ Year	Journal	Paper Title	Location	Method/ Design	Sample	Aim
Markle-Reid et al. (2013)	Journal of Evaluation in Clinical Practice	Nurse-led health promotion interventions improve quality of life in frail older home care clients: Lessons learned from three randomized trials in Ontario, Canada	Canada	Quantitative: RCT x 3	Frail older adults > 65 yrs > 2 chronic conditions n=498	Evaluate the effectiveness of different multi-component nurse-disease prevention interventions
Vanderboom et al. (2013)	Care Management Journals	Developing a community Care team: Lessons learned from the community connections program, a health care home–community care team partnership	USA	Qualitative: Intervention Evaluation	CCP team members n=5 Older adults > 65 yrs with > 2 chronic conditions n=3 Family support persons n=3	Identify strengths and limitations of intervention approach to be consider before broad use of the CCP with patients in ambulatory care settings

First Author/ Year	Journal	Paper Title	Location	Method/ Design	Sample	Aim
Park et al. (2014)	International Journal of Integrated Care	Supporting frail seniors through a family physician and home health integrated care model in Fraser Health	Canada	Mixed Methods: Descriptive Pilot Implementation	older adults > 65 yrs with multiple chronic conditions	Provide higher quality, appropriate, coordinated & efficient care, improved patient, caregiver and physician interactions with health system, improved health and prevention of acute care visits by senior adults
Gustafsson (2015)	BMC Health Services Research	Case managers for older persons with multi-morbidity and their everyday work: A focused ethnography	Sweden	Qualitative: Focused Ethnography	Case managers who care for older adults with multiple chronic conditions n=9	Explore the everyday work of case managers within a CM intervention, with a focus on their experiences
Hjelm (2015)	BMC Geriatrics	The work of case managers as experienced by older persons (75+) with multi-morbidity: A focused ethnography	Sweden	Qualitative: Focused Ethnography	older adults > 65 yrs with multiple chronic conditions n=13	Explore older persons' (75+) with multi-morbidity experiences of case managers

First Author/ Year	Journal	Paper Title	Location	Method/ Design	Sample	Aim
Suijker (2015)	PLOS ONE	Effects of nurse-led multifactorial care to prevent disability in community-living older people: A cluster randomized trial	Netherlands	Quantitative: Cluster Randomized Trial	Seniors > 70 yrs at risk for functional decline and > 2 chronic conditions n=2283 (intervention group n=1209 & control group n=1074)	Evaluate the effects of nurse-led multifactorial care to prevent disability in community living older adults

Table 3-2. Case Management Standards

Client Identification & Eligibility for Case Management	Assessment	Planning	Implementation	Evaluation	Transition
de Stampa et al. (2013) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Landi et al. (2001) Lupari et al. (2010) Markle-Reid et al. (2013) Park et al. (2014) Vanderboom et al. (2013)	Béland et al. (2006) de Stampa et al. (2013) Golden et al. (2010) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Landi et al. (2001) Lupari et al. (2010) Markle-Reid et al. (2013) McWilliam et al. (2000) Onder et al. (2007) Park et al. (2014) Suijker et al. (2016) Vanderboom et al. (2013)	Béland et al. (2006) de Stampa et al. (2013) Golden et al. (2010) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Landi et al. (2001) Markle-Reid et al. (2013) McWilliam et al. (2000) Onder et al. (2007) Park et al. (2014) Vanderboom et al. (2013)	Béland et al. (2006) Golden et al. (2010) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Landi et al. (2001) Lupari et al. (2010) Markle-Reid et al. (2013) McWilliam et al. (2000) Onder et al. (2007) Park et al. (2014)	Béland et al. (2006) de Stampa et al. (2013) Golden et al. (2010) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Landi et al. (2001) Lupari et al. (2010) Markle-Reid et al. (2013) McWilliam et al. (2000) Onder et al. (2007) Park et al. (2014) Suijker et al. (2016) Vanderboom et al. (2013)	Béland et al. (2006) Park et al. (2014) Vanderboom et al. (2013)

Table 3-3. Professional Integrated Care Functions

Collective Responsibility to Provide Continuum of Care	**Inter-Professional Partnerships**	**Shared Account-ability for Integration of Services**	**Intra-Professional Partner-ships**	**Commissioning Services**	**Shared Problem Solving**	**Shared Decision Making**
Béland et al. (2006)	Béland et al. (2006)	Béland et al. (2006)	Béland et al. (2006)	Béland et al. (2006)	de Stampa et al. (2013)	de Stampa et al. (2013)
de Stampa et al. (2013)	de Stampa et al. (2013)	de Stampa et al. (2013)	de Stampa et al. (2013)	de Stampa et al. (2013)	Markle-Reid et al. (2013)	Golden et al. (2010)
Golden et al. (2010)	Gustafsson et al. (2013)	Golden et al. (2010)	Gustafsson et al. (2013)	Gustafsson et al. (2013)	Park et al. (2014)	Gustafsson et al. (2013)
Gustafsson et al. (2013)	Hallberg et al. (2004)	Gustafsson et al. (2013)	Hallberg et al. (2004)	Hallberg et al. (2004)	Vanderboom et al. (2013)	Markle-Reid et al. (2013)
Hallberg et al. (2004)	Hjelm et al. (2015)	Hallberg et al. (2004)	Hjelm et al. (2015)	Hjelm et al. (2015)		Park et al. (2014)
Hjelm et al. (2015)	Landi et al. (2001)	Hjelm et al. (2015)	Landi et al. (2001)	Landi et al. (2001)		Suijker et al. (2016)
Landi et al. (2001)	Lupari et al. (2010)	Landi et al. (2001)	Markle-Reid et al. (2013)	Lupari et al. (2010)		Vanderboom et al. (2013)
Lupari et al. (2010)	Markle-Reid et al. (2013)	Markle-Reid et al. (2013)	McWilliam et al. (2000)	Markle-Reid et al. (2013)		
Markle-Reid et al. (2013)	McWilliam et al. (2000)	McWilliam et al. (2000)	Park et al. (2014)	McWilliam et al. (2000)		
McWilliam et al. (2000)	Onder et al. (2007)	Onder et al. (2007)	Vanderboom et al. (2013)	Onder et al. (2007)		
Onder et al. (2007)	Park et al. (2014)	Park et al. (2014)		Park et al. (2014)		
Park et al. (2014)	Suijker et al. (2016)	Suijker et al. (2016)		Vanderboom et al. (2013)		
Suijker et al. (2016)	Vanderboom et al. (2013)	Vanderboom et al. (2013)				
Vanderboom et al. (2013)						

Table 3-4. Clinical Integrated Care Functions

Coordination of Care for Client	**Matching Services to Meet Client Need**	**Client Engagement & Participation**	**Person Centred Care vs Disease Centered Care**	**Primary Care Delivery**
Béland et al. (2006) de Stampa et al. (2013) Golden et al. (2010) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Landi et al. (2001) Lupari et al. (2010) Markle-Reid et al. (2013) McWilliam et al. (2000) Onder et al. (2007) Park et al. (2014) Suijker et al. (2016) Vanderboom et al. (2013)	Béland et al. (2006) de Stampa et al. (2013) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Landi et al. (2001) Lupari et al. (2010) Markle-Reid et al. (2013) McWilliam et al. (2000) Onder et al. (2007) Park et al. (2014)	Golden et al. (2010) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Landi et al. (2001) Lupari et al. (2010) Markle-Reid et al. (2013) McWilliam et al. (2000) Park et al. (2014) Suijker et al. (2016) Vanderboom et al. (2013)	de Stampa et al. (2013) Golden et al. (2010) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Lupari et al. (2010) Markle-Reid et al. (2013) Onder et al. (2007) Park et al. (2014) Suijker et al. (2016) Vanderboom et al. (2013)	Béland et al. (2006) de Stampa et al. (2013) Golden et al. (2010) Gustafsson et al. (2013) Hallberg et al. (2004) Hjelm et al. (2015) Markle-Reid et al. (2013) Onder et al. (2007) Park et al. (2014)

Table 3-5. Case Management Standards Facilitators and Barriers

Case Management Standards	**Client Identification & Eligibility for Case Management**	**Assessment**	**Planning**	**Implementation**	**Evaluation**	**Transition**
McWilliam et al. (2000)		x	x		x	
Landi et al. (2001)	x	x Facilitator	x Facilitator	x Facilitator	x Facilitator	
Hallberg et al. (2004)	x Barrier	x	x Barrier	x Facilitator	x Facilitator	
Beland et al. (2006)		x Barrier & Facilitator	x	x	x	x
Onder et al. (2007)		x	x	x	x	
Golden et al. (2010)	x	x Barrier & Facilitator	x Barrier	x Facilitator	x	
Lupari et al. (2011)	x Facilitator	x Facilitator		x	x	
DeStampa et al. (2013)	x	x	x	x	x	
Markle-Reid et al. (2013)	x	x Facilitator	x Facilitator	x Facilitator	x Facilitator	
Vanderboom et al. (2013)	x Facilitator	x Facilitator	x Facilitator		x	x
Park et al. (2014)	x Facilitator	x Facilitator	x Facilitator	x Facilitator	x Facilitator	x Facilitator
Gustafsson (2015)	x Barrier & Facilitator	x Barrier & Facilitator	x Facilitator	x Facilitator	x Barrier & Facilitator	
Hjelm (2015)	x Barrier & Facilitator	x Facilitator	x	x Facilitator	x	
Suijker (2015)		x	x		x	

Table 3-6. Professional Integrated Care Functions Facilitators and Barriers

Professional Integrated Care	**Intra-Professional Partner-ships**	**Inter-Professional Partner-ships**	**Collective Responsibil-ity to Provide Continuum of Care**	**Shared Account-ability for Integration of Services**	**Commiss-ioning Services**	**Shared Problem Solving**	**Shared Decision Making**
McWilliam et al. (2000)	x	x	x	x	x		
Landi et al. (2001)	x Facilitator	x Facilitator	x Facilitator		x		
Hallberg et al. (2004)	x Facilitator	x	x Facilitator	x Facilitator	x Facilitator		
Beland et al. (2006)	x Facilitator	x Barrier	x Barrier & Facilitator	x Barrier & Facilitator	x Facilitator		
Onder et al. (2007)		x Facilitator	x Barrier	x	x		
Golden et al. (2010)			x	x			x Facilitator
Lupari et al. (2011)		x Facilitator	x Barrier & Facilitator		x Barrier & Facilitator		
DeStampa et al. (2013)	x Facilitator	x Barrier & Facilitator	x Barrier	x Barrier & Facilitator	x Facilitator	x Barrier & Facilitator	x Barrier & Facilitator
Markle-Reid et al. (2013)	x	x Facilitator	x Facilitator	x Facilitator	x	x Facilitator	x Facilitator
Vanderboom et al. (2013)	x Barrier & Facilitator	x Barrier & Facilitator	x Facilitator	x Barrier & Facilitator	x	x Facilitator	x Facilitator
Park et al. (2014)	x Facilitator	x Barrier & Facilitator	x Facilitator	x Barrier & Facilitator	x Facilitator	x Facilitator	x Facilitator
Gustafsson (2015)	x	x	x Barrier & Facilitator	x Barrier & Facilitator	x Facilitator		x
Hjelm (2015)	x Facilitator	x	x	x	x Facilitator		
Suijker (2015)		x Barrier & Facilitator	x	x			x

Table 3-7. Clinical Integrated Care Functions Facilitators and Barriers

Clinical Integrated Care Functions	**Primary Process of Care Delivery to Individual Patients**	**Person Centered vs. Disease Centered**	**Person Centered vs. Disease Centered**	**Coordination of Care for Client**	**Ensuring Client Engagement & Partnership**
McWilliam et al. (2000)			x	x	x Facilitator
Landi et al. (2001)		x	x	x Facilitator	x Facilitator
Hallberg et al. (2004)	x Facilitator	x	x Barrier & Facilitator	x Facilitator	x Facilitator
Beland et al. (2006)	x Facilitator		x Facilitator	x Facilitator	
Onder et al. (2007)	x	x	x	x	
Golden et al. (2010)	x Facilitator	x		x	x
Lupari et al. (2011)		x Barrier	x	x Facilitator	x Facilitator
DeStampa et al (2013)	x Facilitator	x Facilitator	x Facilitator	x Barrier & Facilitator	
Markle-Reid et al. (2013)	x	x	x	x	x Facilitator
Vanderboom et al. (2013)		x Facilitator		x	x Facilitator
Park et al. (2014)	x Facilitator	x Facilitator	x Facilitator	x Facilitator	x Barrier & Facilitator
Gustafsson (2015)		x Facilitator	x Facilitator	x	x Barrier & Facilitator
Hjelm (2015)	x	x Facilitator	x Facilitator	x Facilitator	x Facilitator
Suijker (2015)	x	x	x	x	x

Table 3-8. Professional Integrated Care Functions and Case Management Standards

Professional Integrated Care Functions & Case Management Standards	Collective Responsibility to Provide Continuum of Care	Inter-Professional Partner-ships	Shared Account-ability for Integration of Services	Intra-Professional Partner-ships	Commiss-ioning Services	Shared Problem Solving	Shared Decision Making
Identify Client	DeStampa et al. (2013) Markle-Reid et al. (2013) Gustafsson (2015)	DeStampa et al. (2013) Vanderboom et al. (2013)	Landi et al. (2001) Markle-Reid et al. (2013) Park et al. (2014)	Vanderboom et al. (2013) Park et al. (2014)	Landi et al. (2001)		
Assessment	Beland et al. (2006) DeStampa et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) McWilliam et al. (2000) Hallberg et al. (2004)	McWilliam et al. (2000) Hallberg (2004) DeStampa et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) Gustafsson (2015) Suijker (2015)	Landi et al. (2001) Hallberg et al. (2004) Markle-Reid et al. (2013) Park et al. (2014)	McWilliam et al. (2000) Hallberg et al. (2004) Vanderboom et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015)	McWilliam et al. (2000) Landi et al. (2001) Onder et al. (2007) Vanderboom et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015) Hallberg et al. (2015) Gustafsson (2015)	DeStampa et al. (2013) Vanderboom et al. (2013) Markle-Reid et al. (2013)	DeStampa et al. (2013) Vanderboom et al. (2013) Markle-Reid et al. (2013)

Professional Integrated Care Functions & Case Management Standards	Collective Responsibility to Provide Continuum of Care	Inter-Professioal Partnerships	Shared Accountability for Integration of Services	Intra-Professional Partnerships	Commissioning Services	Shared Problem Solving	Shared Decision Making
Planning	Landi et al. (2001) Beland et al. (2006) DeStampa et al. (2013) Markle-Reid et al. (2013) McWilliam et al. (2015) Gustafsson (2015)	McWilliam (2000) Landi et al. (2001) Markle-Reid et al. (2013) Park et al. (2014) Gustafsson (2015)	Landi et al. (2001) Beland et al. (2006) DeStampa et al. (2013) Vanderboom et al. (2013) Markle-Reid et al. (2013) Gustafsson (2015)	Landi et al (2001) McWilliam et al. (2000) DeStampa et al. (2013) Vanderboom et al. (2013) Markle-Reid et al. (2013) Heljm (2015) Gustafsson (2015)	McWilliam et al. (2000) Landi et al. (2001) Onder et al. (2007) Markle-Reid et al. (2013) Heljm (2015) Hallberg et al. (2015)	DeStampa et al. (2013) Vanderboom et al. (2013) Markle-Reid et al. (2013)	DeStampa et al. (2013) Vanderboom et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) Gustafsson (2015)
Implementation	Landi et al. (2001) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015)	Landi et al. (2001) Markle-Reid et al. (2013) Park et al. (2014)	Landi et al. (2001) Hallberg et al. (2004) Markle-Reid et al. (2013) Park et al. (2014)	Landi et al. (2001) Hallberg et al. (2004) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015)	McWilliam et al. (2000) Landi et al. (2001) Onder et al. (2007) Markle-Reid et al. (2013) Park et al. (2014)	Markle-Reid et al. (2013)	Markle-Reid et al. (2013)

Professional Integrated Care Functions & Case Management Standards	Collective Responsibility to Provide Continuum of Care	Inter-Professioal Partner-ships	Shared Account-ability for Integration of Services	Intra-Profess-ional Partner-ships	Commission-ing Services	Shared Problem Solving	Shared Decision Making
Evaluation	Beland et al. (2006) Markle-Reid et al. (2013) Park et al. (2014) Hallberg et al. (2004)	McWilliam et al. (2000) Markle-Reid et al. (2013) Park et al. (2014) Suijker (2015)	Hallberg et al. (2004) Beland et al. (2006) Vanderboom et al. (2013) Markle-Reid et al. (2013) Park et al. (2014)	McWilliam et al. (2000) Hallberg et al. (2004) DeStampa et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015)	McWilliam et al. (2000) Hallberg et al. (2004) Onder et al. (2007) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015)	DeStampa et al. (2013) Markle-Reid et al. (2013)	DeStampa et al. (2013) Park et al. (2014) Suijker (2015)
Transition	Beland et al. (2006) Park et al. (2014)	Park et al. (2014)	Beland et al. (2006) Park et al. (2014)	Park et al. (2014)	Park et al. (2014)		

Table 3-9. Clinical Integrated Care Functions and Case Management Standards

Clinical Integrated Care Functions & Case Management Standards	**Coordination of Care for Client**	**Matching Services to Meet Client Need**	**Client Engagement & Participation**	**Person Centred Care vs Disease Centered Care**	**Primary Care Delivery**
Identify Client	Landi et al. (2001) Hallberg et al. (2004) DeStampa et al. (2013) Park et al. (2014)	Landi et al. (2001) Hallberg et al. (2004)	Markle-Reid et al. (2013)	Gustafsson (2015)	
Assessment	McWilliam et al. (2000) Landi et al. (2001) Hallberg et al. (2004) Onder et al. (2007) Golden et al. (2010) Lupari et al. (2011) Vanderboom et al. (2013) DeStampa et al. (2013) Park et al. (2014) Suijker (2015) Heljm (2015) Gustafsson (2015)	McWilliam et al. (2000) Hallberg et al. (2004) Lupari et al. (2011) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015)	McWilliam et al. (2000) Hallberg et al. (2004) Vanderboom et al. (2013) Markle-Reid et al. (2013) Park et al. (2015) Gustaffson (2015) Heljm (2015)	Onder et al. (2007) DeStampa et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015) Gustafsson (2015) Suijker (2015)	Hallberg et al. (2004) Golden et al. (2010) DeStampa et al. (2013) Markle-Reid et al. (2013) Heljm (2015)

