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Akhtar, Loganathan, Nowaczynski, Condon, Ewa, Kirk, & Pham (2019)[20]	Canada	Not a study. Description of Canadian urban home-based primary care programs and initiatives and their core features.	To describe five home-based primary care initiatives in Canada.	Homebound older adults.	Integrated home-based primary care (IHBPC).	A 2015 assessment of the Calgary program reported a 51% decrease in ED visits by program clients 6 months following referral: 32% decrease in clients making multiple ED visits in the first 3 months and a 13% further reduction within 6 months. Winnipeg Regional Health Authority (RHA): Hospital Home Team 2014 - 2017. A partnership between HC and PC for patients with complex needs, frequently used hospital & ED services. Goal - reduce ED visits and hospital admission & length of stay (LOS). Home-care case managers embedded within Interprofessional PC Teams to improve transitions from hospital to home and to provide regular and after hours support as needed. In 2017 funding discontinued between hospitals and PC. Created two new programs - Rapid Response Nursing and Priority Home. Family physicians, primary care nurses and home care case-coordinators continue to collaborate via monthly meetings. Referrals come from Primary Care Physicians (PCPs) or HC case-coordinators. Toronto House Calls - Began as a pilot in 2007, secured Ministry of Health and Long Term Care (MOHLTC) funding in 2009 for a full time interprofessional team, based in community support services agency (Sprint Senior Care). In 2010 partnered with Sinai Health and Unity Health Network providing primary and specialty healthcare in the home. Referrals focused on highest need patients. Caseload grew from 80 at the outset to serving 500-600 annually and an average caseload of 350. Annual attrition 40% either to long-term care (LTC) placement or death. 53% fewer hospitalizations a year and 67% reduction in hospital LOS. U of T Department of Family & Community Medicine Academic Family Health Teams (FHTs) - began in 2005. From 2011-2015 most of the 14 FHTs joined with House Calls to improve Integrated Home-Based Primary Care. Focused on the 5% of homebound community dwelling patients using 50% of healthcare resources in Toronto. Embedded a HC Coordinator to identify patients and mobilize resources in a timely way. Primary and specialty physician driven and assessment and referrals via HC Coordinator. Montreal Home Care Teaching Program - created in 2008. Department of Family Medicine at McGill to train family medicine residents to care for homebound individuals. Comprised of physicians, trainees, and administrative support,	Caregiver surveys reported satisfaction with the Calgary program, which appears to continue to function. This is an example of a specialty program within the broader program of home care in Calgary as well as Alberta. Toronto House Calls - Annual attrition 40% either to LTC placement or death. 53% fewer hospitalizations a year and 67% reduction in hospital LOS. These models focus on frail homebound clients using the greatest amount of healthcare services e.g. hospitalizations, ED visits. Teams are PC-based. A national home-based primary care organization is suggested to attain Integrated home-based primary care within existing models.

						integrated with community services. Offer a virtual ward via Herzl's Family Practice Centre at the Jewish General Hospital to decrease hospitalizations. HBPC caseload averages a caseload of 80 refereed via Herzl's Family Practice and community partners.	
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Duner, Bjalkebring, Johansson (2019)[24]	Sweden	Postal survey data (Swedish National Board of Health and Welfare) from 3 municipalities followed by qualitative interviews.	To investigate how older users of home care services view and experience their opportunities of exerting influence and having choice and control in their everyday living, in terms of receiving preferred services that are flexible and responsive to their actual needs and priorities.	Survey n=2,792 responses. 68.8% women; 14.4% were between 65 and 74 years old, 12% were between 75 and 79 years old and 73.6% were over 80 years old.	Individualised elder-care, Swedish free choice systems (Nordic welfare model)	Choice and control in home care services - majority of users are satisfied; choice and control exist on a continuum from active to passive.	The municipality with provider choice had the highest percentage of positive results on three questions (whether they had the possibility to choose provider, whether they got the provider they wanted, whether the staff respected their views and wishes). The traditional model had the most positive results on two questions (whether the care manager's decisions were adjusted to their personal needs and overall satisfaction with their care). Users were most satisfied with overall quality. The municipality with the service choice model scored lowest on all 5 questions. Users were least satisfied with overall quality. In all 3 municipalities and across models, most users were positive about the home care services received.
