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# How can interprofessional collaboration be fostered and sustained in team-based care integration for older people in community settings? A realist evidence synthesis

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## Abstract

**Background** Community-centred care integration for older adults is a cornerstone of the WHO's Integrated Care for Older People (ICOPE) implementation framework. Realising the potential of care integration for older people requires cohesive coordination of services and interprofessional collaboration (IPC) within and across teams. There is a gap in research evidence to understand how IPC can be fostered and sustained within team-based community care integration for older people. We report on a realist evidence synthesis to identify the contextual influences and mechanisms that support IPC in interprofessional community care teams for older people.

**Methods** The three phases of the realist synthesis included an exploratory scoping of research evidence and consultation with four local stakeholder groups to produce initial programme theories. The second phase involved systematic retrieval and synthesis of evidence, including peer-reviewed published empirical studies and grey literature recommended by an expert panel. The third phase involved the development of refined programme theory with stakeholder validation. The stakeholder cohorts included representatives of older people and caregivers, health-care professionals and operational managers of community specialist older person teams, national policymakers, and programme managers.

**Results** The resource and reasoning mechanisms that enable contexts for IPC and their associated outcomes are identified within seven programme theory areas: (1) professional identity and growth, (2) information sharing and care coordination across boundaries, (3) effective operational and clinical governance, (4) developing a team learning culture, (5) meaningful inclusion of older people and caregivers, (6) quality improvement and programme development, (7) workforce planning and retention.

**Conclusions** The results provide policymakers and clinicians with evidence-based programme theory that will catalyse critical dialogue on IPC implementation. This programme theory informs the prioritisation of resources to enable favourable contexts for successful IPC intervention development and implementation. This research complements

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and expands the work presented in the WHO ICOPE implementation framework. We encourage local realist application and evaluation of the programme theory within varying health system contexts.

**Keywords** Interprofessional collaboration, Older person, Integrated care, Healthcare teams, Interdisciplinary, Realist synthesis

## Background

A clear healthcare strategic commitment to enhanced community-based integrated care for older adults is largely influenced by the World Health Organization's Integrated Care for Older People Framework [1, 2]. Research has documented the impact of integrated care not only on health outcomes and healthcare utilisation but also on workforce capabilities and system enablers to support transitions to new ways of integrated working [3–7]. Enhanced coordination, cooperation, and collaboration within and across interprofessional teams consisting of multiple healthcare disciplines have been identified as a key priority when designing and implementing these new integrated models of care [8–10].

Multiple definitions and understandings relating to integrated care exist [3]. One example is 'processes of bringing organisations and professionals together, to improve outcomes for patients and service users through the delivery of integrated care' [11]. Ireland's health system reform envisions care integration as a horizontal and vertical coordination of services [12]. Horizontal coordination includes various professional, disciplinary, and departmental boundaries. Vertical coordination spans primary, secondary, and tertiary sectors. Effective care integration, particularly for people with complex needs or multimorbidity, requires coordination and interprofessional collaboration (IPC) across horizontal and vertical boundaries of care [13].

Interprofessional teamwork is widely accepted as important to enable quality, safe care integration for older people [10, 14]. A growing body of evidence supports the development of health system capacity and workforce planning for effective team-based IPC in older people's care integration [5, 8, 15]. This evidence provides knowledge on the capabilities required for interprofessional collaborative practices including open communication and information sharing, shared-decision making and psychological safety within the team [5, 15]. There remains a limited understanding of how IPC can be adopted and implemented effectively within team-based care integration for older people [8].

As researchers, we situate our understanding of IPC implementation as a complex and unpredictable social process that is context-dependent. Context forms the social and structural factors operating outside the intervention and characterise the conditions with which

patients, clinicians and healthcare practices operate. The conditions of context directly influence how an intervention works and the effectiveness of implementation efforts [16, 17]. Given the inextricable link between context and implementation, understanding context when building evidence to support implementation is critical. For this reason, realist reviews are favoured over systematic reviews that may limit their focus to effectiveness and overlook context, while the realist approach synthesises evidence to explain why an intervention works, how, for whom and importantly, in which contexts [18].

## Methods

### Objective

The research questions for this review were, 'what are the resources and reasonings that enable contexts for IPC and its associated outcomes in community care teams for older people? Why do these resources work in these contexts, and for whom do they work?' A realist approach facilitates the building of explanatory theories about what works and why to support interprofessional working in community care teams for older people and what could be the outcomes associated with this way of working. This theory-building approach involves the generation and iterative refinement of initial programme theories through the review and synthesis of evidence and stakeholder consultation. The five-step process described by Kantilal et al. [19] guided the realist synthesis. The phases of the process included exploratory scoping to support the development of initial programme theories (IPTs) (steps 1–2), a systematic retrieval and synthesis phase (steps 3–4) and finally the development of programme theories through the adjustment and refinement of IPTs (steps 5).

### Phase 1: exploratory scoping of the evidence

#### *Define the review parameters*

To verify the terminology and literature base relevant to interventions supporting IPC within healthcare teams integrating care with older people, an initial exploratory search was conducted between December 2022 and February 2023. An exploratory search strategy, developed by one review team member (DOD), was implemented in PubMed and CINAHL, focusing on evidence published within the preceding 5 years. The combined search results were deduplicated, and the titles and abstracts

of 4734 retrieved papers were screened by seven review team members (DOD, CD, ENS, GOD, MOS, SD, and ADB). This background search, for which parallel screening was not deemed necessary, identified 43 relevant papers, including reviews, commentaries, and primary empirical research. These papers were subsequently extracted to facilitate the generation of IPTs that would inform the parameters of the subsequent full search strategy and be progressed for stakeholder consultation [20].