Clinical Integrated Care Functions & Case Management Standards	Coordination of Care for Client	Matching Services to Meet Client Need	Client Engagement & participation	Person Centred Care vs Disease Centered Care	Primary Care Delivery
Planning	McWilliam et al. (2000) Landi et al. (2001) Hallberg et al. (2004) Beland et al. (2006) Park et al. (2014) Heljm (2015) Gustafsson (2015)	Beland et al. (2006) DeStampa et al. (2013) Markle-Reid et al. (2013) McWilliam et al. (2000) Hallberg et al. (2004)	Landi et al. (2001) Vanderboom et al. (2013) Markle-Reid et al. (2013) Gustafsson (2015)	DeStampa et al. (2013) Vanderboom et al. (2013) Markle-Reid et al. (2013) Heljm (2015)	Hallberg et al. (2004) Park et al. (2014) Heljm (2015)
Implementation	Landi et al. (2001) Hallberg et al. (2004) Beland et al. (2006) Golden et al. (2010) Lupari et al. (2011) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015) Gustafsson (2015)	Beland et al. (2006) Lupari et al. (2011) Park et al. (2014) Gustafsson (2015)	Landi et al. (2001) Golden et al. (2010) Markle-Reid et al. (2013) Park et al. (2014) Hallberg et al. (2014) Heljm (2015) Gustafsson (2015)	Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015) Gustafsson (2015)	Hallberg et al. (2004) Golden et al. (2010) Markle-Reid et al. (2013) Heljm (2015)

Clinical Integrated Care Functions & Case Management Standards	**Coordination of Care for Client**	**Matching Services to Meet Client Need**	**Client Engagement & participation**	**Person Centred Care vs Disease Centered Care**	**Primary Care Delivery**
Evaluation	McWilliam et al. (2000) Hallberg et al. (2004) Beland et al. (2006) Onder et al. (2007) Lupari et al. (2011) DeStampa et al. (2013) Park et al. (2014) Heljm (2015)	McWilliam et al. (2000) Hallberg et al. (2004) Lupari et al. (2011) Park et al. (2014) Heljm (2015) Gustafsson (2015)	Hallberg et al. (2004) Golden et al. (2010) Vanderboom et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015) Gustafsson (2015)	Vanderboom et al. (2013) Markle-Reid et al. (2013) Park et al. (2014) Heljm (2015) Gustafsson (2015)	Hallberg et al. (2004) Beland et al. (2006) Park et al. (2014) Heljm (2015)
Transition	Beland et al. (2006) Park et al. (2014)	Beland et al. (2006) Park et al. (2014)	Park et al. (2014)	Park et al. (2014)	

Figure 3-1. PRISMA Flow Diagram

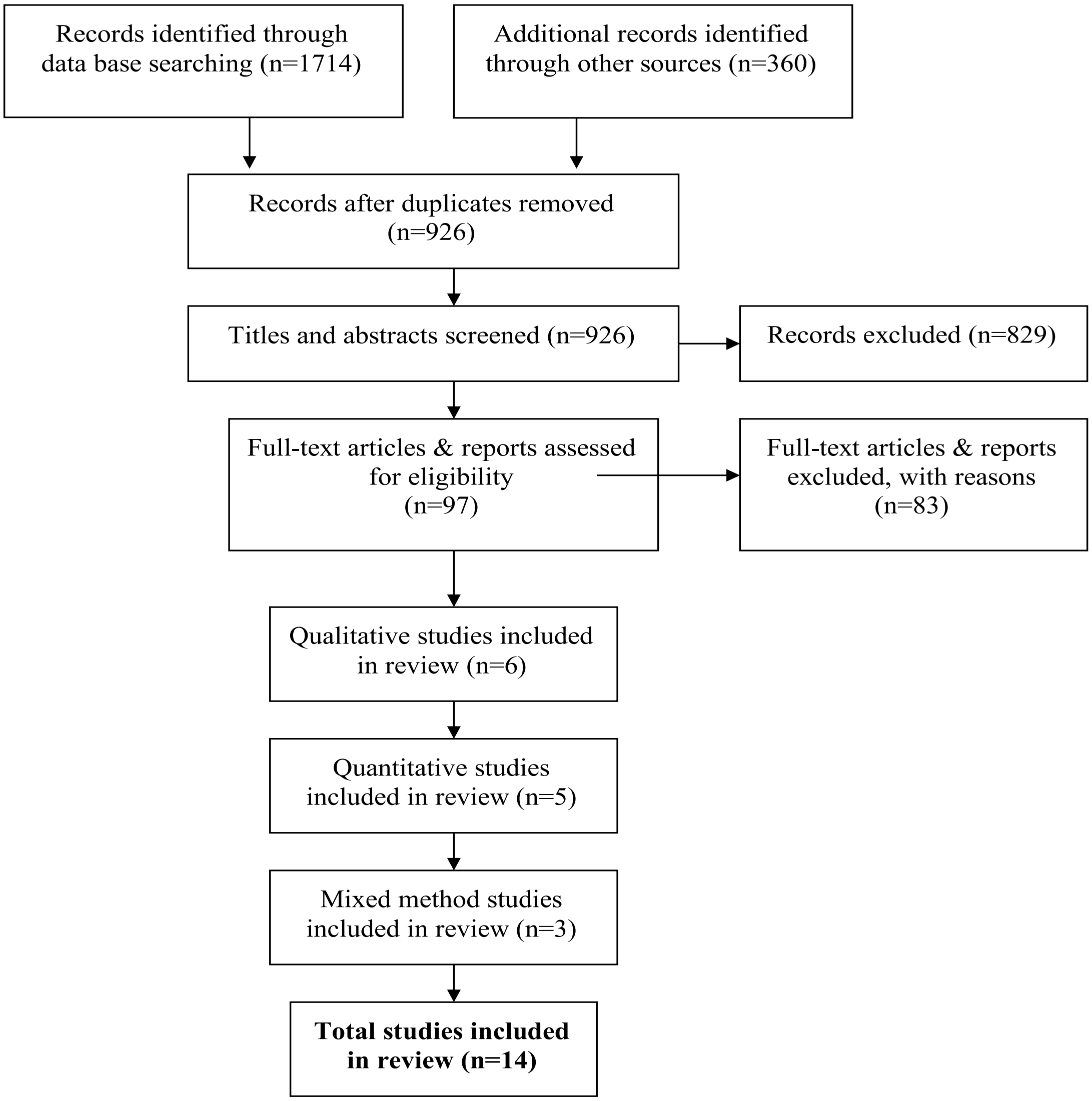


Figure 3-2. Conceptual Framework for Integrated Care Functions (Valentijn et al., 2013)

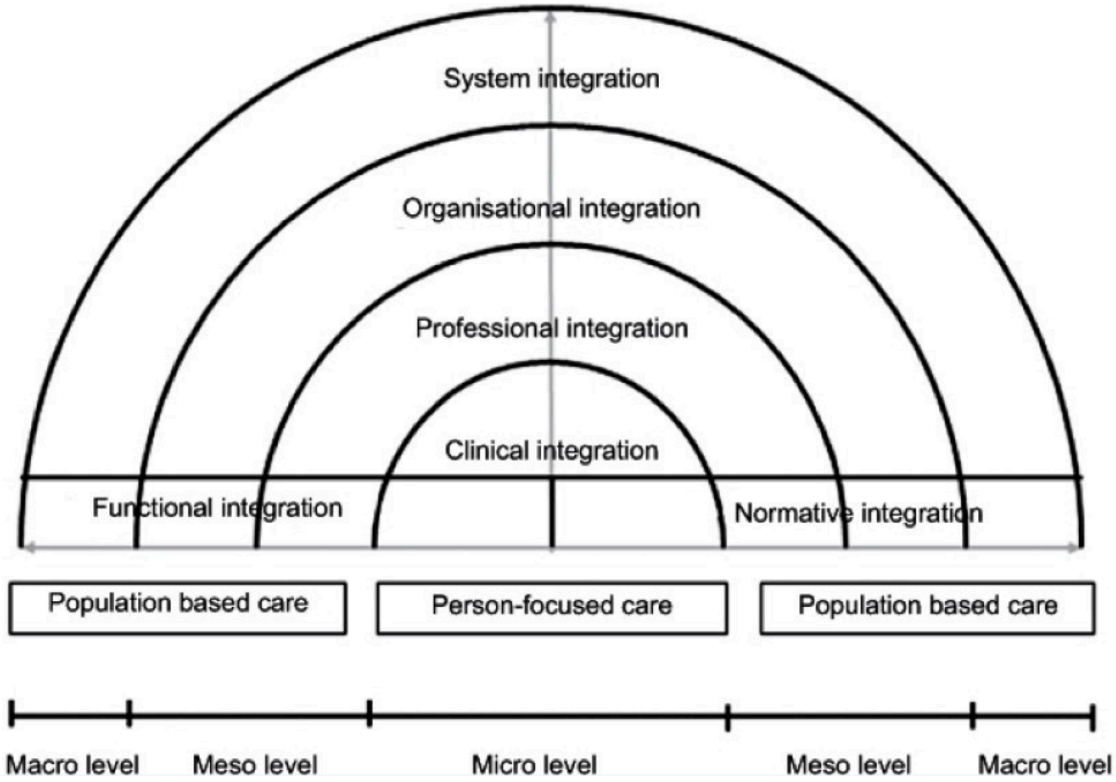
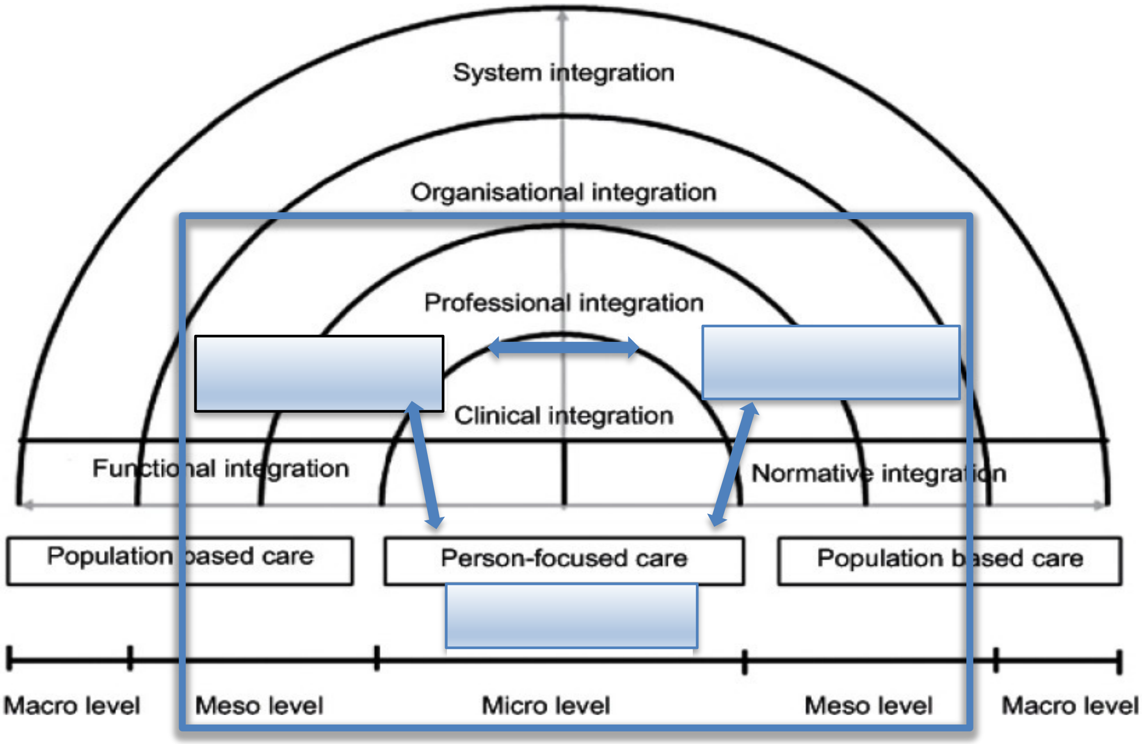


Figure 3-3. Conceptual Framework for Case Management Standards and Integrated Care Functions (Garland Baird & Fraser, 2018b)



Chapter 4: Paper 3

Mapping the Social Organization of Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: An Institutional Ethnography

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Abstract

Over 90% of Canadians age 65 and over live at home or in community assisted living settings. Of this, 33% have two or more chronic conditions, and one in six of this group receive home care services. Home care case managers (HCCMs) strive to provide integrated care within the institutional arrangements of broader health care systems and local home care programs. This context can create challenges for HCCMs to meet the complex needs of older adults with multiple chronic conditions (MCCs). Institutional ethnography (IE) was used to explore and uncover how HCCMs provide, or not provide, integrated care to older adults with MCCs in the home care program of an eastern Canadian province. Data were collected in five rural and urban home care offices with HCCMs and home care leaders using interviews, observations, and documents. Data analysis demonstrated that the home care program, and subsequently HCCMs' work, was seemingly guided by the philosophy and approaches of integrated care. However, we uncovered that health system ruling relations and discourses of management, cost containment, efficiency, and business process management approaches were organizing HCCMs' work in ways that were contradictory to the goals of integrated care. How these processes and texts operated together revealed a complex picture of how HCCMs' care of older adults with MCCs was organized to happen as it did. The institutional health system and home care processes and texts that were intended to increase safety, quality, and consistency of integrated care delivery, paradoxically organized HCCMs' work in ways that were disruptive to their provision of integrated care. This social organization has implications for HCCMs' work and the discipline of nursing, including the subordination and marginalization of nursing knowledge and experience by dominant institutional health system and home care discourses.

Introduction

Home care case managers (HCCMs) strive to provide holistic, client-centred care for older adults with multiple chronic conditions (MCCs). HCCMs coordinate care though anticipating, planning, and responding to the complex and unstable biological, psychological, and social needs of this population (Canadian Home Care Association [CHCA], 2006, 2009, 2012). HCCMs often face challenges while trying to provide contextualized case management within the rigid institutional management processes of health care systems and home care programs. These processes may also paradoxically create barriers to achieving holistic and client-centred care, creating points of tension for HCCMs that can be entered into and examined empirically.

We pursued a line of critical inquiry that started and remained with HCCMs' experiences to illustrate how their tensions were experienced and happened as they did in practice. Using institutional ethnography (IE) (Smith, 2005, 2006), we examined these organizing influences to understand how integrated care is officially known and purported to be delivered through our study on how HCCMs actually provided integrated care for older adults with MCCs. This paper describes how, through existing discourse and conceptual frameworks, integrated care is officially known and managed in a home care program in an eastern Canadian province. This official framing of integrated care is explored alongside HCCMs' everyday knowledge and experiences of providing care. In the home care context, knowing integrated care officially versus actually reveals an important, but taken for granted, picture of the complex and concerning ways that care for older adults with MCCs is currently being managed.

Background

Older Adults with Multiple Chronic Conditions

In Canada, the rising aging population has raised concerns that health care resources will be unable to meet growing needs. Yet, the increasing number of older adults itself will not threaten Canada's health care system (Canadian Institute for Health Care Information [CIHI], 2011; Statistics Canada, 2015). Cost increases are driven by changes in the quantity and types of healthcare received by Canadians of all ages, not by demographic changes (Chappell & Hollander, 2011; CIHI, 2011; Evidence Network, 2014). However, the aging population highlights how Canada's health care system, with its emphasis on acute care, is not designed to best meet the population's need for chronic care, specifically care required to address multiple chronic conditions (Evidence Network, 2014).

Multiple chronic conditions (MCCs) is a term for two or more chronic diseases (McMaster Health Form, 2013). Depending on complexity, MCCs may lead to higher rates of health care resource utilization and higher risks for adverse health outcomes (Markel-Reid et al., 2011) for all age groups. Of all sub populations who experience MCCs, older adults with MCCs account for 30%–40% of health care use among seniors in Canada, with the intensity of use rising as the number of chronic conditions increase (CIHI, 2011; McMaster Health Forum, 2013; Statistics Canada, 2015). Within the health system, many chronic illness management programs are developed around one specific disease, such as diabetes or COPD, and often not a client-centred approach to care (van der Vlegel-Brouwer, 2013). A strategy showing promise of addressing the needs of older adults with MCCs includes access to home care programs that use "integrated care approaches" provided by HCCMs (Broemeling, Watson & Prebtani, 2008; CIHI, 2011; Heckman, 2011).

Knowing Integrated Care Through Home Care Case Management Practice

HCCMs' work is organized around client needs and uses an approach that considers the collaborative input of clients, family caregivers, and interdisciplinary team members (Fraser & Strang, 2004; National Case Management Network [NCMN], 2009). HCCMs strive to meet "continuity of care" standards within clients' ability to "self-manage" and family caregivers' abilities to support the self-management (Chouinard et al., 2013; Jacelon, 2013). HCCMs' practice is guided by these principles, together with professional and case management standards (Community Health Nurses of Canada, 2011; NCMN, 2009, 2012). HCCMs identify and determine eligibility for clients to receive case management services, assess, plan, implement, evaluate, and assist with the transition of clients and their family caregivers between health care settings (NCMN, 2009, 2012).

A health and social care delivery approach that appears to be congruent with HCCMs' standards of practice is known as "integrated care" (Garland Baird & Fraser, 2018b). Integrated care is officially described as a multi-level strategy for improving the coordination and quality of services to meet client needs requiring flexibility on the part of the system, organization, setting, and interdisciplinary professional to remove barriers to client-centred care (CHCA, 2013; Valentijn et al., 2013). The extant literature states that a standard feature of successful integrated care models is facilitated access to case management (Dubuc et al., 2013; Garland Baird & Fraser, 2018b; Johri, Beland, & Bergman, 2003; MacAdam, 2008, 2011). Various reviews propose that specific models of integrated home care can result in improved health outcomes, higher client and HCCM satisfaction levels, as well as cost-effectiveness (Beland et al., 2006; Glasgow et al., 2002; Nutting et al., 2007; Pearson et al., 2005; Piatt et al., 2006). While there is little argument for the appeal of using integrated care to meet complex needs, there are disparities in the definition of precisely what integrated care involves in various settings and circumstances (Armitage, Suter, Oelke, & Adair, 2009; Stokes, Checkland, & Kristensen, 2016).