Forbes & Edge (2009)[21]	Canada	Not a study. A reflection on the home care needs of rural and remote residents in Ontario, Canada.	To present examples of the federal (e.g., First Nations and Inuit Home and Community Care) and provincial (e.g., Ontario's Community Care Access Centres) home care policy context in which Canadian home care is provided, to identify the challenges faced by home care providers in meeting the needs of rural residents, and to offer solutions to these challenges.	Rural and remote home care recipients in Ontario, Canada.	The model in place in Ontario in 2009 was Community Care Access Centres. The model in place in 2025 is Ontario Health atHome, a single organization that will support stability of home care services now, and as care is delivered through Ontario Health Teams.	None.	None.
Jorgensen, Siette, Georgiou, & Westbrook (2020)[26]	Australia	Interrupted time series analysis of secondary data.	Objective: to utilise routinely collected data to examine changes in the client profile of a large, aged care provider before and after commencement of the 2017 policy reforms, whereby home care packages were allocated to individuals rather than providers. Aim: to examine changes in service	n=4132 Clients aged 65 years and older, representing 11% of population across NSW & ACT.	Home Care Packages (HCP) Program - reform initiated to increase choice and control for clients whereby HCPs were allotted to individuals and not providers. ICHC = Increasing Choice in Home Care reform	Service Uptake - 2113 clients commenced HCP services between March 2016 and March 2018. A significant reduction in new HCP clients followed the implementation of ICHC, from a mean of 125 (SD=23) new clients per month to 43 (SD=10). People commencing services after the reforms were more likely to be younger and have a current partner ($P<0.05$). No difference in care needs of new clients before and after reforms. After the reforms, a greater proportion of new clients used Commonwealth Home Support Programme entry-level services on	Significant reduction in new HCP clients following implementation - those commencing the service were more likely to be younger and have a partner. More vulnerable Australians may have difficulty accessing services.

			uptake, use and cessation following Home Care Packages (HCP) allocation reforms for a large provider in New South Wales and Australian Capital Territory.			top of their HCP services compared to pre-reform clients. Service Cessation - A total of 4132 clients (new and existing) used services under the HCP program with the provider at some point between March 2016 and March 2018. On average, 15 clients chose to terminate services with the provider each month before the reforms (0.6% of all clients), and this did not change after ICHC (n=14, 0.6%).	
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Kajonius & Kazemi (2015)[25]	Sweden	National cross-sectional survey.	To investigate the relative importance of structure and process factors for older persons' perception of quality measured in terms of a global sense of satisfaction with their elderly care using Donabedian's model of structure (budget, staffing, equipment), process (all the acts of caregiving) and outcome (satisfaction).	n=57,687 for age 65 and older, living at home, majority female. n=43,310 for age 80 and older n=7,160 for ages 65-74 n=7,217 for ages 75-79	Nordic welfare model	Structural aspects of care showed zero to weak correlations with overall satisfaction with care. Small statistically significant positive relationship between budgets per capita and overall satisfaction with care in nursing homes. Moderate to strong associations between process variables (i.e. respect, information, and influence) and overall satisfaction with care were found. Among structural variables, the only significant predictor of overall satisfaction with care was staffing (b=0.24, P<0.001). Data analysed at the municipality level showed that process-related factors were more strongly associated with older persons' satisfaction in both home and nursing home care than structural factors.	Statistically significant ratings of respect, information sharing, and influence. Structural factors did not rate, likely because Sweden provides the structural conditions necessary for satisfaction with process conditions.