A review of the evidence retrieved through the background search supported the construction of an exploratory descriptive cross-sectional survey administered to members of the 30-community specialist integrated care teams for older people in Ireland (ICPOP-CSTs), as well as the topic guide that was used for subsequent stakeholder consultations (see Additional files 1 and 2). The realist approach adopted for this study emphasised the role of local stakeholder perspectives to shape programme theory [20]. This replaced the need for a formal search for initial programme theories in the published evidence and ensured that the emerging theories are readily transferable to the national clinical programme model adopted in Ireland.

### ***Developing initial programme theories***

The research team developed IPTs from our team reflections on the findings from the background search of international evidence, the results of the exploratory descriptive survey of community specialist team members and the reflections from consultations with stakeholders.

We conducted an exploratory cross-sectional descriptive survey of members of the 30 ICPop-CSTs in Ireland [21]. This included administrative support staff, operational leads, clinical leads and healthcare professionals ( $N = 65$ ). The survey identified high levels of psychological safety and work engagement (vigour, dedication, and absorption) among the respondents as well as positive experiences of interprofessional teamwork. It also identified the respondents' perspectives on enablers and barriers to collaboration within their teams [21].

In addition to the survey, we consulted with four stakeholder groups to assist with the elaboration of the IPTs and to guide the subsequent process of the review. The following stakeholders attended the consultations:

1. Nine healthcare professionals representing various professions who are members of ICPop-CSTs coordinating care for older people (stakeholder 1).
2. Six operational leads representing six different ICPop-CST teams. This group is responsible for the operational governance of the teams (stakeholder 2).

3. Seven policy makers and programme managers from the Irish Health Service Executive, National Clinical Programme for Older People (NCPOP) (stakeholder 3).
4. Five public and patient representatives of older people and caregivers (stakeholder 4).

An expert panel was convened to review the IPTs. This panel ( $n = 10$ ) was composed of representatives from the Health Service Executive with responsibility for programme management within the national older person's service model, healthcare professionals with experience in service delivery for community care, representatives of third sector organisations representing older persons and caregivers and finally international academics with expertise in realist evaluation of health service innovation (see Additional file 3). The panel advised a modified iteration of the strategy developed for the background search to retrieve evidence relevant to the IPTs that would support further programme theory development. The expert panel also recommended key sources of grey literature to supplement the published evidence retrieved through the databases. The grey literature was targeted at supporting the transferability of the programme theory to the older person service model in Ireland.

### **Phase 2: systematic search and appraisal**

#### ***Search for evidence***

A systematic search strategy (see Additional file 4) was developed in collaboration with a university specialist librarian in the field of health sciences. Three concept strings were used to identify relevant keywords and database subject headings: older people, interprofessional teams and community. The search strategy was implemented in the following databases: Embase, CINAHL, and PubMed. The limits applied to the search of the databases included: articles published after 2013, keywords appearing in the title and/or abstract. An initial search was run until May 3, 2023, this was subsequently updated to March 24, 2025. We selected this timeframe for the retrieval of evidence to support the feasibility of the synthesis and the currency of the programme theory.

#### ***Select evidence for synthesis***

The review team used systematic methods for study screening and selection following the PRISMA guidelines [22]. 6311 articles were imported into Covidence from CINAHL ( $n = 1923$ ), PsycINFO ( $n = 622$ ), Embase ( $n = 2309$ ) and PubMed ( $n = 1457$ ), of which 1724 were duplicates. Using Covidence Systematic Review Software (Veritas Health Innovation, Melbourne, Australia, available at [www.covidence.org](http://www.covidence.org)), one reviewer (AR for initial search and SH for updated search) screened the titles

and abstracts of 3393 articles against the inclusion criteria. The reviewer recorded the rationale for the screening decision for each article that was then validated through extensive discussion with a second reviewer (DOD). This process supported parallel initial programme theory refinement.

This screening phase involved extensive dialogue between the reviewers (AR, SH and DOD) and iteration in developing screening criteria in parallel with the initial programme theory refinement [20]. The two theory concepts that provided the largest input into the side-by-side search strategy and theory iteration were a shared understanding of IPC and team-based community care for older people. The iterative nature of this phase of the search ensured a shared understanding of both these concepts emerged between the reviewers that was reflective of the evidence under review and in parallel supported refinement of the programme theory.

Following this iterative screening, 2918 articles were removed from the search retrieval as they were deemed not reflective of a shared conceptual understanding of IPC and team-based community care for older people relevant to the emerging programme theory. Title and abstract screening exclusion criteria included abstracts not published in the English Language, conference abstracts, theses or non-empirical papers. A further 15 articles were not retrieved resulting in 460 articles for full-text screening. The high number of articles excluded at this first round of screening reflects the highly iterative nature of this phase as the reviewers went back and forth between screening and conceptual development of the core IPT phenomena. It also reflects the lack of conceptual clarity for these two concepts in the first iteration of the IPTs and in the evidence retrieved. For example, a considerable proportion of excluded papers conceptualised IPC as collaborating across specialities within the same profession.

The review team ( $N=9$ ) met to develop extensive inclusion and exclusion criteria before full-text screening. These criteria reflected the core conceptual development that resulted from the previous screening phase, and they continued to be reviewed at regular intervals during the screening process to support iteration between the search strategy and the development of the programme theory. The inclusion criteria reflected an emerging conceptual understanding of the following: mechanisms that supported IPC, primary empirical research, interprofessional teams, and home-based community care, older people's care and supporting care transition to the community. The team screened the full-text articles working in dyads, whereby two reviewers screened every article. The wider team was consulted to settle arising conflicts regarding the inclusion of an article and considered these

discussions important opportunities to reflect on the development of core theory concepts and iteration of the search strategy.

Following the full-text screening, 419 articles were excluded as they did not align with the core concepts identified in the refined initial programme theory (Fig. 1), and 41 relevant articles were included for data extraction. As is often the case with realist reviews, studies were not objectively assessed for quality against a checklist; rather, studies were included in the synthesis based on their relevance to theory building and the rigour of the methods described to generate data [23].