Knowing Integrated Care Through Business Process Management

Across Canada, definitions of integrated health and home care appear more often than sustainable models or solutions in practice. Home care is an extended health service whose funding and administration are governed by provincial legislation. While there are common elements for home care reflected in the objectives of provincial and territorial service descriptions (i.e., rehabilitation, palliative care), standards, scopes of entitlement, resource allocation, and programmatic decisions are unique to each province or territory (CHCA, 2012; Health Canada, 2015). Variation in home care services offered, as well as administration and delivery, add to the challenges of implementing integrated care approaches. With a rise in the incidence of MCCs (Statistics Canada, 2015), requests for a more responsive health system to address older adults needs (CIHI, 2011), and policy and practice shifts towards community-based approaches to care delivery (Henningsen & McAlister, 2011), there have been calls for health care reform inclusive of a more standardized approach to home care (CHCA, College of Family Physicians of Canada, & Canadian Nurses Association, 2016). To achieve these aims, health care services, including home care programs, have embraced integrated care models (Buttigieg, Dey & Gaudi, 2016) and adopted business process management (BPM) strategies as a means to increase operational consistency and efficiency to drive quality of care in all health sectors (Elzinga et al., 1995; Hammer, 2010; Rankin, 2014).

The management and measurement of system goals are not easily translated to the highly responsive and individualized care HCCMs provide clients in clinical practice (Townsend, Langille & Ripley, 2003). BPM may be well suited to manufacturing and production processes, but its implementation in health care is troubling, particularly considering the level of complexity for providing care to clients with multiple and competing needs in community settings (Jakubec & Campbell, 2003; Townsend, Langille & Ripley, 2003). However, HCCMs are in a unique position to provide comprehensive care, coordinate services, and promote the health and independence of older adults with MCCs (Jacelon, 2013; Markle-Reid, Brown, & Gafni, 2013). The dearth of literature about how HCCMs understand and approach integrated care in their day-to-day practice led us to explore how HCCMs provide integrated care to older adults with MCCs and explicate the tensions they experience in their daily work within the institutional arrangements of a home care program. We sought to understand a) how do HCCMs provide, or not provide, integrated care for older adults with MCCs? b) how is the work of HCCMs organized by home care's institutional processes, texts, documents, and other practices? and c) what other social and institutional relations and discourses influenced the integrated care of older adults?

Research Approach: Institutional Ethnography

We employed the approach of institutional ethnography (IE) to explore HCCMs' experiences of integrated care. IE is used to explicate how peoples' experiences and actions are socially organized (Smith, 2005, 2006). The ontological shift IE researchers are striving for involves a commitment to seeing the world as brought about in people's activities (Mykhalovskiy & Church, 2006), and includes an explicit commitment to rejecting abstract and speculative ways of knowing about these happenings (Bisaillon, 2012; Deveau, 2009). This shift is achieved by focusing on social relations and keeping peoples' actions, such as the work of HCCMs, at the center of everyday happenings (Campbell & Gregor, 2002).

People know and understand the meaning of their everyday experiences but may not be aware of the broader social organization of these experiences (Adams, Carryer, & Wilkinson, 2015; Jakubec & Campbell, 2003). Prior to starting our inquiry, we were aware that HCCMs experienced tensions between knowing actual day-to-day experiences, such as the work of HCCMs' integrated care of older adults with MCCs, and seeing how integrated care was written, talked about, or organized in official yet contradictory ways. These tensions pointed to important areas requiring exploration. Standpoint is a central tenet in IE. Standpoint refers to the perspective a researcher adopts and maintains throughout their inquiry to challenge the social organization of knowledge of the institutional arrangements under examination (Campbell & Gregor, 2002; Smith, 2005; 2006). Because we aimed to explore the social organization of HCCMs' work (Smith, 2005; Bisaillon & Rankin, 2013), we started our inquiry from the standpoint of HCCMs' points of tension in their practice. By maintaining HCCMs' standpoint throughout our inquiry, we could investigate, analyze and examine taken-for-granted features of their work and practice.

Our central analytic project was to develop a critical explication, a mapping, of how HCCMs experience tensions and contradictions in their work with older adults with MCCs. We identified their everyday experiences, and why these were often eclipsed by dominant, authoritative ways of knowing integrated care (Smith, 2005, 2006). With this kind of mapping, we were able to explicate how HCCMs' work was organized by institutional health and home care arrangements, known in IE terms as *ruling relations* (Campbell & Manicom, 1995; Ng et al., 2013; Smith, 1987; Tummons, 2018). Ruling relations are the socially organized and troublesome exercises of power that shape peoples' actions and lives. Ruling relations are often experienced through abstracted or technical discourses that may bear little resemblance or connection to the everyday experiences of people (Campbell & Gregor, 2002; Prodinger & Turner, 2013). This social organization of power is often achieved by texts that may be written, oral, or visual, such as care management processes or electronic medical record systems.

In IE, texts are not analyzed as a specimen or example, but as a concrete means of access into the relations and sequences of actions they coordinate (Smith, 1987, 2006). Our inquiry located the social organization, ruling relations, and sequences of work embedded in texts that organized HCCMs' work. It is through texts that HCCMs are connected to others in settings outside of the context of their daily work. In this way, texts link HCCMs' local work into trans-local social relations (Bisaillon, 2012; Smith & Turner, 2014). For example, when a client signs a consent for treatment form, this document is simultaneously being used by the HCCM to explain and receive clients' consent for receiving services and potentially invasive procedures, as well as their consent for the sharing of medical and personal information with health care professionals in other settings. In this way, the client and HCCMs' immediate interaction with this form are also connected to the home care program's standardized admission processes and policies, which are in turn connected to health legislation that governs and enforces client consent to treatment, and privacy and confidentiality regulations.

In keeping with the purpose of IE, we intended to map these complex and highly organized social relations. This mapping enabled us to identify how HCCMs' work was organized to provide integrated care within a bureaucratic setting and to uncover the implications for HCCMs' work and experiences in the care of older adults with MCCs.

Research Design

Setting, Recruitment, and Sample

We obtained ethical approval for our inquiry from the university ethics review board (see Appendix 4-A) and the governing provincial health authority (see Appendix 4-B). Our study setting included five urban and rural home care offices. Regional managers and team leaders distributed study information through email, and recruitment posters on staff bulletin boards. With no prescribed number of participants for IE research, we used purposive sampling, with emphasis on experience, diversity, and locations of participants (Bisaillon & Rankin, 2013; DeVault, 2006; Smith, 2006).

There was a total of nine participants in our study. All participants were female, Caucasian and middle aged. Six participants were HCCMs and represented 50% of provincial HCCMs, with representation from all five home care offices. HCCMs included five registered nurses and one social worker. Their range of clinical and case management experience in the care of older adults with MCCs varied, with the majority of participants having more experience in their disciplinary roles than in their current case manager role. Two participants worked as general care coordinators, two were palliative care coordinators, and two long-term care co-ordinator. Three participants were home care leaders in administrative roles with a range of leadership experience. These included two registered nurses and one registered dietician. The first author completed the field work and data analysis. All other authors contributed to the project in a variety of ways.

Data Collection

Data collection and analysis were interdependent and iterative. Nine participant interviews and seven site observations were completed, and nine texts were reviewed between July 2017 and January 2018. Open-ended interviews lasted between 60 minutes and two hours using an interview guide developed *a priori* to prompt HCCM participants' first-hand knowledge and experience about their work processes (see Appendix 4-C). Home care leader participants were interviewed to assist with locating and tracing links to the home care program's institutional texts and processes. Interviews, observations, and site visits occurred concurrently and took place all home care offices. Site observations lasted between two and seven hours. Observational data were generated through field notes and analytic memos, developed while shadowing and observing HCCMs in their daily work and attending client case conferences and interdisciplinary rounds. Participants identified texts during interviews and site observations. We referred to participants as HCCMs or home care leaders. Pseudonyms were assigned to all participants to protect their identities.

Analysis

HCCMs' work processes were followed verbally (interviews) and visually (observations) to understand what work was done when and by whom in the care of older adults with MCCs. HCCMs' participant data was analyzed to seek evidence of the home care program's institutional processes and dominant discourses, and to identify potential home care leader participants. The IE analytic approach of the "act-text-act sequence" (Smith, 2006) was used to explore and map how HCCMs' local work was tied to sequences of work processes directed by institutional texts. These texts, in turn, were organized by dominant extra-local ruling relations of health care (Bisaillon & Rankin, 2013; Campbell & Gregor, 2002; Smith, 2005, 2006). Through this analysis, we were able to locate and explore texts as forms of power embedded in HCCMs' work processes that were simultaneously organizing and mediating HCCMs' work (Smith, 2006; Turner, 2006).

Credibility and integrity of the study were maintained through responsiveness, methodological coherence, purposive sampling, and an active analytic stance (Morse et al., 2002). Analytic accounts from the data were used to identify HCCMs' anecdotal evidence of their work processes and examples of texts. These were used to establish the validity of participants' input. We drew from participants' direct quotes to capture their experiences in their own words (Hughes, 2014). The use of first-hand accounts provided a way to contextualize HCCMs' experiences within the broader sociopolitical arrangements in which institutional health and home care programs operate (DeVault & McCoy, 2006; Hughes, 2014).

Analytic strategies included reading and rereading interview transcripts, field notes, and analytic memos, and writing and rewriting analytic accounts to stay true to the HCCMs' everyday work. Specific activities included writing in the margins, making observations, posing questions, and identifying examples of HCCMs' work processes, texts, and social organization of the home care program (Campbell & Gregor, 2002; Rankin, 2017). Large flip chart paper was used to map, organize, and follow up on crucial pieces of collected data that showed conceptual linkages among HCCMs' quotes, descriptions of work processes, texts, social organization, and institutional arrangements within home care and the broader health care system (Bisaillon & Rankin, 2013; Rankin, 2017).

Findings

Our overall findings demonstrated that within the provincial home care program, HCCMs' work was seemingly guided by the philosophy and approaches of integrated care. However, we uncovered that through the home care program's use of business process management, the dominant institutional health system and home care discourses of management, cost containment, and efficiency, were organizing HCCMs' work in ways that were contradictory to the goals of integrated care. HCCMs' day-to-day work was influenced by documentation processes and texts that informed their case management work, including interactions with clients, family caregivers, and interdisciplinary team members. HCCMs exposed challenges and barriers when using mandated communication strategies with interdisciplinary team members external to the home care program. They also described adapting written and unwritten institutional home care processes to safely and effectively meet clients' needs.

Our findings led us to home care leaders' knowledge and perspectives of the home care program's official processes within which HCCMs' work was organized, in particular – the

Business Process and the Integration Model, which were based on the principles of BPM. Home care leaders identified challenges for HCCMs' practice within these prescribed processes of managed integrated care. The illustrations of HCCMs' local, everyday integrated care work, and our examination of key texts showed and traced the dominant discourses that drove the organization of HCCMs' work to extra-local ruling relations.

HCCMs' Everyday Integrated Care Work

Documenting case management work. HCCMs followed their disciplinary standards of practice and home care's policies and guidelines in their documentation work. HCCMs used a variety of texts in their work such as electronic medical record systems, home charts, collaborative care rounds binders, intake assessments, client consent forms, functional and cognitive assessments. This work included recording descriptions of client and family caregiver observations and interactions during admission and discharge processes, care plan development, and home visits for assessments and evaluations. Colleen explained, "*It is my responsibility to document everything I do related to my clients' care plan to show what I've done to maintain continuity of care."*

Much of the required documentation work focused on writing up activities completed while communicating, coordinating, and making decisions about clients' care with interdisciplinary team members, both internal and external to home care. HCCMs most frequently documented using an electronic medical record system called Integrated Systems Management program (ISM). ISM was a provincial electronic medical record system used in community health and social settings. However, ISM was limited in its use, as HCCMs and interdisciplinary team members could not access client documentation from other community-based programs (i.e., income support, housing). Debbie identified that ISM did not interface with electronic documentation systems in pharmacies, primary, long-term, or acute care settings. She explained, "*It's like managing bombs when caring for clients with many needs. The unpredictability of the clients' needs can be overwhelming. Plus, I don't always know who else is involved in my clients' care*."

Since ISM did not interface with other settings, HCCMs were often unaware when their clients received care in other settings, such as primary care or income support services. Rosanne described, *"Sometimes there's a duplication of services that creates confusion for clients. They don't know whose advice they should follow."* As well as creating challenges for HCCMs' continuity of care, Rosanne felt ISM also impacted family caregivers' care experiences. She explained,

> *When client information isn't shared, the client and family can feel assessed 'to death'. I remember admitting a complex client to home care and the client's daughter became very frustrated. She said they had already answered the questions I was asking and didn't we [interdisciplinary team members] talk to one another?*

ISM was implemented provincially to facilitate and integrate interdisciplinary team members' access to client information and support collaborative care planning. However, ISM did not appear to facilitate integrated care. Instead, it created challenges for HCCMs such as disrupting continuity of client care and contributing to client and family caregiver burden. HCCMs described their documentation work as time-consuming, frustrating and the least satisfying part of their role. Lana shared, "*I can't keep up with my charting. It takes a long time to chart my visits and discussions with clients and colleagues; it's overwhelming."*

HCCMs estimated they spent anywhere from 20%-40% of their workday documenting their activities. The variety and multiple locations for required documentation added to the time and complexity of HCCMs' work. Colleen said, "*Often, I end up writing that I did the same thing in three different places, on ISM and again on paper documents."* As a result, HCCMs expressed that the amount and duplication of their documentation work interfered with and reduced the time they could be visiting clients at home, communicating with family caregivers about identified client concerns, and collaborating with interdisciplinary team members.

Communicating with interdisciplinary members external to home care. HCCMs described the critical role of communication in their work. They communicated daily, sometimes multiple times, with clients, family members, and interdisciplinary team members. Much of their communication with clients and family caregivers was oral or in person during home visits or by telephone. Less frequently communication was in writing using email or notes left in homes. HCCMs said they communicated orally and in writing with interdisciplinary team members within home care by using ISM to send and receive work items, and by email, and in person during client care coordination rounds, in office cubicles, hallways or the breakroom.

HCCMs reported that a vast majority of their written and oral communication efforts occurred with interdisciplinary team members external to home care. Due to the limitations of ISM, communication happened through phone calls, emails, faxes and in person during client care coordination rounds. Similar to documentation processes, HCCMs described their communication efforts with interdisciplinary team members external to home care as time-consuming and challenging. Roberta emphasized,

> *I feel like there is an assumed responsibility that we have to be the ones to reach out to share or ask for clients' information with health professionals that don't work in home care. This happens a lot when working with primary and acute* care.

To facilitate this communication, HCCMs used a standardized communication form called an SBAR (Situation, Background, Assessment, Recommendation). HCCMs used

SBARs to share client information outside of the home care program, mainly with physicians. Pauline expressed her frustrations,

> *This is one of my pet peeves. In home care, we share information. Before my client's appointment with their physician, I fax an SBAR with a client status update and my concerns. Most times, I won't receive any client information back from the physician about treatment or medication changes.*

HCCMs described the time and effort necessary to communicate effectively with physicians to provide necessary health status updates, or when requesting potential medical interventions, such as medication changes for their mutual clients. For example, Rosanne stated,

> *Due to Freedom of Information Privacy Protection (FOIPP) legislation, SBARs can't be emailed, but we can fax them. Doctors still prefer receiving info by fax. It's not efficient. I have to fill out an SBAR form, print it off ISM, and fax it. It adds more steps.*

Physicians' communication preferences, health information privacy legislation, and home care's communication processes were designed to safeguard and protect clients' medical information. However, these worked in concert to organize HCCMs' communication work in ways that were not advantageous for their delivery of integrated care.

When HCCMs first arrived at their office in the morning, their usual practice was to open their work email to check if they had received a "business process" email. This email was generated every morning at six o'clock, acting as an electronic notification for HCCMs. The email attached a list of clients admitted to acute or palliative care in the last 24 hours. Most HCCMs could not describe how these emails were generated, were unaware of how clients' acute care admission information was gathered or shared and could not name the data systems that generated these emails. Debbie asserted,

> *All I know is that when I check my email in the morning, and one of my clients has been admitted [to acute care], I have 48 hours to fill out the transfer document and send it to acute care staff to let them know what the client's care plan is.*

HCCMs expressed frustration when sending a transfer form to acute care. They often did not feel confident that the transfer form achieved the intended results of assisting continuity of care and discharge planning. Andrea declared,

> *I'm not sure that acute care staff even look at the information I send them. But, when I am notified that one of my home care clients is admitted, I follow the rules and send the transfer form and just hope that my client won't be discharged without me knowing.*

HCCMs told us that the efforts they exerted when trying to communicate with interdisciplinary team members external to home care created challenges to maintain continuity of care for clients, both at home and when admitted to acute care. These findings demonstrated that despite formal forms and processes designed to facilitate communication between sectors, barriers remain. Similar to their documentation work, HCCMs said their communication work interfered with and reduced the amount of time they had to visit clients at home, communicate with family caregivers about identified client concerns, and coordinate care.

Creating "work-arounds" to provide actual integrated care. The home care program's mandate was to provide integrated, supportive services to clients and their family caregivers, not primary or emergency care services. However, HCCMs often found that within the home care program, they did not have formal processes or channels to access the resources to adequately respond to vulnerable clients', or family caregivers', financial, environmental, physical, or cognitive needs. Instead, HCCMs used other channels to work-around the confronting barriers to integrated care.

Pauline recounted a story of assisting a client to access medical supplies for an ileostomy (a surgically positioned opening in the abdomen to divert a part of the small intestine). She said,

> *It's not right. I'm explaining to my client that she had to apply for income support and go through an intrusive income assessment process before I can help her access supplies that she needs but can't afford. As her HCCM, I felt awful telling her that.*

The majority of home care clients were over 75 years old with low income and limited access to private health insurance. The home care program provided medical supplies to clients for two weeks post-acute care discharge, but in this case, Pauline's client had her ileostomy for a year. To advocate for funding for the ileostomy supplies, she had to refer her client to income support services to have her income assessed. Pauline explained,

> *The income support referral and assessment take a few weeks to arrange. In the meantime, what is the poor woman going to use? Thankfully, we have a collection of ostomy supply samples in our office from equipment reps and client donations that she could use. The samples are all mismatched, but you get really good at being creative to make it work for the client.*

Pauline knew from experience that if her client's level of income were assessed as too high, she wouldn't qualify for income support. If her client did qualify, it would be several weeks before she received her funding. Her client had to officially be refused funding by income support services before the home care program could assist with her supplies. To mitigate these challenges and ensure clients could access vital medical supplies, Pauline and other HCCMs informally collected and stored ostomy supplies at the home care office.