Kehoe MacLeod (2023)[22]	Canada	Thematic analysis.	To examine how clients and workers experienced care provision under the Ontario-based Seniors Managing Independent Living Easily (SMILE) program, as it was the site that most thoroughly adopted the independent contracting model of funding and service delivery in their provision of home care to older adults aging in place.	n=22 n=5 clients, recent emergency or unscheduled primary care use; the need for assistance with four or more instrumental activities of daily living (IADL); at least 75 years of age or living with a disease of aging; living alone or with a carer unable to consistently assist with IADLs; and risk of hospital or long-term care home admission within the next year.	Integrated Care is the overarching model of care with SMILE as a specialty program, an independent contracting model.	The use of independent contracting arrangements by integrated care programs can offer improved continuity of care (such as flexibility and consistent client-caregiver relationships) while simultaneously reinforcing precarious working conditions for care workers (such as lack of job security and benefits).	Themes - Continuity of care; Collaborative Decision making; Communication/joint working (specific to paid carers). Continuity of care meant having the same or small number of paid caregivers for a long period of time. "Fit" between client and paid carer is needed for a long-term care relationship. Collaborative decision making meant clients being directly involved in decisions about their care or workers being empowered to make decisions about their care work. Administrators confirmed that clients often experienced hiring dilemmas, explaining that they initially found the "idea" of having the choice about who to hire empowering but that in the end, most clients did not actually select their own workers. In the end, the independent contracting model seemed to reduce clients' sense of power and control over their care, instead of increase it, as clients either felt forced to undertake a task they were ill-equipped to manage or felt the need to shift the responsibilities associated with recruiting, hiring, and managing a care worker to a family member in order to participate in the program.

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Laragy & Vasiliadis (2022)[10]	Australia	Quasi-experimental pre-test, post-test, and qualitative thematic analysis mixed methods.	To examine effectiveness of Australia's self-management model to improve home care consumers' perceptions of their choice, control, and wellbeing. The secondary aim was to examine whether provider prior experience with self-managed packages significantly influenced consumers' perceptions of choice, control, and wellbeing.	Pre and Post survey n=60 Interviews (Pre & Post trial) - consumers n=9; carers n=13; joint consumer-carer n=2 Post trial consumers age ranged from 53-100 years with a median age of 82. Family carers are ranged from 38-97.	Government funded Home Care Packages (HCPs), Consumer-Directed.	Quality of Life - significant improvement post-trial. Quality of support and information - no significant pre-trial and post trial difference. Financial autonomy and control - significant improvement in understanding self-management, expectations and finances and payment method. Relational and psychological outcomes - no significant difference. Confidence to self-manage - no significant improvement.	Overall consumers and carers were positive about self-management. It is necessary to ask what factors contribute to self-management resulting in better outcomes and not if offering choice and control in self-management results in better outcomes. Consumers and carers need clear guidelines. Self-managed services require profound provider organizational change.
McCaffery, Gill, Kaambwa, Cameron, Patterson, Crotty, & Ratcliffe (2015)[27]	Australia	Discrete choice experiment.	To determine what features of consumer-directed, home-based support services are important to older people and their informal carers to inform the design of a discrete choice experiment and future consumer-direct care (CDC) model.	n=17 older people, all over 70 years of age, 10 lived alone. n=10 informal carers.	Consumer-directed care model, publicly subsidized home-care packages.	Information and knowledge - "[Information] is very fragmented."	Information and knowledge – "[Information] is very fragmented."
Moran, Glendinning, Wilberforce, Stevens, Nettens, Jones, Manthorpe, Knapp, Fernandez, Challis, & Jacobs (2013)[30]	United Kingdom	Randomized controlled trial and qualitative description.	This study aims to report on the impacts and outcomes for older people of an innovative cash-for-care pilot scheme (specifically, the English Individual Budget pilot project) in England. The study seeks to provide insights into the reasons why results show that older people spend most of their Individual Budget (IB) on personal care with less resources put towards social or leisure activities, and why the older people using IB have higher levels of psychological ill health, lower levels of wellbeing, and worse self-perceived health than older people in receipt of	Total n=959 Older people n=263 Interviews conducted with n=14 aged 60-74 years, n=26 aged 75 and older	Cash for Care Schemes - Direct Payments.	Higher levels of psychological ill health, lower levels of wellbeing, worse self-perceived health, increased choice and control, continuity of care worker, ability to reward some family carers, anxiety over responsibility of organizing self-support and budget.	Quantitative: older people spent IBs predominantly on personal care, had higher levels of psychological ill health, lower levels of wellbeing, worse self-perceived health than older people in receipt of conventional services. Qualitative: Plans for using IB - personal care and domestic support. Support planning (how to use IB) - most reported receiving some help. Potential advantages - those with IBs in place could see advantages such as continuity of support worker. Concerns about IB Increased choice and control, continuity of care worker, ability to reward some family carers, anxiety over responsibility of organizing self-support and budget. Conclusion - Cash for Care needs sufficient resources to purchase more care and advice in planning and managing a budget.