### **Extract and synthesise data**

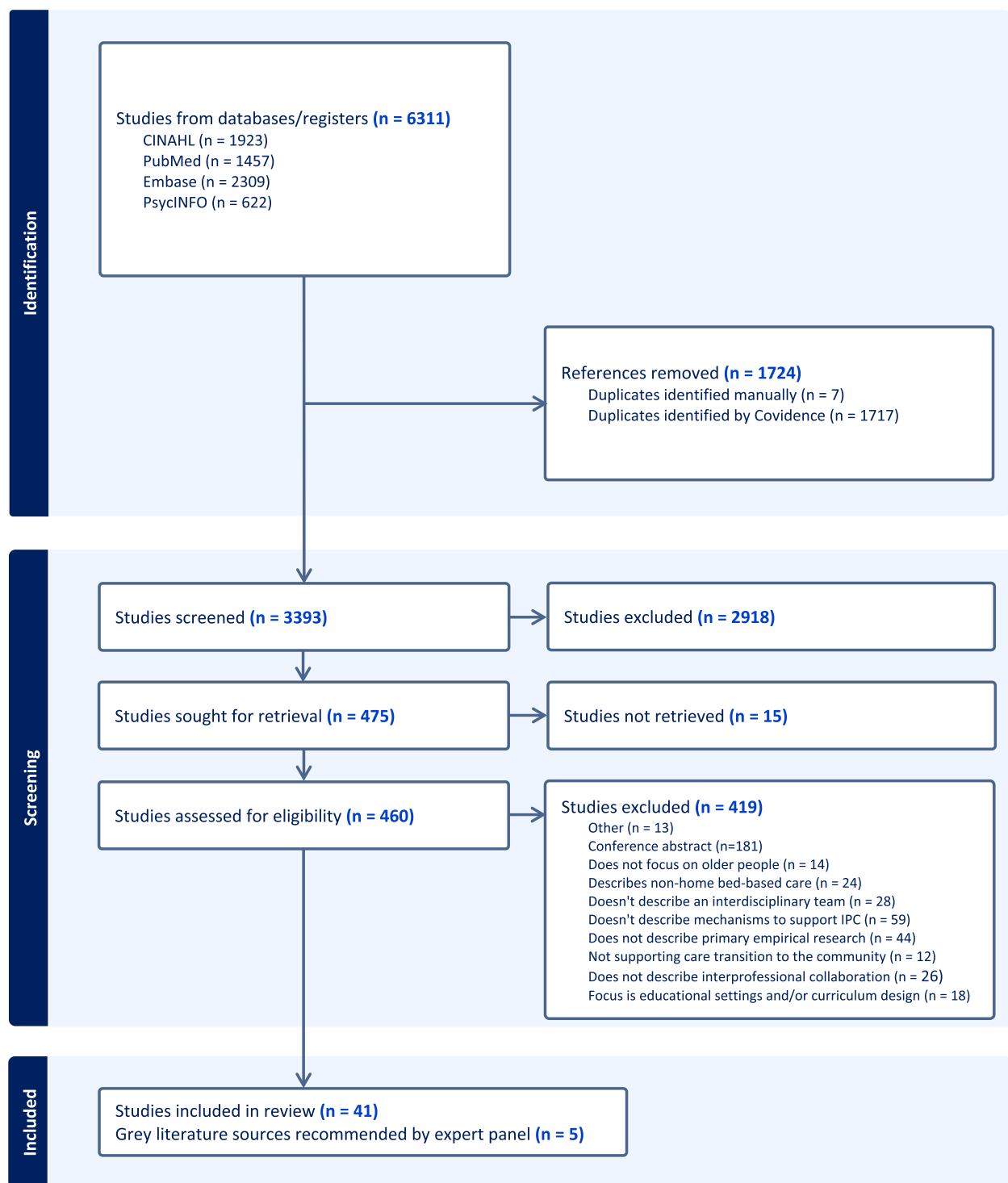
Two reviewers (DOD and AR) constructed a meta-data extraction form to provide an overview of the 41 papers included in the evidence synthesis. The meta-data extracted included year of publication and authorship as well as a description of the study aims, geographical location, study design and participants, team composition and service population. In addition, five sources of grey literature identified by the expert panel were added to the retrieved published evidence to support programme theory development and translation to the Irish older person health service model.

The wider review team met to identify criteria for in-depth data extraction to support the development of programme theory statements. A data extraction table was developed using the IPT statements identified in phase 1 of the study to assist with the identification of extraction themes. The following headings for evidence extraction were developed: description of the context for interprofessional teamwork, key resources, reasonings or explanations for causal relationships and outcomes. Eight members of the review team undertook data extraction working in dyads. The 41 papers and five sources of grey literature were divided among the four dyad groups. Each reviewer extracted their allocated papers and documents independently and then met with their dyad to discuss and agree on a merged extraction table.

### **Phase 3: development of programme theory**

Realist programme theories are abstract descriptions of the mechanisms generated within contexts in response to interventions and how they are assumed to cause different outcomes [24, 25]. These theories illustrate the relationships between contexts, mechanisms and outcomes and are expressed as context-mechanism-outcome configurations (CMOCs) [26].

One reviewer (DOD) assessed the four extraction tables to identify CMOCs for discussion and validation with the four stakeholder groups identified in phase 1 of the study. Consultations were held with each of the

**Fig. 1** PRISMA flow diagram

stakeholder groups where the CMOCs extracted from the evidence that was most relevant to the stakeholder group were restructured into programme theory (PT) under seven domains. In the final step, the PT was reviewed by

the expert panel for the study. The focus of the panel discussion was to prioritise PT for testing in a subsequent planned realist case study evaluation study [27].