Andrea spoke about providing client-centred, holistic care in non-traditional ways to support her palliative clients' wishes to receive end-of-life care at home. She recalled a client whose roof had a leak in their bathroom*, "She was so upset by this leak, she was really sick and wanted to stay home as long as possible. I had to do something—the family had nothing, no money to fix the roof.*" Although beyond the scope of providing home care, Andrea recounted that she returned to the home care office and sought community donations for supplies to fix the client's roof, "*Before noon, we had gathered supplies. A family member fixed the roof, and she was able to remain at home for her palliative care. She was so grateful."*

Pauline and Andrea's examples demonstrated the gap that existed in the services and resources they needed to access to support their client's financial and housing needs. This highlighted that home care was not integrated with other community-based health and social programs, as Pauline and Andrea were not able to address their clients' needs in a holistic and client-centred manner. A truly integrated home care program would include greater support and mechanisms for HCCMs to access resources across health and social sectors.

Long-term care placement is coordinated through the home care program. Lana spoke of an incident that occurred when the spouse of a complex client with dementia being cared for at home called because the client's behaviour had become violent. Lana shared, *"I called his family physician, and he just said, 'go to the hospital'. But that wasn't an option. Anybody involved in dementia care knows that acute care is last place these people need to be."*

Lana explained that because the client was on long-term care placement list, he had been put into what she called a "client grouping" that made him ineligible for the services of home care's Frail Seniors program. Lana was frustrated with this barrier to appropriate geriatric care, "*Often primary care physicians don't have the time to talk to me about clients,* *and sometimes I find that they are not as aware of what medications they should be prescribing or deprescribing for geriatric syndromes like dementia."*

At this point, Lana decided to call a geriatrician (a medical specialist in older adults' health) she had collaborated with in client rounds. The geriatrician had previously assessed this client and agreed to call the primary care physician to recommend appropriate medication to treat the client's acute dementia symptoms. Lana emphasized, "*As a HCCM, you're never sure if you can reach out to a specialist, but I knew I had to do something to help this client and his wife."*

This collaboration with the geriatrician was outside of Lana's usual practice. It spoke not only of her inability to access resources like those offered by home care's Frail Seniors program but indicated there were both institutional and unwritten rules about whom HCCMs could collaborate with directly in their day-to-day work. Institutional health care arrangements that organized how home care programs, and subsequently HCCMs, could access specialist physician knowledge restricted Lana's access to the geriatrician.

These barriers explicitly show how HCCMs' work is organized. Lana's direct collaboration with the geriatrician at the moment that her client needed immediate support was a necessary work-around. Her improvisation, in this case, was instrumental for her to provide the client-centred and integrated care. These unintentional, but inappropriate barriers prevented HCCMs from accessing appropriate services and resources to care for older adults with MCCs. HCCMs expressed that when they were unable to meet their client's needs, they had to create work-arounds to provide holistic, integrated care.

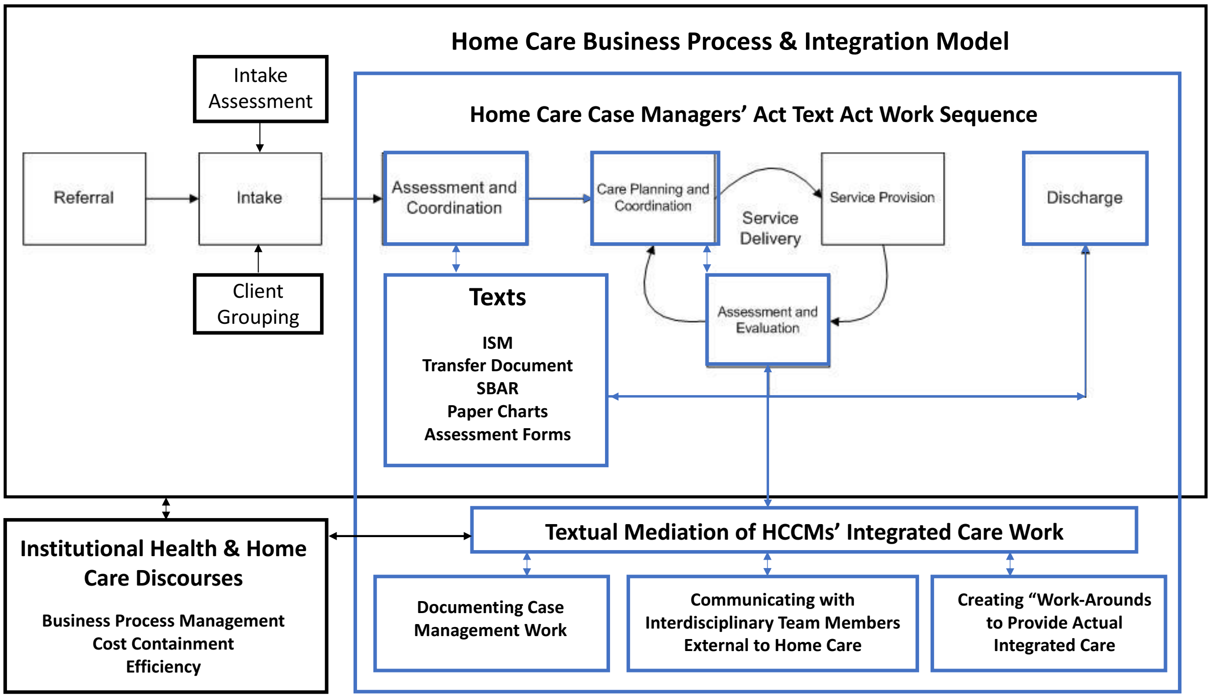
Textually Mediated Integrated Care Work

HCCMs' challenges of documenting and communicating and their attempts at creating work-arounds led us to two central organizing texts: The Business Process, and the Integration

Model. Using Smith’s (2006) “act-text-act sequence” approach, we analyzed and traced how HCCMs’ work was linked into and then mediated by the Business Process and the Integration Models’ work processes and explicated the impact this had on HCCMs’ provision of integrated care.

Figure 4-1 illustrates the steps of the Business Process and the Integration Model (referral, intake, assessment and coordination, care planning and coordination, assessment and evaluation, service provision, and discharge), and depicts the act-text-act work sequence whereby HCCMs’ work can be mapped to demonstrate how they are being textually mediated and organized by the local Business Process and the Integration Model’s processes, as well as the extra-local institutional health and home care discourses. This organization of HCCMs’ work was found to result in the activities of documenting case management work, communicating with interdisciplinary team members external to home care, and creating “work-arounds” to provide actual integrated care.

Figure 4-1. Home Care Case Managers' Act Text Act Work Sequence



The business process and the integration model. Home care leaders described that the Business Process and the Integration Model's development and implementation occurred following a province-wide health system evaluation in 2009. Within the home care program, both the Business Process and the Integration Model were intended to drive operational consistency and efficiency through a single administrative client intake process.

The Business Process included five steps 1) referral, 2) intake, 3) assessment and coordination, 4) service delivery, and 5) discharge. An 80-page implementation manual supported the Business Process with detailed guidelines and diagrams for each of the steps, as well as descriptions of roles of HCCMs and interdisciplinary team members. The process was intended to streamline the intake through discharge processes for clients and directed HCCM roles and responsibilities in caring for older adults with MCCs.

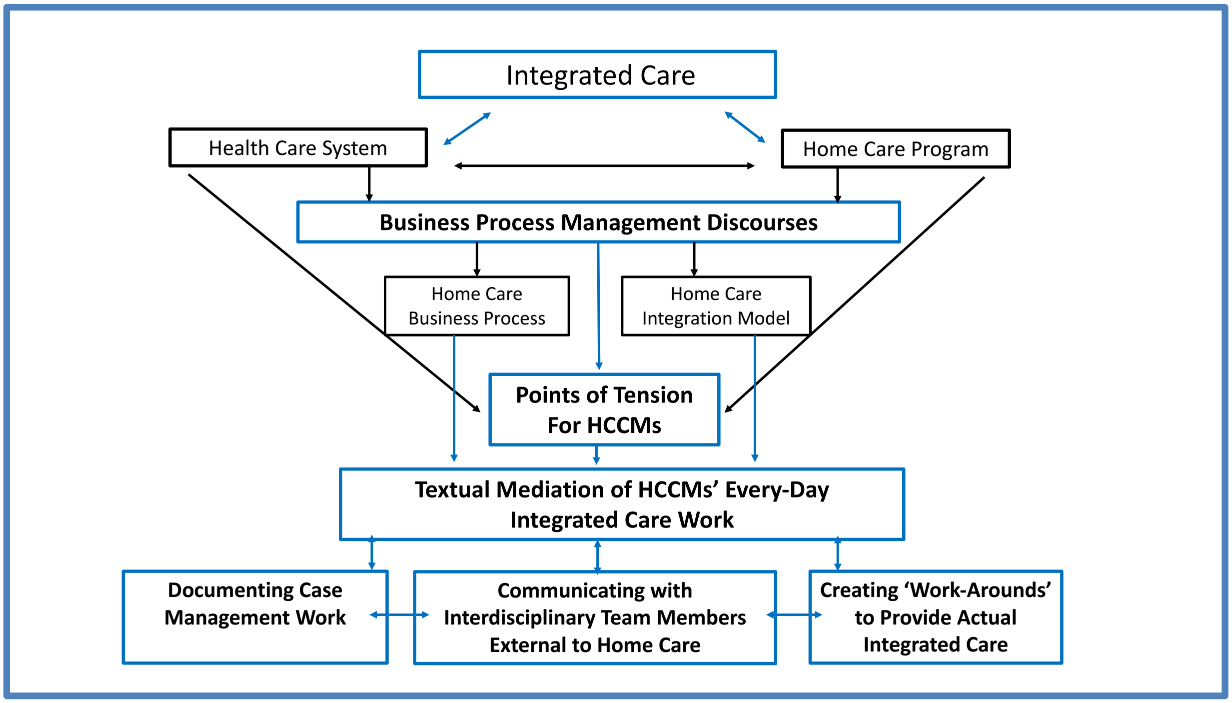
The purpose of the Integration Model was to support HCCMs' work at the client level. It was also intended to create partnerships with system level health and social care services to achieve integration provincially. It included a 25-page conceptual framework that outlined principles of integrated care and case management. It was designed to be consistent with the steps contained within the Business Process that directed HCCMs' work of assessment and coordination, care planning and coordination, assessment and evaluation, and discharge.

Both the Business Process and the Integration Model specified the categorization of clients into “client groupings", adapted from the Canadian Institute for Health Information Home Care Reporting System (CIHI, 2018), and were assumed to support operational consistency. During intake, the intake coordinator completed a client assessment by telephone. Then using the client grouping guidelines, the client was assigned to an acute, rehabilitation, palliative, long-term maintenance, long-term supportive, or frail senior category. Applying the client grouping and assessed level of case management need, the intake coordinator assigned the client to the most appropriate HCCM's caseload. The HCCM then arranged a home visit to complete the client's admission and comprehensive assessment.

Troubling texts in use for HCCMs. The implementation manuals and frameworks for both the Business Process and the Integration Model incorporated many fundamental integrated care principles and approaches, such as client-centered care, coordination, partnership, and accountability. Despite this, we found incongruencies between how HCCMs knew and experienced the actual, complex day-to-day work of providing integrated care to older adults with MCCs and the official, sequential flow of the Business Process and the Integration Model intended to organize their work. Consequently, HCCMs' work was linked into official textual processes which they adapted to their actual practice to fit within the organizational boundaries defined by the Business Process and the Integration Model.

Figure 4-2 maps the social organization of HCCMs' integrated care. This illustration shows how integrated care discourses (as represented in the research literature) and business process management (BPM) discourses have been adopted by the broader health care system and home care programs and are managed through the Business Process and the Integration Model texts. This deference to official ways of knowing integrated care, versus HCCMs' actual ways of knowing integrated care creates points of tension. HCCMs work can be mapped and shown as textually mediated and organized into specific activities that create challenges for HCCMs to provide integrated care.

Figure 4-2. Social Organization of HCCMs' Integrated Care



The Business Process included the texts and associated guidelines that HCCMs had described in their work accounts. These included but were not limited to ISM, transfer documents, and SBAR forms. ISM, in particular, was integral to HCCMs' implementation of the Business Process. HCCMs used it to send information to the next interdisciplinary team member completing a step in the Business Process. Jo-Ellen affirmed, *"HCCMs are expected* *to check for work items at least twice a day*." As evidenced from HCCMs' accounts, the transfer document and SBAR forms had become taken-for-granted requirements of HCCMs' communication work. Extra-local texts also organized HCCMs' local work. Emily, a home care leader, explained how processes changed before and after accreditation, *"After our last accreditation, the transfer and SBAR documents were added to the Business Process."*

Emily was referring to Accreditation Canada's (2015) required operational processes of safety and efficiency of client transfers between care settings. In addition, challenges associated with client groupings conflicted with the intent of the Business Process and the Integration Model to support client-centered care, particularly when clients in the same household were assigned one HCCM to reduce resource duplication. Emily described,

> *Looking from the outside, it seems like a client-centred approach. But it's created problems for HCCMs when clients belong to different client groupings, like "long-term maintenance" and "palliative". HCCMs caring for palliative clients need time to visit, assess, and coordinate their care. The HCCM struggles to provide either client the coordination they need.*

While client groupings may be useful when determining and managing home care's resource needs, inadvertently, they created inequities in services and resources available to particular HCCMs and clients. This inequity was evident from Lana's story of her client waiting for long-term care placement. Her client's specific client grouping was outside of the Frail Seniors program, where HCCMs had direct access to an interdisciplinary team with specialized geriatric knowledge. As per the Business Process, a client waiting for long-term care placement, or under 75 years, and grouped as "long-term supportive", was not eligible for that support even though they had similar needs and would benefit from this specialized geriatric care program. Despite increasingly complex home care clients, the Business Process and the Integration Model’s client grouping process unintentionally set up barriers that HCCMs had to overcome to provide what they perceived as an integrated and equitable approach to care.

We also learned that the provincial health authority had not implemented the system level components of the Integration Model. Many of the Integration Model’s underlying principles and outcomes were designed to support the Business Process to facilitate case management and integrated care activities across external health settings (i.e., acute care, primary care and other community-based services). Without the system implementation of integrated care, HCCMs' case management efforts were disconnected from interdisciplinary team members in other community health and social settings.

In addition to the Integration Model’s goals of system integration not being achieved, Nicole, a home care leader, told us, “*The education component of the Integration Model was not implemented. HCCMs and interdisciplinary team members didn’t learn the fundamental roles of case management in home care and across other settings.”* Home care leaders believed this led to HCCMs’ lack of clarity around role responsibilities and how they could best adapt their work to meet the needs of complex home care clients. The home care program expected HCCMs to practice according to a “case management” and “integrated care” model. However, HCCMs did not receive the education for the processes or tools they required. Instead, they learned this role through experience in their daily work. Home care leaders perceived that insufficient funding, and perhaps health authority senior administrators’ lack of understanding of the level of education, knowledge and skills level required for HCCMs’ work had been barriers to HCCMs’ professional development opportunities.

Business process management and the ruling relations of integrated care. Through our critical examination of the origins of the Business Process and the Integration Model, we were led to the 2009 provincial health systems' evaluation report. Final recommendations suggested an extensive restructuring and integration of all health services, including home care, through the implementation of operational system improvements using BPM. Jo-Ellen, a home care leader, said, "*A national consulting agency that specialized in conducting large-scale evaluations of health authorities said our health system needed to increase efficiency and reduce costs."* This evaluation led to the development of the Business Process and the Integration Model, that ultimately reflected the broader health system discourses of system management, cost containment, and efficiency.

HCCMs did not specifically identify the Business Process and the Integration Model as organizing their work or experiences. However, the activation of these texts by HCCMs through their day-to-day work was essential for the implementation of the sequential processes and texts that organized their work when providing integrated care. Although the processes of the Business Process and the Integration Model appeared linear, sequential, and even simplistic, the HCCMs' work was non-linear, non-sequential, and complicated. These true features of HCCMs' integrated care work and experiences were impossible to account for in both the Business Process and the Integration Model.

The principles of business process management, cost containment, and efficiency did not allow for an adequate description or clear picture of how HCCMs *could* practice in an integrated way within the context of the home care program. Instead, the work processes of both the Business Process and the Integration Model unintentionally organized HCCMs' work in ways that were a departure from their knowledge and experience of providing integrated care. In reality, these texts, influenced by dominant health care management discourses, created barriers for HCCMs to provide holistic and comprehensive care to older adults with MCCs. Through the critical approach of IE, we saw the reality of HCCMs' everyday work.

Discussion

The consequences of the adoption of BPM by the health system and, more specifically, home care programs for the management and delivery of integrated care, presents a compelling issue requiring further exploration. BPM approaches have demonstrated an ability to increase efficiencies and productivity in production and manufacturing (Ferreira et al., 2018; Hammer, 2010). However, it is argued that this approach may be inadequate to manage and organize the implementation of integrated care within the complex processes of health care systems. It fails to capture the sophisticated knowledge, experience and highly relational work of HCCMs, many of whom are nurses (Jakubec & Campbell, 2003; Townsend, Langille & Ripley, 2003).

HCCMs call upon their disciplinary nursing knowledge, as well as case management standards of practice and competencies to guide their work. In our inquiry, five of the six HCCM participants were registered nurses. These nurses' day-to-day knowledge and experiences of providing care for clients were not included or taken into account in the home care program's highly managed and disembodied sequential work processes. The power that plays out between texts is known as an inter-textual hierarchy where certain texts have more organizational power over what occurs in a setting than others (Smith, 2005). The Business Process and the Integration Model, reflective of BPM and health care discourses of management, cost containment, and efficiency, were given authority over HCCMs' disciplinary knowledge and personalized case management experience.