			conventional services.				
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Park, Miller, Tien, Sheppard, & Bernard (2014)[23]	Canada	Implementation research.	To demonstrate positive trends from an Integrated Primary Care Pilot in extending client survival time at home in the community.	Implementation of primary pare in home care for Seniors recovering in their own homes after a hospital stay. Sample – chronically ill patients of 50-60 family physicians – n not reported.	"Home is Best" strategy - acute care Medicine and the Home Health community programme work together to facilitate seniors recovering their health in their own homes after a hospital stay	Preliminary data - survival time in the community. Fraser Health pilot - There was a reported 33% decrease in patient visits to the emergency room and a 61% decrease in the hospitalisation of a group of Home Health clients as well as increased client satisfaction.	Preliminary Data - Evaluation of survival data one year into the pilot (2011) shows a tendency to live longer in community than two years previous.
Rostgaard & Szebehely (2012)[7]	Sweden and Denmark	Secondary data analysis.	To investigates the consequences of the two policy approaches for older people of different needs and socio-economic backgrounds and evaluate how the development corresponds with ideals of universalism in the Nordic welfare model.	n=1,158 total, community-dwelling older adults aged 67–87 years needing practical help. Denmark: n=827 respondents Sweden: n=331 respondents	Nordic welfare model.	Denmark: Higher rates of public home care use, especially for those with low needs. Sweden: Increased reliance on informal (family) care and privately purchased services. Both: Social class impacts care source - lower-educated individuals use more family care; higher-educated individuals purchase private care. Clients with high needs in both countries are likely to get the care they need. Suggests risks to equity and universality in Sweden's growing shift to a model of reliance on family.	None.
Smith, Grundy, & Nelson (2010)[28]	Australia	Case study participatory action research.	This case study aims to describe, from the analytic standpoint of community control and cultural comfort, the main features of the 'Family Model of Care', which underpins the operations of the service and Yuendumu Old Peoples Program (YOPP) management processes.	Community groups such as Old Peoples Forums, YOPP, Women's Centre and Steering Committee, Frontier Services (aged care provider).	Family Model of Care - for the people by the people.	The concepts of community control and cultural comfort are considered central to supporting older aboriginal people to remain in their home communities.	It is feasible to promote high levels of cultural comfort and community control in an Indigenous aged care setting, and that these characteristics should be used to assess quality of care in such a context, along with the accommodation of medical and mainstream aged care standards. YOPP supports older people to remain in community.
While, Winbolt, & Nay (2020)[29]	Australia	Constructivist grounded theory	To understand the lived experience of those receiving services in the home and its impact on the meaning of home.	n=29; 11 people with dementia (4 living alone), 18 family carers of people living with dementia (PLWD).	Consumer-Directed Home Care	Clients and families reported positive and negative characteristics of the care. Positive characteristics included teamwork and responsiveness offset by poor communication, service limitations and staff retention. Relationships between care recipients and care staff and trust are valued and absent with poorly trained and task-oriented staff.	None. .
Liveng (2011)[31]	Denmark	Ethnographic approach.	To investigate the needs, wishes and expectations in relation to home-based care of the elderly among the receivers of care with so-called 'complex problems'.	n=6 older clients and their caregivers (3 clients and 2 caregivers).	Nordic welfare model.	Analysis resulted in 3 themes; the elderly want: 1. To live as they have always done. Even though elderly persons have become weak, lost some functional abilities or are possibly ill or disabled, they wish to live as they always have, without changing their habits or routines.	None.

						2. To be respected as a responsible and competent human being in their own home, despite their need for help. 3. To be identified through the life they have lived and the interests they have had – and not through their illness, weakness, disability or abuse. Above all, the empirical data of the investigation reveal the tension between dependence and autonomy.	