## Results

### Initial program theory

The first phase of the study involved an exploratory scoping of evidence to generate initial programme theory (IPT). We generated 14 IPTs (Table 1) expressed as 'if...then...because' statements, theorising the relationship between resources and outcomes in community care settings for older people [25]. These statements underpinned the subsequent development of a systematic search strategy and the generation of refined programme theory in phases two and three.

Four of the IPTs were categorised as being relevant to enhancing team capabilities for interprofessional working in these community settings. The IPTs provided generative explanations for the resources and outcomes associated with team members having a strong professional identity and understanding of team roles (IPT1). The necessity to work across disciplinary boundaries was hypothesised to lead to expanded professional competence due to mutual respect and trust (IPT2). Furthermore, experience-based knowledge and understanding of the pathways of care for older people across care boundaries was identified as an important enabler of IPC (IPT3) as well as dedicated team-based interprofessional training and education (IPT4).

Three of the IPTs were categorised as enabling coherent operational governance and management within the teams. The necessity to align operational governance with a clearly defined service model was hypothesised to support local adaptation with core service fidelity (IPT5). Standardised referral pathways to and from the teams were considered to lead to enhanced system visibility and integration of care across sectoral boundaries (IPT6). It was observed that the role of the operational lead/manager required structural support to enable coherence between management, clinical supervision and the service model (IPT 7).

A further three IPTs were developed about the involvement of older people and caregivers in integrated interprofessional care planning. Meaningful inclusion and shared decision-making were considered to lead to increased goal clarity and more responsive and effective care plans (IPT 8). A case manager role was identified as a critical enabler of older people's involvement, as it was theorised to lead to improved communication and increased involvement in the development of the care plan for older people and caregivers (IPT9). Recognition of family carer needs in clinical assessment and care planning was theorised as improving carer outcomes through increased care confidence and ability to cope (IPT10).

Finally, four IPTs were generated to support the understanding of the resources and outcomes associated with national clinical programme design and workforce

planning. The importance of monitoring collaborative practices was theorised as supporting system evaluation and design by increasing workforce investment in a shared goal and purpose (IPT11). It was theorised that a process to enable feedback between management and workforce on system evaluation is important to identify opportunities for learning and successful implementation of programme development as it increases staff confidence (IPT 12). Workforce training and development to enable teams to learn from each other and psychological safety were theorised as important enablers for workforce development (IPT13). Finally, workforce planning to support IPC capacity was theorised to lead to increased job satisfaction, retention, and team cohesiveness as this model of care will attract specialist staff who are empowered to create and deliver the programme vision for care (IPT 14).

### Summary of evidence included for extraction and synthesis

The 14 IPTs formed the basis of the data extraction from the 41 published research studies retrieved through the systematic search strategy (Table 2). Most studies were mixed methods, followed by qualitative studies. The greatest proportion of papers came from Canada ( $n = 14$ ) followed by the USA ( $n = 10$ ) and the UK ( $n = 6$ ). European representation includes the Netherlands ( $n = 4$ ), Sweden ( $n = 3$ ), and Norway ( $n = 3$ ), with single studies from Switzerland and Denmark. There were also single studies from Chile, Australia and New Zealand.

Fourteen teams were in mixed urban and rural settings, with another 14 based in urban locations. Two teams were based in regional locations, and another two were rural based whilst one team was in a suburban location. It was unclear in five papers where the teams were based. Most of the papers did not outline the details of the referral pathways to and from the team ( $n = 26$ ). Six of the studies described referrals to the teams coming via discharge pathways from the acute or rehabilitation setting. Referral from primary or community care was outlined in seven studies whilst two outlined a self-referral process by an older person or a family carer.

Five sources of grey literature were purposively identified by the study expert panel, to provide additional insight into programme theory development (Table 3). The grey literature was identified following the presentation of the 14 IPTs developed during the first phase of the study. The panel identified sources aligned to IPTs on service model design, workforce development and planning, person-centred care planning and meaningful inclusion of older persons and family carers. This included two guidance documents developed by the Irish Health Service Executive [28] and the National Clinical

**Table 1** Initial programme theory (IPT) statements

#	If there is...	Then there is...	Because there is...
<b>Enhancing team capabilities</b>			
1	a strong professional identity for each team member with a clear understanding of team member roles	expanded professional competence as well as integrated care planning	role appreciation, empowerment, mutual respect and trust
2	working across disciplinary boundaries in joint case management while also maintaining discipline-specific specialism	strong professional identity among team members; increased staff empowerment, integrated care planning (across professions) and person-centred care	a fixed composition of interdisciplinary team members with time allocated during team meetings to discuss profession specific topics and present professional perspectives, allowing for a transference of professional skills across team members
3	experience-based network knowledge of local pathways of older person care across sectoral boundaries (primary, community and secondary)	improved communication and care coordination through appropriate referrals, care transitions and timely access to care	wider system awareness and knowledge of appropriate referral options for older people who have complex care needs. There is improved patient trust in the system (as team have shared information effectively), and there is clarity around the older person's care plan across healthcare professionals in different sectors
4	education, training and support for interprofessional collaboration	better understanding of each other's roles, enhanced personal practice, care coordination and patient care quality	a sense of being supported and psychological safety because they work in a learning environment. There is improved confidence and a sense of trust in team
<b>Operational Governance and Management</b>			
5	coherent governance and management that is aligned with the service model of care	effective system-wide implementation of the service model with fidelity to the core programme elements	Services that fit the need and particularities of the local contexts and localised ways of working
6	a standardized and well-understood referral pathway to access the team	increased care coordination, appropriate referrals and better information flow across boundaries of care (primary, to specialist community to secondary)	increased clarity on the role of the CST and an understanding of the criteria for referral
7	preparation, training and support for the role of the operational team lead which is underpinned by a vision for shared leadership	coherent governance aligned with a shared vision for the service and effective relationships within the team	alignment between operational supervision and the service model with opportunities for critical reflection and relational dialogue among team members
<b>Involvement of older people and family carers</b>			
8	meaningful inclusion of the older person and family carer in care planning	clarity on patient's goals, shared goal development, improved patient centred care and care plans are responsive to the older person's needs/preferences. This supports an effective therapeutic relationship and avoidance of hospital admissions	capability of team members in motivational interviewing and shared decision-making leading to patient trust and confidence in their care plan. Team members see the older person (and carer if relevant) as a resource so they are open to involving the older person
9	key or case manager role within the team	improved access to care for clients, greater patient and carer satisfaction, more timely and efficient care and better quality of life for carers	clearer communication and coordination between team members and patients develop a connection to healthcare staff on the team
10	routine assessment of carer needs where possible these needs addressed in the care plan	increased carer quality of life, reduction of stress and isolation	support for caregivers to access healthcare services, enhanced carer confidence, readiness, and ability to cope
<b>Iterative programme design and workforce planning</b>			
11	monitoring of interprofessional collaboration through performance metrics/Indicators	improved implementation processes with iterative service evaluation and development	motivation of the workforce to 'buy-in' to the service design and there is a shared purpose and goal within the team and within organisations