Smith emphasizes that specific forms of knowing are the basis for ruling - in management, health care, and professional practice – and textually mediated ruling practices impose ruling perspectives that subordinate local knowing (Jakubec & Campbell, 2003; Smith 2006). Nurses working in clinical settings are often subjected to institutional and administrative processes created from dominant ideologies and knowledge, such as biomedicine and health care management (McGibbon, Peter, & Gallop, 2010). Rankin (2014) also describes the managerial and standardized textual practices currently directing the organization of health care programs as working to subordinate the professional and experiential knowledge and skills of both nurses and their clients' expressed needs and lived experiences.

Bjornsdottir (2014) explained the impact of increasing use of standardized work methods for nurses providing home care. The evidence-based movement has shifted the focus from the knowledge and skills of the nurse to the knowledge found in texts and processes such as clinical guidelines, as well as reliance on standardized assessments, care plans, and tools used for documentation. These textual accounts become authoritative representations of nurses' knowledge and actions, and clients' unique and complex needs (Rankin, 2001; Smith, 2005, 2006). Clients' experiences of living with MCCs in the community are intertwined with multiple factors such as income, housing, and social support, however, these are not consistently represented in health and home care processes and texts (DeVault & Sinding, 2010).

In an era of expanding management tools aimed at monitoring service quality and efficiency (Bjornsdottir, 2014), as well as population data-driven decision making, written accounts generated from standardized texts stand in for the professional knowledge and experience of nurses. These representations fail to adequately represent the complexity of nurses' work (Rankin & Campbell, 2009) and client and family caregivers' experiences of living with MCCs. Through the use of these texts, nurses' knowledge, skills, and work activities are at risk of being unrecognized or acknowledged and as such, remain hidden from view. The concern is the erosion of skilled clinical knowledge (Adams, Carryer, & Wilkinson,

2015) of nurses and others that occur while working through mandated standardized processes, such as the Business Process and the Integration Model.

When nurses' work is organized and directed by standardized systems and management processes, they are often prevented from exercising their professional discretion (Rankin, 2009). They experience tensions and contradictions between what they are administratively required to do and what they know and believe is a client-centered approach to care for their clients in various contexts (McGibbon, Peter, & Gallop, 2010, Rankin, 2014). This has resulted in sick and stressed nurses at best, and worse, nurses leaving the profession (McGibbon, Peter, & Gallop, 2010; Urban, 2014).

Management texts and processes that are introduced into nurses’ work are often purported to lead to improvements in the provision of care for clients (Rankin, 2002). If these proceed without critique or evaluation, then nurses and other health professionals remain unaware that their activation of these texts may have negative consequences for their clients and themselves (Rankin, 2014). Explicating the ruling relations of HCCMs and nurses may increase their awareness of the impacts on client care, and potentially enable HCCMs, many of whom were nurses, to engage more critically with their work within institutional health systems and home care processes.

Conclusion

Starting from the standpoint of HCCMs’ everyday experiences and the points of tension they experience, we mapped how their work was ruled by home care and system-wide texts and procedures reflective of the health care discourses of BPM, cost containment, and efficiency. Wider implications of these findings include the subordination of HCCMs’ and nurses’ professional knowledge and case management experience; as well as a call for critical exploration of the adoption of BPM approaches for the management and delivery of integrated care in health care settings generally.

Employing IE enabled us to uncover how HCCMs work and experiences were linked into and organized by both the home care program's Business Process and the Integration Model. These texts and processes were designed to ensure the delivery of holistic, comprehensive, integrated care. Instead they created contradictory, redundant, and time-consuming activities that distracted and moved HCCMs away from providing actual integrated care for older adults with MCCs. This contributes to the fractured home care experiences so often the focus of professional and public concern. Being aware of how and where this breakdown occurs, drawing on our knowledge of integrated care, and understanding nurses' and HCCMs' expert knowledge and work experiences, are the first steps to positive change in the provision of quality, equitable home care services. The growing number of older adults with MCCs needing home care depends on this critical awareness and action.

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Chapter 5: Paper 4

Standpoint in Institutional Ethnography: A Critical Approach to Nursing Knowledge Development

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Abstract

The pivotal role of “standpoint” as a philosophical tenet of institutional ethnography (IE) is introduced as relevant to qualitative inquiry generally, and specifically for a study of home care case managers’ (HCCMs) integrated care of older adults with multiple chronic conditions (MCCs). Illustrative accounts and examples from this study are presented to demonstrate the value and challenges of using standpoint to enter into, shape, and guide a study of the social organization of integrated care for this population. The congruency of standpoint in IE with the development of nursing knowledge is discussed.

Introduction

The aim of this paper is to discuss the pivotal role of “standpoint” as a philosophical tenet of institutional ethnography (IE) (Bisaillon & Rankin, 2013; Deveau, 2009; Rankin, 2017; Smith, 2005, 2006) for the development and analysis of an inquiry of home care case managers’ (HCCMs) integrated care of older adults with multiple chronic conditions (MCCs) (Garland Baird & Fraser, 2018b). Clients, families, nurses, case managers, health authority administrators and authors of all levels of best practice processes and guidelines, intersect in the social organization of HCCMs’ integrated care for older adults with MCCs. To explore these social relations, HCCMs’ activities were closely examined to uncover sources of complex and externally driven organization of their work in home care.

While the IE approach is used for exploring these organizing practices (Campbell & Gregor, 2002; Smith, 2005), IE’s particular use of standpoint serves as an important entry point for inquiry. In the case of our study, the standpoint of HCCMs provided a base of experience from which to map the social organization of their integrated care for older adults with MCCs. This paper illustrates the background, congruency, and challenges encountered in this focus of standpoint specifically in the case of a study of HCCMs (Garland Baird & Fraser, 2018b), and in the use of IE, more broadly, as a critical approach for the development of nursing knowledge.

Standpoint

Between the 1970s and 1980s, standpoint theory emerged as a critical feminist theory of relations between knowledge production and practices of power. Nancy Hartstock’s epistemological and methodological argument about standpoint theory is that it is women's unique standpoint in society that provides the justification for the truth claims of feminism, while also providing a method with which to analyze reality (Heckman, 1997). Hartstock’s goal was to define the nature of the truth claims that feminists advance and to provide a methodological grounding that would validate those claims (Heckman, 1997). As a method, standpoint theory guides feminist research and is used as a way to value oppressed groups' experiences and empower them. This is achieved by challenging the assumption that political influences on research practice is incongruent with the development of scientific knowledge (Harding, 2004). Harding identifies standpoint in terms of the social positioning of the subject knowledge, the knower and creator of knowledge (Smith, 2005). Within this social position is the categorization of race, class, or gender within society.

Although Smith (2005) recognizes Harding's (2004) definition of standpoint theory, Smith's view of standpoint is that it is a subjective position that anyone can occupy. Standpoint as a key philosophical tenet of IE (Bisaillon & Rankin, 2013; Deveau, 2009; Rankin, 2017; Smith, 2005, 2006), is created by socially organized knowledge and not by sociopolitical or economic categorizations (Smith, 2005; Tummons, 2018). In this way, standpoint is not a neutral or value-free position but is a part of an active and complex larger social organization. Smith (2005) defines the utility of standpoint as providing a point of entry into IE inquiries to explore social relations that does not objectify the knowledge or actions of people.

Institutional Ethnography

Institutional ethnography, similar to other qualitative approaches, begins in people's every day experiences. However, this approach is different from other qualitative approaches in that analysis not only begins in people's everyday experiences but remains in people's material activities. IE was developed by Dorothy Smith as a Marxist feminist sociology for women, for people (Prodinger & Turner 2013; Smith, 2005, 2006). IE is now widely applied to social science, education, policy, and nursing research. As a theoretically informed research strategy (Rankin, 2014), IE is based on the philosophical tenets and assumptions of social organization, social relations, ruling relations (i.e., organizational and institutional influences), dominant texts, standpoint, and points of tension (Campbell & Gregor, 2002; Smith, 2005). IE is used for mapping the social relations that organize people's daily work and activities (DeVault & Sinding, 2010).

The social ontology of IE describes social organization as the underlying fundamental principle that unites people’s activities (Campbell & Gregor, 2002; Smith, 2005, 2006). In this inquiry, the social organization arises in HCCMs’ activities and through the complex institutional arrangements, or ruling relations, of their work when providing integrated care to older adults with MCCs. In this context, HCCMs’ work is seen as organized by the ruling relations of health and home care’s institutional processes and texts. HCCMs’ decisions and actions about client care are organized both within and outside home care, often without their conscious awareness. It is this interplay that constitutes social organization (Campbell & Gregor, 2002; Smith, 2005).

Standpoint in the Examination of Integrated Care in Home Care Case Management

Standpoint was an important aspect of the design, implementation, and analysis of my IE inquiry of HCCMs’ integrated care of older adults with MCCs. Standpoint assisted the exploration of actual HCCMs’ experiences to uncover how their work was being organized by institutional health and home care programs and to understand the impact this was having on HCCMs’ integrated care of older adults with MCCs. Health and home care organizational processes and texts were examined as a form of power to address how these externally organized texts organized HCCMs’ work and activities (Griffith & Smith, 2014; Smith, 2005, 2006). My goal was to make these ruling relations visible by exploring the health and home care institutional processes and associated texts that coordinated HCCMs' integrated care of older adults with MCCs.

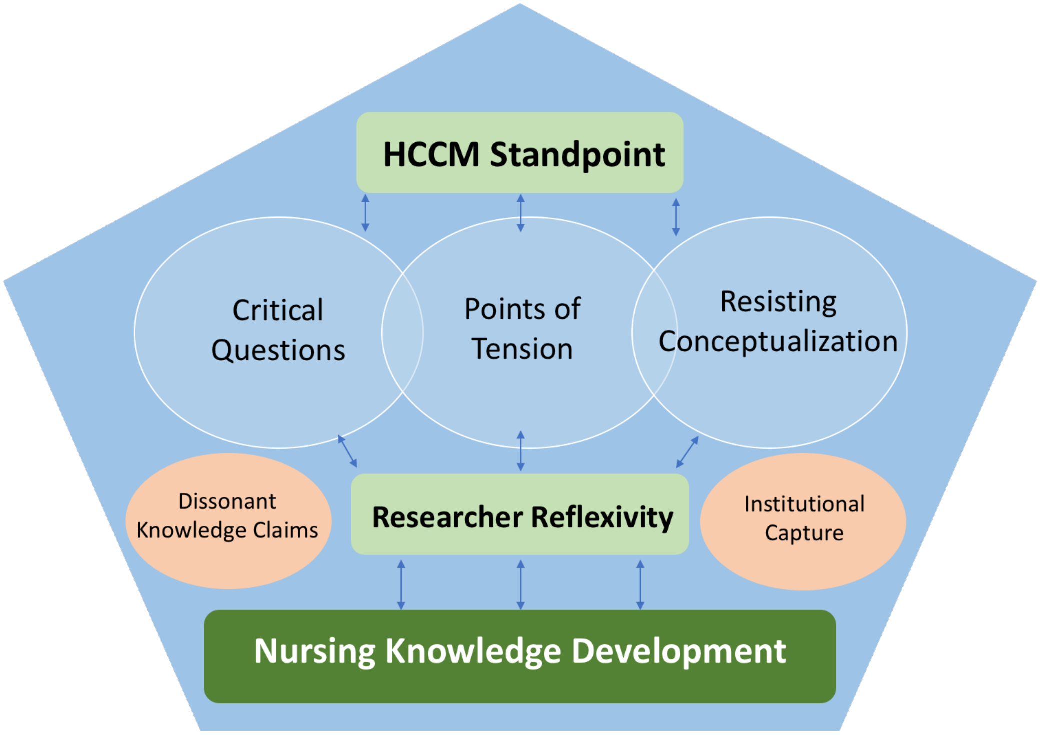
My experiences as a home care nurse, nurse educator, and nurse researcher moved me to adopt the HCCM standpoint as the entry into my inquiry (Bisaillon & Rankin, 2013). HCCM participants included five registered nurses and one social worker whose roles included care coordinator, palliative care coordinator, or long-term care coordinator with extensive experience caring for older adults with MCCs in home care settings. As a registered nurse, former home care nurse, nurse educator, and now home care nurse researcher, I was able to reflect on my experiences in relation to the HCCMs in this study. Although not a requirement to conduct IE research, a researcher's experience can be used to highlight and examine the points of tension, or where problems exist, experienced from a participant's specific standpoint. I have held HCCM roles and possess an in-depth knowledge of home care and broader health system organizations and processes. My experiential and theoretical ways of knowing home care nursing practice, education, and research provided me with a specialized location from which to explore HCCMs' points of tension and the social relations that organize their work.

However, as previously described, standpoint does not stem from personal or unique every day experiences; rather, it locates a point of entry from which to examine how experiences are being organized. As a researcher using IE, my aim was to explore HCCMs' social relations that could be traced from the HCCM standpoint, such as the ruling relations of health and home care management. I achieved this by focusing on the HCCM standpoint, which I used as an entry into my study.

Methodological challenges also arose from my unique knowledge of the broader mandates and processes of home care programing, and HCCMs' professional practices and routines. The HCCM standpoint could have led to me taking for granted how things work as they do for HCCMs. If I reflected on my (and others') institutional knowledge and ideological ways of thinking about HCCMs' integrated care, rather than critically analyzing the empirical data, the institutional relations and social organization of HCCMs' experience would have remained hidden (Smith, 2005, 2006). Further in this paper, I describe the various strategies I used to avoid institutional capture during my data collection, analysis, and writing activities. Overall, the HCCMs' standpoint guided my development of critical questions used to explore the antecedents to HCCMs' organized work, examine the points of tension HCCMs encounter in their care of older adults with MCCs and focus and illuminate actual and poignant work experiences of HCCMs.

Figure 5-1 illustrates the place of entry and HCCM standpoint taken in my inquiry that led me to critical questions, points of tension, data gathering, and analysis, all of which required reflexivity to hold attention to and mitigate dissonant knowledge claims and potential for institutional capture. Moving from this standpoint through the research process, I discovered new knowledge of HCCMs' integrated care for older adults with MCCs and for the discipline of nursing. This kind of discovery enabled an alternative analysis of what is occurring in HCCMs' practice and what can be known about case management and integrated care from the standpoint of those who are organized and influenced by the management of home care programs.

Figure 5-1. The HCCM Standpoint



Standpoint and the Uncovering of Critical Questions

I used the standpoint of HCCMs to explore the points of tension they experienced in their work, and to develop my subsequent critical research questions. Through my previous nursing roles, I have gained a solid knowledge of the points of tension that HCCMs experience while caring for older adults with MCCs. From these practice, education and research experiences, I know that HCCMs navigate the everyday realities of providing contextualized and complex case management within the institutional arrangements of broader health care systems and local home care programs. In my inquiry, I explored the institutional arrangements that were influencing and organizing the work of HCCMs (Campbell & Gregor, 2002), thus making holistic and person-centred care difficult for HCCMs to achieve. Yet, prior to my study (Garland Baird, Fraser, Jakubec, Stahlke, & Duggleby, 2018), how HCCMs provide, or not provide, integrated care for older adults with MCCs, particularly while collaborating with inter-professional teams within home care and across broader care settings, was poorly understood in the research literature (Stuckey et al., 2009; Vargas, Mangione, Steven Asch, Keesey, & Mayde, 2007; Walters, Adams, Nieboer, & Bal, 2012). Without a clear view of how integrated home care case management could happen, the official version, established within management frames and discourse, altered what could be known about the everyday experiences of caring for older adults with MCCs. It was these points of tension that led me to this inquiry and take up the standpoint of HCCMs.

To fully address my research question, I needed to examine literature that framed how HCCMs' integrated care of older adults with MCCs was understood and being managed. This provided a view into how HCCMs' integrated care was known in the broader health and home care discourses and how these discourses were being manifested in processes and practices. As such, I was able to view what was already known, or not known, about integrated care and HCCMs' work to understand how that knowledge was organized and then directing the actual work of HCCMs in practice. Using standpoint enabled my exploration of the social organization of HCCMs' actual work experiences, while considering the knowledge and discourses emerging from the research literature on HCCMs and integrated care. This process helped me frame my critical questions from the point of view of the HCCM.

Exploring Points of Tension

I used standpoint to further explore and expand my understanding of the points of tension that arose when HCCMs attempted to provide integrated care while working in complex systems. With this increased understanding, I was able to identify how their work was organized around three work processes: documenting the work of case management, communicating with interdisciplinary members external to home care, and creating "work arounds" to provide integrated care. Standpoint helped me uncover how HCCMs' work was organized and identify that their work was not supported by home care's organizational processes that were in place to deliver integrated care. The following illustration demonstrates my use of standpoint as I explored a point of tension that led me to understand how a HCCM's immediate work of caring for her client with dementia was organized to happen as it did.

Lana. Lana, a HCCM, told the story of a panicked phone call she received from Mary, the spouse and family caregiver of John, a home care client. John's cognitive health was declining due to dementia. He was on a lengthy wait list for admission to long-term care (LTC), and during this time Mary was caring for John at home. Lana explained,

> *Mary called me after only having about three hours sleep. She was so upset. She told me that just the evening before, she watched John calmly take a steak knife out of the kitchen drawer and put it in his pocket as he told her he planned to kill her through the night. He told Mary he thought people were in their home and were going to kill him. Mary was able to take the knife away from John and hide it, along with all the other kitchen knives. Apparently, this was a complete change in behavior for John. I have never met John or Mary, as he is not on my case load. John's regular HCCM was on vacation at the time.*

Lana was covering her colleague's caseload and was not familiar with John's circumstances. HCCMs often manage each other's caseloads, and it is difficult to be fully aware of all client circumstances. Lana said,

> *I had been given* [a] *report on John and Mary, but this was something acute that happened. So even though home care doesn't provide primary care services and is not meant to be used as an emergency service, these people depend on my expertise to help them. I had to respond immediately for both Mary and John's safety.*

Lana had previously reflected on the needs of clients on the long-term care wait list, "*Many of them have dementia and live with assistance in their own home or with family caregivers.*" Despite this, HCCMs who care for complex clients, like John, did not have an official process to access geriatricians with specialties in geriatric syndromes, including dementia. Lana described,

> *My only option was to call John's primary care physician to explain these new, troubling behaviours and discuss potential courses of action. The primary care physician just said, "go to the hospital". But going to the hospital wasn't really an option. Anybody involved in dementia care knows that acute care is not where these people need to be.*

Lana called a geriatrician, who collaborated with home care and occasionally attended client care coordination rounds. She explained John's circumstances to the geriatrician, and because he had previously assessed John, he agreed to call John's primary physician to recommend medical intervention and prescribe appropriate medication to treat John's dementia symptoms. He also called Mary to reassure her that she could call him directly if needed while awaiting John's placement in a long-term care facility. Lana explained,

> *I knew from John's chart that a geriatrician had just assessed John two months ago. But you're never sure about when you can reach out to a specialist. I did it because my gut was telling me that that's what I needed to do to support John and Mary. So, it was great to know that it was acceptable for me to contact the geriatrician directly and that we are working together.*

From her HCCM standpoint, Lana considered this collaboration with the geriatrician as extraordinary, yet it was instrumental in how she could provide what she considered the quality of client-centred and integrated care for John and Mary that she strived to provide.

This collaboration, or lack of, impacted Lana's ability to use integrated approaches for client care viewed as valuable by the client and family caregivers, and seen as vital by the geriatrician and others in health care leadership for older adults with MCCs, especially those with dementia.

HCCMs expressed difficulties in accessing primary care physicians with geriatric expertise in a timely manner, even when clients were in potential crisis situations. HCCMs described instances of the primary care physician prescribing inappropriate doses or contraindicated medications, resulting in a decline of an older adult client's cognitive status. This left HCCMs with minimal access to the most appropriate health care professionals who could intervene in an appropriate and timely manner. Without appropriate interventions, it impacted HCCMs' ability to provide safe and timely integrated care.

The point of tension arising from Lana's interactions with Mary and John may not be readily apparent to others within, or outside of, the institutional arrangements of the home care program and who have not experienced or share the HCCM standpoint. From her position, Lana felt she had no choice but to respond rapidly and urgently to address John's issues to ensure that both he and Mary remained safe in their home. All too frequently, HCCMs have reduced or non-existent access to supportive resources that can integrate care across needs and settings within a system that is so disintegrated, it prevents integrated care. Often, these gaps in the institutional processes that organize care delivery remain hidden and unidentified. Standpoint provided a location and experience from which to identify and explore the contradiction that HCCMs experience in their work as a result of the provincial home care program's mandate to provide integrated supportive services, without due attention to the primary or emergency care services for these same clients.

Remaining in the Everyday of Home Care Case Managers' Work

Using the HCCM standpoint anchored me within HCCMs' everyday experiences and enabled me to remain focused on descriptions of HCCMs' actual work and their work activities during data collection. Standpoint prevented me from moving into conceptualizations or abstractions about HCCMs' work experiences of providing integrated care. An IE inquiry may start by exploring the experiences of people who are directly involved in the institutional setting, however they are not the object of the investigation. Rather, it is the aspects of the institution that organize people's experiences, not the people themselves, that constitute the inquiry (Smith, 2005). As a result, standpoint in IE research can yield a very different knowledge product—one that explicitly avoids interpretation and higher levels of abstraction, but, instead, looks at the materiality of how people's experiences are organized as they are. The essence of my IE inquiry came from me taking up and exploring the HCCM standpoint to better understand how their work and activities are organized. In doing so, I was able to uncover and explicate HCCMs' everyday work experiences.

Bisaillon and Rankin's (2013) analytic guide (see Appendix 5-D) provided a touchstone during the gathering of data and analysis, as a way to reflect on any insertion of objectifying language or departure from understanding how HCCMs' work was organized. The guide includes eight analytic concepts that drove my analytic intentions from the HCCM standpoint, while conducting interviews and exploring, reading, re-reading, writing, and re-writing about HCCMs' work activities and processes. These intentions included *further exploring* the points of tension that HCCMs experienced in their work, *orienting* my interviews towards aspects of social life that linked HCCMs' activities within home care to broader social relations external to home care, *listening* to HCCMs' work stories to learn about their practices and activities, *being attentive* to how HCCMs described their work and their use of institutional language and authoritative reasoning to explain events, *ascertaining* the implicit and explicit social relations that organized HCCMs' work, *finding* out about how texts organized what HCCMs say, *developing* an understanding about how home care functioned to show the social organization and ruling relations, and *acquiring* understanding about how HCCMs used texts in their work (Bisaillon & Rankin, 2013).

I used these intentions in a continual analytic process, always returning to the HCCMs' standpoint and work experiences to uncover how their work was organized, as well as identifying and examining central discourses, processes, and texts that impacted the home care program. This was challenging at times because, as Bisaillon and Rankin (2013) suggest, participants tend to veer away from discussing their knowledge of material conditions of their ordinary lives and work activities due to their own familiarity. As a result, participants may assume the researcher's attention is solely focused on examining their experiential reflections and inner emotions. Certainly, within an IE approach the researcher begins an inquiry by exploring participants' experiences, but within the context of the institution. Then as per the IE tradition, the researcher's analysis moves from exploring participants' experiences to exploring and explicating participants' actual day-to-day material activities and how they are organized by the institution. Guiding interview questions supported both my participants and me to remain focused on HCCMs' work activities, processes, and texts used in their daily work life and to avoid institutional capture. Institutional capture is a term unique to IE (Campbell & Gregor, 2002; Smith, 2005) that describes when a researcher or study participants are so familiar with the institutional stories and discourse (in this case, home care and integrated care) that assumptions and taken-for-granted views potentially dominate their personal and everyday knowledge of their own experiences. During interviews, HCCMs often provided abstract and conceptualized descriptions of their activities such as "developing partnerships with clients," "using evidence-based practice," and "coordinating client care". To avoid institutional capture, I prompted participants to explain terms and activity meanings and explicitly describe how they achieved these in their practice to avoid reconceptualizing or abstracting their work and experiences.

Standpoint Politic and Dissonant Knowledge Claims

A "standpoint politic" (Bisaillon & Rankin, 2013) is way of articulating the challenges that arise when a researcher adopts a standpoint outside a dominant institution's authoritative ways of knowing to reveal the social organization often unseen or unknown from advantaged positions within the institution. This standpoint politic may occur when research is independent of the organization under inquiry and is not under its control (Bisaillon & Rankin, 2013). In this way, the research may be viewed as potentially subversive or disruptive of the routine systems of management, upon which the investigation is focused (Campbell & Gregor, 2002).

Colleen and Rosanne. This sense of standpoint politic was experienced in my study of HCCMs and home care leaders. It was particularly evident when knowledge HCCMs shared about their actual work and activities providing integrated care to older adults with MCCs was different from the home care leader's perspectives on HCCMs' care. Colleen, a HCCM, and Rosanne, a home care leader, discussed Accreditation Canada's required organizational practice (ROPs) for skin and wound care practice. Colleen spoke about her work as a member of home care's provincial quality committee and the preparation required for the accreditation process and Accreditation Canada's planned site visit. I noted that each home care office had a designated bulletin board covered with Accreditation Canada information posters, process dates, diagrams, and ROP material.

All home care staff were required to complete the designated online learning modules and watch instructive videos to achieve the required skin and wound care ROP prior to the accreditation team's visit to the home care office. Colleen explained,

> *There's a fair bit of work and stress around the required organizational practices. Although I agree with needing to have current knowledge and skills for skin and wound care assessment. But because the ROP modules and videos had to be done all at once to meet the accreditation deadline, [it] was really disruptive to our routines for home care client's home visits.*

Accomplishing the "work of the ROP" impacted Colleen's workload, with key texts of Accreditation Canada's ROPs highly consequential in how Colleen's work activities were prioritized. On the days Colleen attended the quality committee meetings, she reduced the number of home care clients she could visit, in order to have time to attend. The management of the quality for accreditation disrupted the quality of the actual client work that the HCCMs could accomplish and created a point of tension within the HCCMs themselves who wrestled with the dueling priorities. Colleen reported, "*So, there's been months of work done on this new ROP. Some days, I'm so busy with client visits and charting, it's challenging to get to the meetings. Really, my priority is my clients*."

Rosanne, a home care leader, did not share Colleen's perspective on the disruption in client visits and care caused by the skin and wound care ROP. She said, "*The ROP education modules are a mechanism to improve client care. These ensure all HCCMs and home care staff have the knowledge to provide evidence-based skin and wound care for home care clients."*

Despite learning of Colleen's concerns about the potential impact of the ROP education on client care, Rosanne supported the authoritative ROPs that home care was required to meet in order to achieve Accreditation Canada's standards. Colleen's standpoint was informed by her experiences of employing a ROP that subsequently disrupted client home visit schedules and created challenges for herself and her delivery of client care. As Rosanne was informed by her leadership roles and responsibilities for achieving quality management and improvement activities, her standpoint within the institution was not congruent with Colleen's standpoint as a HCCM.

Standpoint enabled me to identify and maintain that Colleen's perspectives and experiences with Accreditation Canada's ROPs were outside the dominant institutional requirements for home care programs to meet accreditation standards. In this way, it was only by starting from this standpoint that I could reveal how the work of HCCMs and client care was being organized in a way unknown to Rosanne, who, as a home care leader, was perhaps in an advantaged position within the institution.

Avoiding Institutional Capture

Beginning my study from the standpoint of HCCMs was crucial but presented the potential for institutional capture (i.e., perpetuating taken-for-granted assumptions about HCCMs' work) for both the HCCM participants and me. My previously described home care experiences created this vulnerability (Campbell & Gregor, 2002; Smith, 2005) during data collection and analysis and in writing up my findings.

To mitigate this risk, I began each HCCM's interview by emphasizing that although I may be knowledgeable of home care's programs, practices, and texts, I relied on HCCMs to describe their work experiences as if I had no prior home care nursing knowledge. It was their perspective and their current work activities that I was studying, rather than any preconceived knowledge I might have, or they might perceive I had. Anytime a HCCM spoke about their work in generalized terms (i.e., "I provide holistic, client-centred care to my clients"), I asked them to describe what actions and work they actually did to provide holistic, client-centred care. During an interview with Jo-Ellen, a HCCM, I realized she was using shortened terms and acronyms (i.e., SAST, intake) in her work accounts, and I was slipping into institutional capture. From my experience as a home care nurse and nurse educator in this setting, I knew that "SAST" is the Seniors Assessment Screening Tool used to assess a client's physical and cognitive function, and that "intake" refers to the process used to screen, assess, and admit clients to the home care program. To avoid institutional capture, I asked Jo-Ellen to explain in detail her use of the SAST and the work activities that were carried out during a home care client's intake process.

During data analysis and writing up findings, I sometimes found myself reflecting on a HCCM's account that triggered memories of similar experiences I had, working as a home care nurse (i.e., use of specific assessment tools, interactions with clients and family caregivers). At these points, I used reflexive practice to consciously prompt me to stop my analysis and/or writing to untangle HCCMs' data from my personal experiences. Taking a reflexive approach in those instances involved clarifying, locating, and identifying my personal and professional positioning (Morse, Barrett, Mayan, Olson, & Spiers, 2002). I documented my thoughts apart from my data and analytic work through journaling. Adoption of Bisaillon and Rankin's (2013) analytic guide supported my process and helped make my assumptions visible to protect me against institutional capture throughout my research process.

Standpoint and Nursing Knowledge Development

Relationships with the environment, well-being, living with chronic illness, and quality of life are only some contemporary examples of concepts and practice issues central to nursing knowledge development (Meleis, 2012). Standpoint is a social position from which most IE research and activist work originates (Bisaillion & Rankin, 2013). In my inquiry, I took the standpoint of HCCMs that was informed by their everyday experiences and challenges when striving to provide integrated care to older adults with MCCs within institutional health systems and home care programs (Garland Baird et al., 2018). The discipline of nursing has, and continues to require, knowledge that describes, explains, understands, and includes the complexities of nursing phenomena such as case management and integrated care. The discipline also considers the congruencies of research approaches and tools that explore and explicate the diversities of historical, cultural, and sociopolitical contexts of nursing interactions and practices (Higgins & Moore, 2000; Im & Chang, 2012; Im & Meleis, 1999; Meleis, 2012).

Meleis (2012) believes that current and future nursing knowledge development would do well to concentrate on the evolution of concepts that originate in the nursing domain, the action and practice of nurses. There are a variety of ways of producing nursing knowledge from practice. Standpoint in IE can be used as a strategy to answer critical questions, including those that *arise* from nursing practice to support the development of nursing knowledge that is *relevant* to guide practice (Risjord, 2010), policy, and future research endeavors. As with many qualitative approaches, IE inquiries are primarily concerned with exploring issues of power and objectification. Most qualitative methods aim to theorize or develop interpretations of participants' experiences for the creation of essential nursing knowledge development, whereas standpoint keeps the research participants front and centre to remain in the everyday material experiences of people (Smith, 2005, 2006). Since IE's goal is to avoid abstraction of people's experiences, this approach can offer an alternative kind of analysis and knowledge development for the discipline of nursing.

IE has utility for the exploration of how institutional ruling relations leads to power imbalances between nurses and management practices, as well as the subjugation of nursing's contributions to health and social practices, such as integrated care. Uncovering the dominant ruling relations that organize nurses' practice and renders their experiences invisible is an important analytic task for the discipline of nursing at this time. Perceptions that an aging population is correlated with increasing health care expenditures (Chappell & Hollander, 2011; CIHI, 2011), and a focus on efficiency and quality, are some of the reasons why many health systems have adopted business process management (BPM) approaches. BPM originated in finance and management domains and aims to analyze, improve, control, and manage processes with the aim of improving the quality of products and services (Elzinga, Horak, Lee, & Bruner, 1995). BPM may be useful in the management of health care budgets but are wholly incapable of capturing and accounting for the complexity of nurses' empirical, ethical, personal, aesthetic, and socio-political ways of knowing and subsequent work of providing care (Carper, 1978; Jill, 1995; Khuan, 2006). With the widespread use of BPM in health care system's institutional processes and practices, there is a risk that the everyday realities of practice and knowledge of nurses and HCCMs can readily disappear.

Earlier illustrations in this paper demonstrated how home care's management and practices of integrated care organized and impacted HCCMs' ability to provide holistic and client-centred care—and how aspects of their work and subsequent knowledge gained from their experiences with dominant processes remained unaccounted for within the institution (Garland Baird et al., 2018). Urban (2013) explored how the oppressive conditions in acute care settings have become an ordinary part of nurses' work. This research uncovered how prevailing ideologies and institutional discourses make nurses' work invisible and taken-for-granted and how this normalizing of nurses' work contributes to the sustaining of power over nursing practice in the acute care setting.

Melon, White, and Rankin (2013) examined the social organization of emergency nurses' work to manage the safe passage of patients through an acute care emergency room (ER) and care process. Melon started with the standpoint of ER triage nurses and identified the problematic role of the Canadian Triage and Acuity Scale (CTAS) text, acting as a high-level organizer of triage work and knowledge production. CTAS was a document that underpinned and textually mediated the way those who administer the system in trans local settings define emergency care, and then used it to reorganize ER nurses' work into "rapid patient processing" within the local setting of the ER. Their research revealed that industrial production line values and principles, in the form of quality assurance, have infiltrated health care management and reframed how nurses provide care (Melon, White, & Rankin, 2013).

Janet Rankin's research focuses on exploring the impact that accountability practices and outcome measures in acute care hospitals have on nursing work, professionalism, nurses' patient care goals, and patients' health experiences and outcomes (2002, 2014, 2017). Rankin's IE inquiries start from the standpoint of nurses dealing with the points of tension arising from new managerial discourse of efficiency and effectiveness within acute care settings and the way they organize their nursing practice and patient care. From the standpoint of nurses working in acute care settings, Rankin builds an account of what nurses know and do in their practice when dealing with the new managerial discourse as it enters and reconstructs the acute care setting. Rankin uses IE in the acute care context to explicate and guide nursing action by offering nurses a way to talk back to the objectified forms of health care knowledge that are authorized by other ways of knowing, such as evidence-based practice and quality improvement outcome measures (Rankin & Campbell, 2009; Rankin, 2002, 2014).

These examples of research demonstrate a contribution to the advancement of nursing knowledge by providing a critical analysis of the ideologies of BPM, new accountability practices, quality assurance, and outcome measures (Melon, White, & Rankin, 2013; Rankin, 2002, 2014, 2017; Rankin & Campbell, 2009; Urban, 2013) within health care institutions. By using IE to guide their inquiries, these nurse researchers uncovered a number of deleterious consequences that these ideologies have for the nursing profession, nursing care and care goals, and patients' health experiences and outcomes. As a whole, these findings contribute to our broader understanding of the ruling relations within health systems and their political implications for nursing research, policy, and practice development in integrated care.

Approaches that expose nurses' realities within institutional arrangements can contribute to the development of nursing knowledge concerned with experiences of everyday invisible and silent care activities and the emotional or affective world that is so often dismissed within health care. Standpoint from nurses' locations and activities enable a view and understanding of how points of tension, dominance, and subordination come to be. This kind of knowledge production can provide an alternative analysis that may prevent nursing work from being further pushed to the margins within health care (Rankin, 2002, 2014; Rankin & Campbell, 2009; Urban, 2013). Advancing this knowledge can enable nurses to lead the dialogue and dissemination of these findings and for the establishment of connections to those in authority in health care systems' governance structures (Melon, White, & Rankin, 2013). I advocate that the discipline of nursing could benefit from the use of standpoint in IE to explore how nursing practice is organized to happen as it does. Standpoint assists with the production of knowledge that exposes social relations that render nursing knowledge and work invisible and, ultimately, supports nurses to practice according to the emancipatory goals of the nursing disciplines' social justice in health and social outcomes for clients.

Conclusion

Standpoint is a critical approach to enter into, shape, and guide research and knowledge development in nursing. An exploration of the social organization of HCCMs' integrated care of older adults with MCCs provides a specific exemplar of standpoint as a particular point of entry into an IE study. From this exemplar, the organization of HCCMs' work and experiences could be examined, revealing the challenges and barriers to HCCMs' provision of integrated care that might otherwise have remained uncovered. Adopting the standpoint of HCCMs, I explored points of tension and identified critical questions to explore the everyday activities of HCCM work and the practices organizing that work from outside of the HCCM standpoint.