**Table 1** (continued)

#	If there is...	Then there is...	Because there is...
12	a feedback loop for system development with discussions between management, staff, and other service providers to negotiate new processes	increased opportunities for re-design of services and patient pathways to meet the needs of service population	there is increased confidence among those working in the service as well as service users
13	workforce training and development	upskilling of team members leading to an increased understanding of their own role as well as the roles of others. There is enhanced personal practice, care coordination and patient care quality	Teams learning from and supporting each other thereby increasing psychological safety, confidence, and sense of trust in the team
14	workforce planning which focuses on building capabilities for interprofessional working	increased job satisfaction and retention because there is an increase team cohesiveness, sense of ownership of a shared philosophy of care, and shared governance of the service	attraction of staff with specialist expertise and experience of older person's care. They are enabled and empowered to co-create the vision for the service



**Table 2** Meta data extraction of 41 papers included in synthesis

Title	Year of pub	Authors	Country in which the study was conducted	Aim of study	Study design	Methods for data collection	Which of the following population groups are contributing data to the study?	Total number of participants	Aim or purpose of the team	Which of the following roles are represented in the team?	Description of the older population serviced by the team	Team Setting
Improving transitional care communication for older Australians from hospital to home: Co-design of the TRANSITION tool.	2022	Allen, Huthchinson, Brown and Livingston	Australia	This study aimed to develop and evaluate a communication tool to guide transitional care for older patients.	Qualitative research	Interviews (individual); Focus groups	Nurse; Physician; Occupational Therapist; Pharmacist; Physiotherapist; Social Worker; Older person; Family carer/ informal carer	103	A multidisciplinary care team in acute care that is responsible for transitional care planning for older people.	Nurse; Occupational therapist; Pharmacist; Physiotherapist; Social worker	Other specific chronic illness (eg diabetes, COPD, cancer, hypertension, heart disease)	Urban
Relational coordination in inter-organizational settings. How does lack of proximity affect coordination between hospital-based and community-based healthcare providers?	2020	Bligaard Madsen & Burau	Denmark	The study examined relational coordination in relation to a collaboration between a hospital-based geriatric team and a community-based acute care team.	Qualitative research	Interviews (individual); Observation	Administrators/ Managers; Nurse; Other: Specialist geriatrician	7	Inter-organisational collaboration between a hospital-based geriatric team and a community-based acute care team offering home-based care for frail elders. The central goal is to prevent avoidable acute hospital admissions.	Operations management; Nurse; Other: Specialist geriatrician	Frailty	Urban
One Client, One Team: Health system integration for leaders.	2016	Daub, Goldhar and Purbhoo	Canada	This article describes the implementation of the strategy and integrated Client Care Program in Canada.	Mixed methods	Interviews (individual); Focus groups; Documentary analysis; Other: Time studies and longitudinal statistical analysis.	Other: Unknown	Unknown	The One Client, One Team is located in the Toronto Central Community Care Access Centre. The team provides functional integration at the point of care across providers from various sectors (primary care, specialty, acute care, complex continuing care, rehabilitation, Emergency Medical Services (EMS), social services, and others). The goal of the One Client, One Team approach is for the providers to act as one team, coordinating care based on what is most important to clients and their families and/or caregivers.	Other: Unknown	Other: Complex health conditions.	Urban

**Table 2** (continued)

Title	Year of pub	Authors	Country in which the study was conducted	Aim of study	Study design	Methods for data collection	Which of the following population groups are contributing data to the study?	Total number of participants	Aim or purpose of the team	Which of the following roles are represented in the team?	Description of the older population serviced by the team	Team Setting
Observations of community-based multidisciplinary team meetings in health and social care for older people with long term conditions in England.	2022	Douglas, Mays, Al-Haboubi, Manacorda, Thana, Wistow and Durand	UK	The study aimed to understand how multidisciplinary team meetings coordinate care and identify their 'added value' over bilateral discussions.	Other: Observational study	Observation	Administrators/Managers; Nurse; Occupational Therapist; Physiotherapist; Other: GP and mental health workers	N/A	The Health and Social Care integrated community-based MDTs involved in the study included primary and social care, allied health care professionals, and the community and voluntary sector. These professionals were involved in a shared process of care coordination. The sites sought to prevent hospital (re)admission or manage post-hospital discharge.	Administrator; Nurse; Occupational therapist; Physiotherapist; Other: GP and mental health workers	Other specific chronic illness (eg diabetes, COPD, cancer, hypertension, heart disease)	Other: The inner city and mixed urban-rural area
Care planning and decision-making in teams in Swedish elderly care: A study of interprofessional collaboration and professional boundaries.	2013	Duner	Sweden	The aim of this study was to examine professional collaboration and professional boundaries in interprofessional care planning teams.	Qualitative	Interviews (individual); Observation	Nurse; Occupational Therapist; Physiotherapist; Social Worker	N/A	The study included three teams responsible for performing care planning for older people. The teams performed care planning either at the hospital ward before the old people's discharge or in the homes of older people just after their discharge from hospital.	Nurse; Occupational therapist; Physiotherapist; Social worker	Falls risk; Frailty	Urban