The HCCM standpoint enabled me to maintain focus on the actual experiences of HCCMs as they worked to provide integrated care, but often found themselves part of a health system whose official integrated care processes often did not support HCCMs' actual integrated care. Challenges arising from resisting conceptualization of HCCMs' experiences, dissonant knowledge claims between HCCMs and dominant institutions, and the potential for institutional capture were also mitigated by preserving the HCCMs' standpoint throughout my inquiry. IE's philosophical tenet of standpoint was pivotal for mapping the social relations, everyday embodied activities, and actions of what HCCMs do when confronted with home care's institutional structures and practices as they strove to provide integrated rather than disintegrated care to older adults with MCCs. Ultimately, standpoint in IE offers an approach that is congruent with the development of nursing knowledge originating within nursing practice.

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Chapter 6. Summary, Contributions, and Conclusions

My dissertation has contributed to the development of knowledge about HCCMs' integrated care of older adults with MCCs. In this chapter, I summarize my findings and provide the strengths, limitations, and contributions of my research to understand how HCCMs provide, or not provide, integrated care for older adults with MCCs in the home care setting. In light of this analysis, I conclude by presenting implications for future research, practice and policy development.

Summary of Findings

My overall findings were developed through a scoping review and an empirical study. In my scoping review, presented in Chapter 3, I explored how home care case management standards of practice (NCMN, 2009) correspond with the clinical and professional functions of integrated care (Valentijn et al., 2013). I identified facilitators and barriers to HCCMs' case management and integrated care delivery. In my institutional ethnography, presented in Chapter 4, I explicated how HCCMs' day-to-day work of providing integrated care for older adults with MCCs was organized and textually mediated by the ruling relations and official discourses of institutional health systems and home care programs.

Scoping Review: Understanding the Many Ways Case Management Standards and Integrated Care are Known

A scoping review approach provided me with a way to frame my IE inquiry and to understand the many ways that integrated care can be known. In my IE inquiry, I explored how HCCMs knew and experienced their provision of integrated care for older adults with MCCs. I also examined and uncovered how the health system and home care program's authoritative and institutional ways of knowing integrated care through the Business Process and the Integration Model served to disrupt HCCMs' work in ways that eclipsed their nursing knowledge and case management practice. The scoping review findings presented here increased my awareness of how case management and integrated care is constructed to organize HCCMs' work.

Through the scoping review method, I demonstrated that although case management standards of practice and integrated care are each complex phenomena, HCCMs' work of providing case management and integrated care are often interdependent. HCCMs consistently used case management standards of assessment, planning, implementation and evaluation to provide professional and clinical integrated care functions. They were least likely to use the standards of identification of client and eligibility for case management and transition to provide professional and clinical integrated care functions, such as shared problem solving, shared decision making, and primary care delivery. HCCMs' use of professional and clinical integrated care functions was inconsistent and varied.

I found that case management standards and integrated care functions could act as either a facilitator or barrier, but most often they facilitated HCCMs' integrated care work. Different factors influence whether case management standards and integrated care functions act as facilitators, barriers, or both in HCCMs' provision of integrated care of older adults with MCC. The greatest facilitators and barriers to integrated care are those case management standards and clinical and professional integrated care functions that focus on partnerships, collective and shared responsibility, accountability, coordinated client-centred care, and ensuring engagement and partnership in self-management.

Also, the standards of assessment, planning, and implementation were more likely to facilitate functional integration. Functional integration includes how health systems are formally organized and structured such as financial management, human resources, strategic planning, information management and quality improvement. On the other hand, the integrated care functions of intra and inter-partnerships, shared accountability, person centered of care, and engagement for client self-management were more likely to facilitate normative integration. Normative integration is less tangible than functional integration and includes coordination mechanisms based on shared values, culture, and goals across and between interdisciplinary health care professionals and organizations towards patient-centred care, teamwork, and communication efforts (Valentijn et al., 2013). Overall, I identified that HCCMs use case management standards and integrated care functions to provide care for older adults with MCCs at the professional (meso) and clinical (micro) levels.

Institutional Ethnography: The Social Organization of HCCMs' Integrated Care of Older Adults with MCCs

My institutional ethnographic findings demonstrated that HCCMs' work within the provincial home care program was seemingly guided by the philosophy and approaches of integrated care. However, health system ruling relations and discourses of business process management, cost containment, and efficiency organized HCCMs' work in ways that inserted a level of disintegration into HCCMs' practice. I uncovered that extra-local ruling relations and dominant discourses were organizing HCCMs' local work and experiences in the home care program in ways that were contradictory to the goals of integrated care. Analysis of HCCMs' activities and experiences of providing integrated care to older adults with MCCs demonstrated that their work was coordinated by two central texts – the Business Process and the Integration Model – and their linear, sequential work processes. Ultimately, the Business Process and the Integration Model were introduced to the home care program following a 2009 provincial health system evaluation that focused on improving operational consistency and reducing system resource use. Ultimately, the Business Process and the Integration Model were examples of broader business process management (BPM) approaches that were focused on management, cost containment, and efficiencies in the health system and home care programs.

Incongruence between how HCCMs knew and experienced the actual, complex day-to-day work of providing integrated care and the home care program's BPM approaches surfaced as their work was experienced through the official, sequential flow of processes and texts. The strategies and processes specified in the Business Process and the Integration Model textually mediated HCCMs' day-to-day work. HCCMs reported that the amount and frequency of required documentation of their case management activities and use of multiple electronic and paper texts reduced their time for interacting with clients, family caregivers and interdisciplinary team members for care coordination.

HCCMs exposed challenges and barriers when using the communication methods and texts mandated by the Business Process. This included responding to Business Process emails and sending transfer documents and SBAR forms by fax when communicating with interdisciplinary team members external to the home care program, particularly primary care physicians. HCCMs also described having to adapt written and unwritten institutional home care processes to create "work-arounds" to access program resources and specialist physicians to safely and effectively meet their clients' needs in an integrated and equitable way. How HCCMs' work was organized and linked into the sequential work processes of the Business Process and the Integration Model, diverted their time and energy from the development of trusting relationships and partnerships between the HCCM, client, and family caregiver (Garland Baird & Fraser, 2018a). These are central activities to the successful outcomes of integrated care.

In summary, my inquiry uncovered how institutional health system and home care program processes and texts that were intended to deliver increased system safety, efficiency, and quality care, actually organized HCCMs' work in ways that led to challenges and barriers for HCCMs to provide integrated care for older adults with MCCs. Consequently, and in addition to their case management responsibilities, HCCMs' work was organized by and linked into official integrated care processes where they had to adapt their case management practice to fit within the organizational boundaries of both the Business Process and the Integration Model.

Strengths and Limitations

Strengths

Scoping review. My scoping review identified and provided a descriptive and analytic account of the available research literature in four unique, yet often intersecting areas of home care, case management, integrated care, and older adults with MCCs. To my knowledge this is the first-time case management and integrated care, two interrelated activities or approaches, were illuminated and described this way. This study led to my suggestions of realistic practice, policy and research recommendations for HCCMs and integrated care of older adults with MCCs in the home care setting. Also, to adequately address my scoping review's research question, I needed to explore the literature focused on how HCCMs' integrated care of older adults with MCCs was understood. I approached my scoping review as a window into how HCCMs' use of case management standards and integrated care functions was known in broader health and home care discourses and how these were being manifested in practice. As such, I was able to view what was already known about HCCMs' case management and integrated care work to understand how this knowledge was structured and how it then organized the actual work of HCCMs in practice. These findings informed my empirical study in ways that would not have been possible without this type of review. In addition, my scoping review findings may offer future researchers, policy developers and practitioners' clarity around the concepts of case management and integrated care, a grounding in case management and integrated care knowledge, and a demonstration of how when these complex concepts are applied in HCCMs' practice, they are often interdependent.

Institutional ethnography. Embarking on my IE from the HCCMs' standpoint enabled me to maintain focus on the actual experiences of HCCMs as they worked to provide integrated care, while often finding themselves part of a health system that perpetuated a fragmented approach to caring for older adults with MCCs. By maintaining the HCCM standpoint throughout my inquiry, I was able to avoid the conceptualization of HCCMs' experiences, identify dissonant knowledge claims between HCCMs and dominant institutions, and mitigate the potential risk of becoming institutionally captured during data collection and analysis. This standpoint was a strength, helping me anchor this study and its findings firmly in the actualities of the day to day work of HCCMs. This standpoint was pivotal for mapping the social relations and the everyday embodied activities and actions of what HCCMs do when confronted with home care's institutional structures and practices as they provide integrated rather than fragmented care to older adults with MCCs. Drawing on this knowledge, my findings can raise awareness of the social organization of HCCMs' work. This has significance for practice, policy, and research and have the potential to impact the health outcomes of older adults with MCCs receiving home care.

Limitations

Scoping review. In keeping with current standard practices of scoping reviews (Arksey & O'Malley, 2005), the quality of research evidence included in my review was not appraised. This could potentially increase bias in my results. Either the empirical research in this area was limited in its rigor, or the rigor of primary studies was not made explicit. Also, my scoping review did not address the issue of "synthesis", or the weight of evidence in favor of the effectiveness of case management standards and integrated care functions. This is also the case in most scoping review methods.

Institutional ethnography. My IE contributes to the development of knowledge that offers a comprehensive social analysis of institutional organization. Seeing and understanding the social organization of HCCMs' work and experiences does not immediately change the context and circumstances in which the Business Processes, Integration Model and broader system-level BPM approaches exist. Instead, the change required to respond to these findings requires time and commitment to develop and implement, given the dominant and well-established health system and home care discourses, policies and processes (DeVault, 2006). In this way, the descriptions and analysis provided here are meant to offer a 'map' to guide me, or others, to move my work forward with a critical lens in the areas of home care case management and integrated care.

The inclusion of participants from non-nursing disciplines in my sample could be considered a potential limitation of my study. Questions can be raised about how to account for the experiences of non-nurse HCCM participants in the same way as HCCM participants who were nurses. However, nationally, and in the province where this study occurred, the HCCM role is interdisciplinary (i.e., registered nurses, social workers, physiotherapists), and the small number of potential HCCM participants for my study and desire to achieve a provincial representation in my sample required the inclusion of non-nursing HCCMs. In total, five of the six HCCM participants and two of the three home care leader participants were registered nurses. However, our analytical focus was on HCCMs' broader organizational work activities, and not their individual disciplinary perspectives.

The homogenous social location of our participants (i.e., female, Caucasian, middle-aged) could be seen as a limitation, as well as our exclusive focus on the population of older adults with multiple chronic conditions. Future research should consider the inclusion of HCCMs with a diversity of social locations, and a focus on different populations with multiple chronic conditions (i.e., children) to determine if the findings from this research holds true.

Scholarly Contributions

Collectively, my dissertation findings are of significance because they address issues related to the subjugation of HCCMs' and nurses' integrated care knowledge and case management experiences in the care of older adults with MCCs. The needs of the population of older adults with MCCs are well represented in the research literature. However, the day to day work of HCCMs and the impact of the use of business process management (BPM) approaches in health and home care is not so well known. Critical approaches, such as IE, contribute to an understanding of the impact of taken for granted standardization and management strategies used to organize health care delivery on home care case management and nursing practice. While BPM strategies may be successful in the manufacturing and financial sectors, when implemented in complex and highly relational health care environments, they serve to render invisible what HCCMs and nurses know, see and do in their day-to-day practice. Clients and family caregivers are also impacted, as their knowledge and experiences of living with and managing chronic illness are also marginalized. Below, I provide a summary of the scholarly contributions for each of my four papers.

Paper 1: Conceptualization of the Chronic Care Model: Implications for Home Care Case Manager Practice

In this paper, I explored Wagner et al.'s (2001) Chronic Care Model (CCM) as an alternative model of care that aims to transform the daily care for clients with chronic illnesses from acute and reactive responses to proactive care that is planned and uses a population-based approach. In reviewing available CCM research literature, I focused on the implications for HCCMs’ and home care nurses’ practice. In particular, this conceptual review concentrated on the CCM and positive chronic illness health behaviors and outcomes, the CCM and delivery of quality chronic illness care, and the importance of the supportive role of the home care nurse in home care case management.

This work adds to the broader knowledge and awareness of the need for further exploration of HCCMs’ and home care nurses’ roles and contributions to chronic illness care for clients and their family caregivers in the home care setting. This paper compliments the body of knowledge related specifically to the CCM, and generally to knowledge about community-based chronic illness care by HCCMs and home care nurses. This work identified and demonstrated the crucial role that HCCMs and home care nurses have to play in understanding clients’ and family caregivers’ experiences of managing chronic illness. It also raises awareness about the concept and impact of developing partnerships and reciprocal trust between HCCMs and clients living with chronic illness and their family caregivers in the home setting to improve health outcomes.

Paper 2: Home Care Case Managers’ Integrated Care of Older Adults with Multiple Chronic Conditions: A Scoping Review

To my knowledge, this study is the first scoping review that broadly examined both case management and integrated care in the context of home care for older adults with MCCs. My findings contribute to the research areas of home care, case management, integrated care and older adults with MCCs. My findings identified that HCCMs provide integrated care at clinical and professional levels, and variations in HCCMs' practice might impact the delivery of case management standards when caring for older adults with MCCs. This has implications for the comprehensiveness and consistency of home care case management practice, as well as interdisciplinary health professionals' and clients' awareness of the HCCMs' role when providing integrated care to older adults with MCCs within home settings.

All case management standards and integrated care functions acted as facilitators and barriers, but I found that they were more likely to facilitate HCCMs' work. The identified facilitators (i.e., intra-professional partnerships, inter-professional partnerships, collective responsibility to provide a continuum of care) are essential mechanisms to support strategies for coordination of client care through health care professionals' shared values and common goals of collaboration and partnership development to achieve patient-centred care (Valentijn et al., 2013). Barriers to integrated care included lack of shared values or disagreements over the goals or benefits of integrated care interventions between interdisciplinary staff, and lack of clarity in health care professionals' roles and responsibilities. This is problematic as the development of intra- and inter-professional partnerships and collaboration are critical mechanisms to effectively coordinate client care within and across care settings (Valentijn et al., 2013). The identification of these facilitators and barriers are congruent with extant case management and integrated care knowledge and reinforce the consideration of factors that are facilitators or barriers when developing home care services for older adults with MCCs.

In this paper, I also proposed a case management (NCMC, 2009) and integrated care framework (Valentijn et al., 2013) to inform practice, policy, and research development for HCCMs' integrated care of older adults with MCCs. I offer that there are potential research opportunities for the development and testing of my theoretical framework to determine how case management standards of practice and their corresponding professional and clinical integrated care functions could enhance HCCMs' practice, policy development and future research in this area.

Paper 3: Mapping the Social Organization of Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: An Institutional Ethnography

To my knowledge, this is the first IE inquiry to explore the social relations of the work of HCCMs' integrated care of older adults with MCCs. IE offered an innovative and critical approach to examining the social relations of HCCMs in the provision of integrated care in the home care setting. By examining a "strand within an institutional complex" (Devault & McCoy, 2006, pg. 17), this inquiry shed light on the actualities of HCCMs' work and experiences of providing integrated care to older adults with MCCs within home care programs, as well as how their work is organized and shaped by institutional ruling relations within the broader health system.

Using the tenets and strategies of IE, HCCMs' and nurses' work activity can be mapped within the socio-political context of health and home care programs. These findings contribute to the knowledge and understanding of what happens when HCCMs' and nurses' work is organized by institutional health systems and home care discourses of management, cost containment, and efficiency. In my earlier illustrations, I demonstrated how home care management and practices of integrated care organized and impacted HCCMs' ability to provide holistic and client-centered care – and how aspects of HCCMs' work and experiential knowledge remained unaccounted for within dominant institutional processes (Garland Baird et al., 2018). Within health and home care's institutional arrangements, there is a risk that the everyday realities of practice and knowledge of nurses and HCCMs can readily disappear.

HCCMs and nurses are equipped to understand and describe the complexity of clients' health and social challenges. Mapping this complexity to ruling relations mediated by organizational documents may guide HCCMs and nurses to identify possible actions to overcome social injustice and exclusion. By critically reflecting on their practice, HCCMs and nurses can gain insight into the influence of ruling relations affecting their profession and practice. Nurses can apply this analytical expertise to their own and other organizations to plan, influence and carry out change in contexts where possibilities for nursing-based and client-centered practices are restricted (Carrier & Prodinger, 2014).

My findings offer a demonstration of a critical approach that exposes nurses' realities within institutional arrangements. This, in turn, has contributed to the development of nursing knowledge concerned with experiences of everyday invisible and silent care activities, and the emotional or affective world, that is so often dismissed within health care. This kind of knowledge production can provide an alternative analysis for the nursing discipline.

Paper 4: Standpoint in Institutional Ethnography: A Critical Approach to Nursing Knowledge Development

In paper 4, the tenet of standpoint and its methodological use in an IE inquiry was showcased demonstrating how standpoint provides an approach to the development of knowledge that is compatible with the emancipatory goals of the discipline of nursing. This paper contributes to an awareness and understanding that standpoint in IE can be used as a tool to enter into, shape, and guide research and knowledge development in nursing; and as a strategy to answer critical questions, including those that *arise* from nursing practice to support the development of nursing knowledge that is *relevant* to guide practice (Risjord, 2010), policy, and future research endeavors. Standpoint remains in the everyday material experiences of people (Smith, 2005, 2006) and offers nursing knowledge development that has utility for the exploration of how institutional ruling relations leads to power imbalances between nurses and management practices, as well as the subjugation of nursing's contributions to health and social practices.

Standpoint in IE offers an alternative approach that is methodologically congruent with the emancipatory goals nursing research and knowledge development (Bisaillon & Rankin, 2013; Meleis, 2012). I advocate that the discipline of nursing can benefit from the use of standpoint in IE to explore how nursing practice is organized to happen as it does. Standpoint assists with the production of knowledge that exposes social relations that render nursing's knowledge and work invisible and supports nurses to practice in a way that advances the nursing discipline's goal of addressing social inequities associated with health and well-being for clients, families, communities and populations (CNA, 2017).