**Table 2** (continued)

Title	Year of pub	Authors	Country in which the study was conducted	Aim of study	Study design	Methods for data collection	Which of the following population groups are contributing data to the study?	Total number of participants	Aim or purpose of the team	Which of the following roles are represented in the team?	Description of the older population serviced by the team	Team Setting
Crafting intermediate care: One team's journey towards integration and innovation	2015	Elbourne and May	UK	The study describe the work of a community-based nursing home intermediate care (IC) unit during its first 2 years of functioning and aims to evaluate the effectiveness of the model of care being used.	Mixed methods	Interviews (individual); Survey/questionnaire; Documentary analysis; Other: Activity data	Administrators/Managers; Nurse; Occupational Therapist; Physiotherapist; Social Worker; Older person; Other: Rehabilitation assistants, health care workers, key informants (charity's CEO, Centre Manager, Practice and Staff Development Manager)	12 staff, 4 key informants and 94 older people.	This paper describes one multi-disciplinary, multi-agency team's development of Person-Centred Intermediate Care (PCC) for older people. This development involved integrating three separate enterprises – a not-for-profit charitable organisation, a local primary health care trust and referring hospitals and their local social care providers. The team worked in a purpose-built unit housed in a Total Care Living complex.	Nurse; Occupational therapist; Physiotherapist; Social worker; Community/Social service provider	At risk of hospitalisation (risk not specified)	Other Sub-urban
Coordinating care for older adults in primary care settings: understanding the current context.	2018	Elliott, Stolee, Boscart, Giangregorio and Heckman	Canada	The aim of this study was to develop a deeper understanding of the current operations of two family health teams in Ontario, including their current processes for referrals, information sharing, and engagement of patients in decision-making.	Qualitative research	Interviews (individual); Focus groups	Nurse; Social Worker; Other: Care coordinator	30	Two primary care sites and a community care organisation that received referrals from the primary care centre. Community care providers represented organisations providing care including both community support services and home care services.	Nurse; Social worker; Other: Care coordinator	Other specific chronic illness (eg diabetes, COPD, cancer, hypertension, heart disease)	Mixed urban/rural

**Table 2** (continued)

Title	Year of pub	Authors	Country in which the study was conducted	Aim of study	Study design	Methods for data collection	Which of the following population groups are contributing data to the study?	Total number of participants	Aim or purpose of the team	Which of the following roles are represented in the team?	Description of the older population serviced by the team	Team Setting
Early findings from the evaluation of the Integrated Care and Support Pioneers in England.	2017	Erens, Wistow, Mounier-Jack, Douglas, Manacorda, Durand and Mays	UK	To identify the objectives, plans and activities of 25 Integrated Care pioneer sites and to assess the extent to which they have overcome barriers to integration.	Mixed methods	Interviews (individual); Survey/questionnaire; Documentary analysis	Administrators/Managers	197 (interview) and 98 (survey)	25 pioneer sites with responsibility to deliver improved patient experiences and outcomes; realise financial efficiencies; encompass whole system integration involving health, social care, public health and potentially other public services and the voluntary sector; and make central to their plans the Narrative on person-centred care.	Other: Unknown	Other specific chronic illness (eg diabetes, COPD, cancer, hypertension, heart disease)	Mixed urban/rural
Interdisciplinary Home Visits for Individuals with Advanced Parkinson's Disease and Related Disorders.	2018	Fleisher, Barbosa, Sweeney, Oyler, Lemen, Fazl, Ko, Meisel, Friede, Dacapano, Gilbert, Di Rocco, and Chodosh.	United States	This study details the success of a novel, interdisciplinary home visit program specifically designed for individuals with PD and related disorders and their family caregivers, built upon best practice principles in the care of multimorbid geriatric populations.	Other: Retrospective chart review	Patient records/charts	Older person	85	The team engages in a home visit program specifically designed for individuals with PD and related disorders and their family caregivers, built upon best practice principles in the care of multimorbid geriatric populations.	Nurse; Social worker; Other: one movement disorders neurologist and one movement disorders fellow	Other: Parkinson's disease and related disorders	Urban

**Table 2** (continued)

Title	Year of pub	Authors	Country in which the study was conducted	Aim of study	Study design	Methods for data collection	Which of the following population groups are contributing data to the study?	Total number of participants	Aim or purpose of the team	Which of the following roles are represented in the team?	Description of the older population serviced by the team	Team Setting
Understanding how context and culture in six communities can shape implementation of a complex intervention: a comparative case study.	2022	Gaber, Datta, Clark, Lamarche, Parascandolo, Di Pelino, Forsyth, Oliver, Mangin and Price.	Canada	This study aimed to explore and describe the nature of and differences between communities implementing Health TAPESTRY, a complex primary care intervention aiming to keep older adults healthier in their homes for longer.	Qualitative research	Interviews (individual); Focus groups	Older person; Other: Clinical managers, healthcare providers, volunteer coordinators, volunteer	135	Interprofessional primary care teams working with community volunteers to support older adult clients in staying healthier at home for longer	Administrator; Nurse; Pharmacist; Other: Physician	Frailty	Mixed urban/rural
The Kintun program for families with dementia: From novel experiment to national policy (innovative practice).	2020	Gajardo, Aravena, Budinich, Larrain, Fuentes and Gitlin	Other: Chile	The study outlines the lessons learned from implementing the Kintun programme.	Mixed methods	Other: Unknown	Other: Unknown	Unknown	The team is designed to enhance participation and engagement of persons with dementia and to help caregivers' and family's adaptation to the condition based on a comprehensive geriatric assessment.	Administrator; Nurse; Occupational therapist; Physiotherapist; Dietitian; Social worker; Other: Geriatrician and psychologist	Dementia	Urban
The effects of multi-disciplinary integrated care on healthcare utilization: Evidence from a natural experiment in the UK.	2021	Goldzahl, Stokes and Sutton	UK	To evaluate a common integrated care intervention, multi-disciplinary group (MDG) meetings for discussion of high-risk patients, introduced in one socio-economically deprived area in the UK	Non-randomised experimental study	Survey/questionnaire; Patient records/charts	Older person	Unknown	The team is a patient-facing, easily understandable form of vertical integration. The team engages in multi-professional group meetings, sharing information, discussing and care planning for pre-identified high-risk patient cases.	Nurse; Social worker; Other: GP, mental health professional and geriatrician	At risk of hospitalisation (risk not specified)	Urban