Implications for Research, Practice, and Policy

Research

My dissertation findings have implications for home care programs within publicly funded health systems and include applying various research approaches for the development of nursing knowledge, such as IE. Most health systems apply fiscal accountability approaches to their performance management and evaluation strategies. Often this type of evidence is generated through quality measurement and improvement methods that rely on administrative processes and population-based data. Fragmentation within health programs and services persist, and HCCMs and nurses continue to struggle with the delivery of holistic and client-centered care. I suggest that, in addition to the traditional measurement approaches, health systems, and home care programs use critical methods, such as IE and other qualitative methods, to explore between the lines of HCCMs' and other health care professionals' work processes and subsequent client and family caregiver outcomes.

IE offers an approach to nursing knowledge development through making HCCMs' work and practices visible in a map of what is going on in their everyday work. This has utility for the exploration of how institutional ruling relations leads to power imbalances between nurses and management practices, as well as the subjugation of nursing's contributions to health and social practices. An additional benefit of using IE for nursing research is that it has been successfully applied by other practice disciplines, such as education and social work, lending it legitimacy for nursing knowledge development. IE inquiries performed by nurse researchers benefit the collective work that focusses on supporting a critical approach to the development of nursing knowledge.

Developing a reliable and valid framework using Case Management Standards of Practice (NCMN, 2009) and Valentijn et al.'s (2013) Conceptual Model of Integrated Care could assist in the development, implementation, and evaluation of home care case management research. This would be useful in exploring case management and integrated care models that better support HCCMs in their provision of integrated care to older adults with MCCs. This new framework could also guide home care case management integrated care practice and policy development to support client and family centred care and foster shared values for sustainable partnerships across care settings. It would require testing and evaluation to ensure reliability and validity for advanced intervention and measurement research in this area. I agree with Joo and Huber (2017) who advised that well-designed research studies are required to inform the development of appropriate and practical frameworks. This framework could then be used to explore the components of case-management and integrated care interventions in the assessment of their clinical effectiveness in a variety of settings and populations.

In addition to functional integration, integrated care research that explores the mechanisms and impacts of normative integration (Valentijn et al., 2013) is required. Normative integration is less tangible than functional integration but is an essential feature to facilitate inter-sectorial collaboration and ensure consistency between all levels of an integrated system. Functional integration focuses on shared policies and practices for support functions across partnerships within a system, whereas normative integration assists in the development and maintenance of a standard frame of reference, such as a shared mission, vision, values, and culture, between individuals, professional groups and organizations (Valentijn et al., 2013). To maximize successful integration efforts, the unique frames of reference of interdisciplinary team members need to be combined to provide client-centered care and effective population health approaches. Mutual shared goals and an integrative culture are necessary at all levels of an integrated system and can be created by leadership, particularly at the professional and management level. Research that focuses on exploring how leadership at the professional and managerial level can support normative integration efforts could offer knowledge that could be used to propagate an integrated approach within health systems (Suter, Oelke, Adair, & Armitage, 2009; Valentijn et al., 2013).

Practice

Implications for HCCM practice include the need for health systems and home care programs to create practice environments that advocate for, respect and trust the knowledge, skills, experience, and autonomy of HCCMs in their case management and integrated care practice. Business process management approaches that focus on management, cost containment, and efficiency do not include or acknowledge HCCMs' comprehensive and holistic approaches and impede HCCMs' autonomy for decision making in the assessing, planning, implementation and evaluation of their client's care.

Other implications for practice include ensuring home care programs provide HCCMs with opportunities for professional development (i.e., case management and integrated care approaches and strategies, impact of multiple chronic conditions on older adults) to gain and build on their specialized knowledge and skills to identify and address the complex needs of clients and family caregivers in the home and community. As HCCMs increase their unique understanding of client and family caregivers’ illness experience, there is potential for HCCMs to alleviate the client’s feelings of loneliness and isolation. Furthermore, HCCMs may affect the impact of family caregiver burden through understanding the shared illness experience of the client, caregiver and the HCCM (Hynes, Stokes & McCarron, 2010). With this increased understanding of the client and family caregiver's perspectives, HCCMs can enhance their ability for reciprocal trust and partnership development (Garland Baird & Fraser, 2018a).

Variation in HCCMs' practice has implications for the comprehensiveness and consistency of practice, as well as interdisciplinary health professionals' and clients' awareness of HCCM roles when they are providing integrated care to older adults with MCC within home settings. The design of practice guidelines requires strong engagement and input from HCCMs and could combine case management standards with functions of integrated care to provide integrated care functions across all case management standards (Joo & Huber, 2017). These guidelines could potentially add to role clarity and increased awareness of HCCMs' scope of practice for clients, family caregivers, and inter-disciplinary health care professionals within the home care setting and broader health system (Reilly, Huges & Challis, 2010).

Policy

Policy implications include the need for the development of case management policies that support the work of HCCMs in the delivery of seamless and collaborative case management and integrated care functions. This would include the development of policies and programs inclusive of both functional and normative integration strategies. These strategies could foster collaboration and sustainability of partnerships between HCCMs, clients, family caregivers, and interdisciplinary team members that focus on coordinated patient-centered care and population health approaches. Policies reflective of functional and normative integrated care are more likely to support both professional and managerial leadership in developing an integrative culture within home care programs and across the broader health and social system (Kodner & Spreeuwenberg, 2002; Suter, Oelke, Adair, & Armitage, 2009; Valentijn et al., 2013).

Development and implementation of policies that increase the visibility of HCCMs' work and practices will provide a broader view of how their integrated care of older adults with MCCs is socially organized and impacted by trans-local ruling relations (i.e. policies that support and enable HCCMs who are registered nurses to practise to their full scope to accelerate nursing innovation and improve quality care). Recommendations and strategies can be made to develop integrated health system and home care programs that improve HCCMs' work and experiences in providing integrated care for older adults with MCCs by using this type of knowledge (i.e., HCCMs who are registered nurse can lead health programs to enable older adults with MCCs to be effectively and appropriately cared for in home care and across community settings). These recommendations and strategies can be presented to appropriate audiences such as provincial home care administrators, policy-makers, and home care leaders thereby potentially improving home care and health outcomes for older adults with MCCs.

Reflections on Dissertation Learning

I have experienced significant personal and professional growth throughout my doctoral program, and particularly in the completion of my research project. It is impossible to "tease apart" the relational, scholarly, and research learnings I've gained, as each is a product of the circular and iterative learning that occurred during my course-work, development of my research proposal, implementation of my research project, and in the writing of my dissertation. However, I wish to briefly highlight my reflective learning on the relationship between my scoping review work and recommendations, and my use of a critical institutional ethnography approach to explore HCCMs' integrated care of older adults with MCCs.

My scoping review provided me a window into what was already "known" about HCCMs' work and integrated care within the literature, as well as the institutional arrangements of health systems and home care programs. This work, and my thinking at that point in my dissertation, yielded research findings and recommendations for nursing practice, policy development and future research that focussed on the development of HCCMs' practice guidelines, policies and programs supportive of the HCCMs' role, and the testing and evaluation of a proposed case management and integrated care framework.

At this point in my doctoral journey, I have reflected on and acknowledge the juxtaposition between the presented scoping review recommendations in Paper 2 and my goal of exploring and explicating the ruling relations of texts (i.e., evidence-based guidelines, business process models) that socially organize and create points of tension for HCCMs' work as they care for older adults with MCCs in Paper 3. The evolution of my research and critical learning through the implementation of my IE inquiry, has advanced my understanding of the reality of how broader integrated care knowledge and discourses, such as those identified in my scoping review, can intersect with and socially organize HCCMs' actual, material work experiences of caring for older adults with MCCs. As a beginning researcher, I can expect and will be accountable for the ongoing progression of my critical learning and advancement of my theoretical nursing and research knowledge.

Building on this Work

My goal is to pursue future lines of analysis originating from my dissertation findings. I will achieve this by continuing to develop a program of research that focuses on the intersection of home care, case management, integrated care, and older adults with MCCs to inform nursing research, practice and policy development. During my doctoral education and parallel strategic research training (McMaster Aging, Community and Health Research Unit

[ACHRU], Transdisciplinary Understanding and Training on Research in Primary Health Care [TUTOR-PHC], and Strategies for Patient-Oriented Research Primary and Integrated Health Care Innovations Network [SPOR PIHCI Network]), I have collaborated with and developed professional relationships with research trainees, early career researchers, mid-career and senior researchers across Canada. These relationships have inspired and yielded current and potential future research collaborations in which to mobilize and build upon the knowledge generated from this dissertation project.

Conclusion

My dissertation contributes to the body of research concerned with home care case managers' integrated care of older adults with MCCs. To my knowledge, this is the first research conducted and published that is focused on the intersection of home care case management and integrated care for older adults with MCCs. I conducted a scoping review and qualitative institutional ethnography study to explore the knowledge and practice of integrated care from the standpoint of HCCMs—and the authoritative health system and home care programs and discourse within which HCCMs' work is organized—to explicate how HCCMs provide, or not provide, integrated care for older adults with MCCs.

My dissertation findings demonstrated that HCCMs' work and experiences of providing integrated care for older adults with MCCs were sequentially linked into and organized by the home care program's Business Process and the Integration Model. Although these texts described the philosophy and approaches of integrated care and were designed for delivery of holistic, comprehensive, collaborative care delivery, they actually represented the health system ruling relations and discourses of management, cost containment, efficiency, and BPM approaches.

The social organization of integrated care within institutional health systems and home care programs created work environments, by which HCCMs, who were nurses, experienced their knowledge and experience in contrast to the management processes applied to their work. The privileging of dominant managerial discourses that undermine the principles of integrated care creates inequities in the delivery of nursing practice and integrated care for older adults with MCCs. Furthermore, textual organization of nurses' work through these processes and discourses marginalizes nurses' actual knowledge and experiences, making them invisible within health care, and in the creation of nursing knowledge.

Uncovering the dominant ruling relations that organize nurses' practice is an important analytic task for the discipline of nursing at this time, as the increasing need for community-based home care services demands awareness and action. The use of critical approaches in my dissertation contributes to an awareness of how and where this breakdown for nursing practice occurs. Advocating for health systems and home care programs that create policies and practice environments respectful of the autonomy of HCCMs in practice is required. Ultimately, understanding nurses' everyday integrated care knowledge and case management practice experience is essential to move towards positive change for nurses' practice and in the provision of quality, equitable home care services for older adults with MCCs.

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Appendix 4-A
University of Alberta Ethics Approval

Notification of Approval

Date: March 9, 2017

Study ID: Pro00065467

Principal Investigator: Lisa Garland Baird

Study Supervisor: Kimberly Fraser

Study Title: Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: An Institutional Ethnography

Approval Expiry Date: Thursday, March 8, 2018

Approved Consent Form:	Approval Date 3/9/2017	Approved Document Informed Consent Form

Thank you for submitting the above study to the Research Ethics Board 1. Your application has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

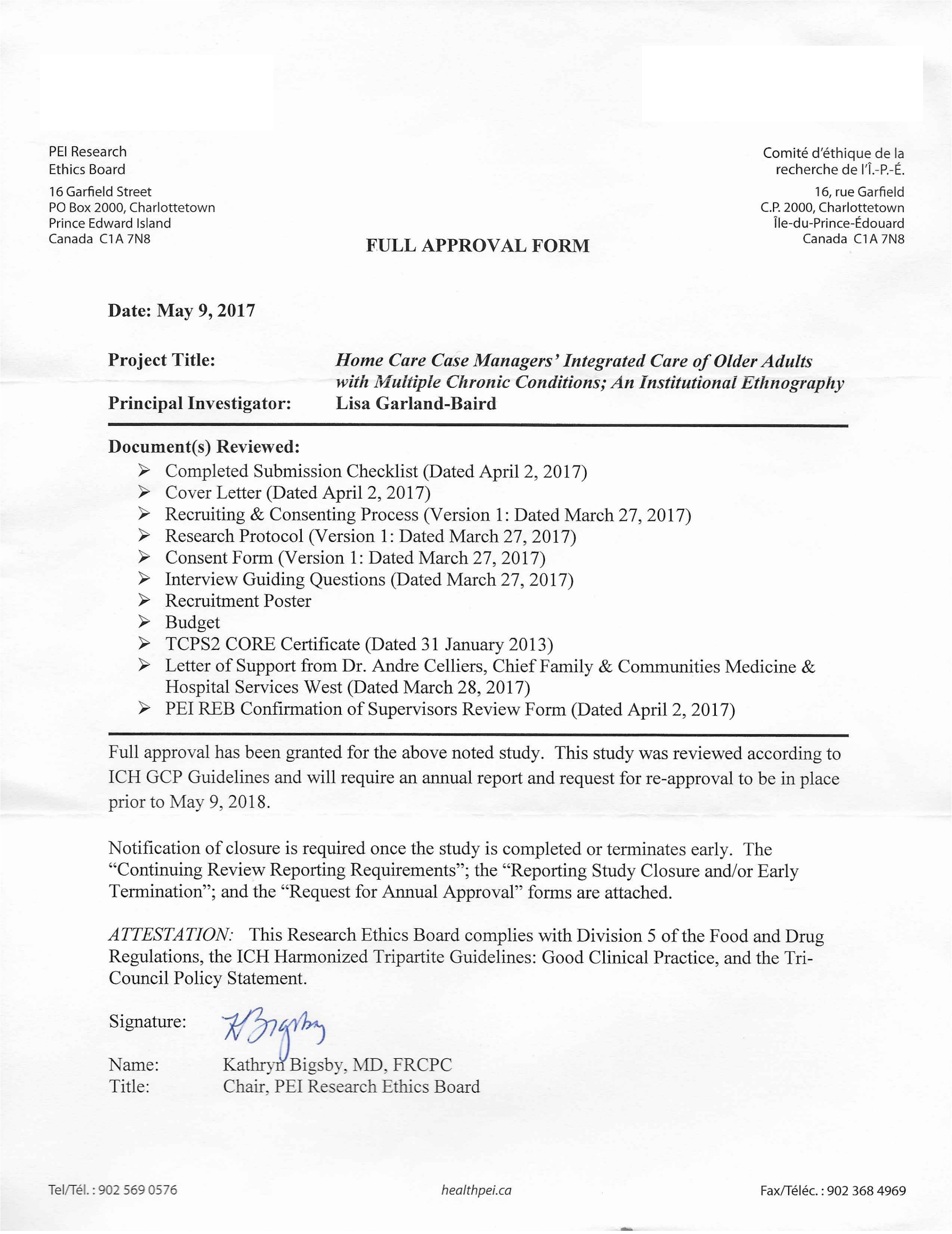
Approval by the Research Ethics Board does not encompass authorization to access the staff, students, facilities or resources of local institutions for the purposes of the research.

Sincerely,

Anne Malena, PhD
Chair, Research Ethics Board 1

Note: This correspondence includes an electronic signature (validation and approval via an online system).

Appendix 4-B
Health PEI Ethics Approval



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recherche de l'Î.-P.-É.
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C.P. 2000, Charlottetown
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FULL APPROVAL FORM

Date: May 9, 2017

Project Title:	***Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions; An Institutional Ethnography***
Principal Investigator:	**Lisa Garland-Baird**

Document(s) Reviewed:

- Completed Submission Checklist (Dated April 2, 2017)
- Cover Letter (Dated April 2, 2017)
- Recruiting & Consenting Process (Version 1: Dated March 27, 2017)
- Research Protocol (Version 1: Dated March 27, 2017)
- Consent Form (Version 1: Dated March 27, 2017)
- Interview Guiding Questions (Dated March 27, 2017)
- Recruitment Poster
- Budget
- TCPS2 CORE Certificate (Dated 31 January 2013)
- Letter of Support from Dr. Andre Celliers, Chief Family & Communities Medicine & Hospital Services West (Dated March 28, 2017)
- PEI REB Confirmation of Supervisors Review Form (Dated April 2, 2017)

Full approval has been granted for the above noted study. This study was reviewed according to ICH GCP Guidelines and will require an annual report and request for re-approval to be in place prior to May 9, 2018.

Notification of closure is required once the study is completed or terminates early. The "Continuing Review Reporting Requirements"; the "Reporting Study Closure and/or Early Termination"; and the "Request for Annual Approval" forms are attached.

ATTESTATION: This Research Ethics Board complies with Division 5 of the Food and Drug Regulations, the ICH Harmonized Tripartite Guidelines: Good Clinical Practice, and the Tri-Council Policy Statement.

Signature:

Name: Kathryn Bigsby, MD, FRCPC
Title: Chair, PEI Research Ethics Board

Appendix 4-C
Interview Guiding Questions

I'd like to learn from you about how you provide care for your clients who are 65 years or older and who have two or more diagnosed chronic illnesses.

- Can you tell me about what your typical daily work looks like?
- How do you organize and/or prioritize your daily work activities?
- What types of resources (forms, charts, guidelines, policies) do you use in your daily work?
- Who do you communicate with in your daily work and how do you communicate with them?
- Who do you collaborate with in your daily work? Within home care and other health/community agencies?

Appendix 5-A
Bisaillon and Rankin's (2013) Analytic Guide

Analytic concept	Analytic intent
Inquire from a perspective rooted in the activities of standpoint informants. This position is maintained throughout the inquiry that explicates how organizations work.	*Learn* about the issues, tensions, and contradictions that people experience in their lives (problematic).
Examine work practices and processes in organizational and bureaucratic settings in such a way that the researcher "think[s] organizationally"	*Orient* interviews toward features of social life that link standpoint informant activities to activities occurring more broadly (social relations).
Investigate the material, empirically observable events of peoples' lives.	*Listen* to people's "stories" of what practices and activities they engage in
Uncover the research problematic over time through the researcher's immersion in the field.	*Be* attentive to how informants describe the events of their lives. Listen for how people use institutional language and official or authoritative reasoning to explain events. People's accounts might actually be dissonant from what they experience and know.
Study features operating across multiple sites and explore how these are connected through circulating texts and documents.	*Ascertain* the implicit and explicit social relations that shape informants' activities.
Identify the texts people use in their daily activities and examine how they use them.	*Find* out about how texts organize what informants say and do (discursive organization).
Focus on how an informant's social location informs her/his knowing and consider what the person can say from this position.	*Further Develop* understandings about how institutions function because this provides about social organization and power or ruling relations.
Cultivate understandings about the organization of institutional places from informants and texts. Researcher follows up on analytic clues of thread gathered in one interview or observational setting to the other.	*Acquire* understandings about how people use texts. Informants talk about peoples' work practices, and the researcher prepares to dialogue with and/or observe extra-local informants in later stages of fieldwork.