**Table 2** (continued)

Title	Year of pub	Authors	Country in which the study was conducted	Aim of study	Study design	Methods for data collection	Which of the following population groups are contributing data to the study?	Total number of participants	Aim or purpose of the team	Which of the following roles are represented in the team?	Description of the older population serviced by the team	Team Setting
The reablement teams' voice: a qualitative study of how an integrated multidisciplinary team experiences participation in reablement	2016	Hjelle, Skutle, Førland and Alvsvåg	Norway	The aim of this study was to explore and describe how an integrated multidisciplinary team in Norway experienced participation in reablement.	Qualitative research	Focus groups	Nurse; Occupational Therapist; Physiotherapist; Other: Social educator, auxiliary nurse and caring assistant	14	A multidisciplinary care team focused on improving independence and functioning of older adults through reablement services in a home dwelling environment	Nurse; Occupational therapist; Physiotherapist; Other: Social educator, auxiliary nurse and caring assistant	At risk of hospitalisation (risk not specified)	Rural
Reablement teams' roles: a qualitative study of interdisciplinary teams' experiences	2018	Hjelle, Skutle, Alvsvåg and Førland	Norway	This study's objective is to explore and describe the roles of interdisciplinary teams in reablement services in a Norwegian setting.	Qualitative research	Interviews (individual); Focus groups	Nurse; Occupational Therapist; Physiotherapist; Other: Social educator and home care personnel (auxiliary nurses and nursing assistants)	30	The reablement team focuses on the improvement of the person's function and coping of his or her valued daily activities. The health care professionals and the home care personnel are working together with the older person toward his goals. In reablement, health care personnel are organized in an interdisciplinary team and collaborate with the older person in achieving their goals.	Nurse; Occupational therapist; Physiotherapist; Other: Social educators, auxiliary nurses and caring assistants.	At risk of hospitalisation (risk not specified)	Mixed urban/rural



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Integrated Care for Frail Elderly: A Qualitative Study of a Promising Approach in The Netherlands.	2019	Hoedemakers, Leijten, Looman, Czaplonka, Kraus, Donkers, van den Henden, Wijlands, van den Broek and Rutten-van Molken	Netherlands	The goal of the current study was to gain a deeper understanding of this programme and how it was successfully put into practice in order to contribute to the evidence-base surrounding complex integrated care programmes for persons with multi-morbidity.	Qualitative research	Interviews (individual); Documentary analysis	Administrators/Managers; Older person; Family carer/Informal carer; Other: Initiators of the care programme, representatives of the payer organisations and medical and social care staff (discipline not specified)	11	The aim of the team is to support elderly with case and care complexity living at home with the best possible health and quality of life.	Nurse; Occupational therapist; Pharmacist; Physiotherapist; Speech and language therapist; Other: GP, elderly care physician, case worker dementia, psychologist and geriatrician	Frailty	Mixed urban/rural
Working towards integrated community care for older people: empowering organisational features from a professional perspective.	2015	Janssen, Snoeren, Van Regenmortel, and Abma	Netherlands	The study aims to detail how professionals experience the provision of integrated care in the community and the organisational features they identify as empowering during this cooperation process	Qualitative research	Interviews (individual); Focus groups; Observation	Administrators/Managers; Nurse; Physician; Other: Homecare worker and certified professional consultant on ageing	12	The team is a multidisciplinary geriatric team providing integrated care in the community.	Operations management; Nurse; Physician; Other: Homecare worker, certified professional consultant on ageing and case manager	Frailty	Other: Unknown
The interagency care team: A new model to integrate social and medical care for older adults in primary care.	2023	Kanne, McConnell, Disco, Black, Upchurch, Matters, Halpern, White, and Heflin.	United States	The purpose of this study was to describe and evaluate the impact of the ICT model on older adults and referring care practices over 2 years.	Mixed methods	Survey/questionnaire; Patient records/charts	Nurse; Older person; Family carer/informal carer; Other: primary care providers, Geriatric medicine and geriatric psychiatry	140	The team aims to improve health outcomes for older adults by developing a healthcare workforce that maximizes patient and family engagement, and by integrating geriatrics and primary care.	Nurse; Pharmacist; Community/Social service provider; Other: Primary Care Team and Care managers with health system's accountable care organization	At risk of hospitalisation (risk not specified)	Other: Unknown

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Integrated Care for Older People with Different Frailty Levels: A Qualitative Study of Local Implementation of a National Policy in Luton, England.	2023	Khan, Randhawa, and Hewson.	UK	The aim of this study was to gain a deeper understanding of the Luton Framework for Frailty and the factors that affect the implementation of a proactive integrated care service for older people with different frailty levels.	Qualitative research	Interviews (individual); Documentary analysis	Administrators/Managers; Physician; Pharmacist; Other: Programme leads, commissioners and geriatricians.	18	To implement the Luton Framework (LFF) programme which targets older residents of Luton and offers interventions according to their frailty level	Physician; Dietitian; Other: The falls prevention team, palliative care team, care coordinator and a consultant from the Department of Medicine for The Elderly at the hospital.	Frailty	Urban
Collaborative Falls Prevention: Interprofessional Team Formation, Implementation, and Evaluation.	2016	Lasater, Cottrell, McKenzie, Simonson, Morgove, Long, and Eckstrom.	United States	This article describes how the interprofessional teaching team came together to use a unique cross-training approach to teach each other and to foster the integration of team-based falls prevention strategies into practice.	Qualitative research	Interviews (individual); Documentary analysis	Nurse; Physician; Pharmacist; Social Worker	25 community practice teams.	A community practice team implementing a falls-prevention strategy.	Nurse; Physician; Pharmacist; Social worker	Falls risk	Mixed urban/rural
Complex caring needs without simple solutions: the experience of interprofessional collaboration among staff caring for older persons with multimorbidity at home care settings.	2017	Larsen, Broberger and Petersson	Sweden	The aim of this study was to illustrate how various professionals belonging to homemaker services, home care services in municipality and hospital-based home care services experience collaboration in caring for older persons with multimorbidity	Qualitative	Interviews (individual)	Administrators/Managers; Nurse; Physician; Occupational Therapist	11	The team involves interagency collaboration between professionals in primary health care, municipality home care services (MHCS), municipality homemaker services (MHMS) and hospital-based home care service (HBHCS) for patients in home health care.	Administrator; Nurse; Occupational therapist; Physician	At risk of hospitalisation (risk not specified)	Other: Unknown

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Healthcare providers' intentions to engage in an inter-professional approach to shared decision-making in home care programs: A mixed methods study.	2013	Légaré, Stacey, Brière, Fraser, Desroches, Dumont, Sales, Puma, and Aubé.	Canada	sought to evaluate health professionals' intentions to engage in a interprofessional approach to shared decision-making in home care and explore the factors associated with this intention.	Mixed methods	Interviews (individual); Focus groups; Survey/questionnaire	Administrators/Managers; Nurse; Physician; Occupational Therapist; Physiotherapist; Dietitian; Social Worker; Other: Home support worker and activities coordinator.	282	The team is a home care team focusing on elderly care and clinical issues with high prevalence.	Administrator; Operations management; Nurse; Occupational therapist; Physician; Physiotherapist; Dietitian; Social worker; Other: Home support worker and activities coordinator.	Frailty	Urban
Teambuilding across healthcare professions: the ELDER project.	2014	Mager and Lange.	United States	The purpose of this study is to improve communication and teamwork among interprofessional health care providers (HCPs) by using innovative teambuilding activities over three years.	Mixed methods	Survey/questionnaire; Other: Interactive sessions	Nurse; Occupational Therapist; Physiotherapist; Speech and Language Therapist; Social Worker; Other: Nursing assistants, pastoral personnel and dietary personnel.	97	The interprofessional healthcare providers work within long term and home care settings for older adults.	Nurse; Occupational therapist; Physiotherapist; Speech and language therapist; Social worker; Other: Nursing assistants, pastoral personnel and dietary personnel.	At risk of hospitalisation (risk not specified)	Other: An underserved region of New England.
Falls prevention education: Interprofessional training to enhance collaborative practice.	2017	McKenzie, Lasater, Delander, Neal, Morgove, and Eckstrom.	United States	This article describes a project that engaged an interprofessional teaching team to support interprofessional practice teams to reduce falls in older adults via implementation of evidence-based practice guidelines	Qualitative	Interviews (individual); Survey/questionnaire; Other: Workshops	Administrators/Managers; Nurse; Physician; Occupational Therapist; Pharmacist; Physiotherapist; Social Worker; Other: Nursing assistants, medical assistants, activities directors and pastoral services.	Unknown	The teams were interprofessional practice teams working within ambulatory, long term care, hospital, and home health practice settings.	Administrator; Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Social worker; Community/Social service provider; Other: Nursing assistants, medical assistants and an activities directors.	Falls risk	Mixed urban/rural

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A nurse-led interdisciplinary primary care approach to prevent disability among community-dwelling frail older people: A large-scale process evaluation.	2013	Metzelthin, Daniels, van Rossum, Cox, Habets, de Witte, and Kempen	Netherlands	This study examines the extent to which the interdisciplinary care approach is implemented as planned and to gain insight into healthcare professionals' and frail older people's experiences regarding the benefits, burden, stimulating factors and barriers.	Mixed methods	Interviews (individual); Focus groups; Other: Logbooks and evaluation forms	Nurse; Physician; Occupational Therapist; Physiotherapist; Older person	239	The team works as part of an interdisciplinary primary care approach, involving individualized assessment and interventions (tailor-made care), case management and long-term follow-up. The practice nurse as part of a general practice is the case manager and plans, organizes and monitors the care process and facilitates cooperation between professionals.	Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Social worker; Other: geriatrician and home care providers	Falls risk; Frailty; Mental health	Other: South of the Netherlands
Working with/hands-off support: a qualitative study of multidisciplinary teams' experiences of home rehabilitation for older people.	2014	Randström, Wengler, Asplund, and Svedlund.	Sweden	The aim of the study was to explore multidisciplinary teams' experiences of home rehabilitation for older people.	Qualitative research	Focus groups	Nurse; Occupational Therapist; Physiotherapist; Other: Nurse assistant, home helper, home help officers responsible for needs assessment and home help officers in charge of home help.	28	The team performed rehabilitation services within a geographically defined area in the municipality for older people with illnesses and injuries.	Nurse; Occupational therapist; Physiotherapist; Other: Nurse assistant, home helper, home help officers responsible for needs assessment and home help officers in charge of home help.	At risk of hospitalisation (risk not specified)	Mixed urban/rural

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Geriatrics, interprofessional practice, and interorganizational collaboration: a knowledge-to-practice intervention for primary care teams.	2013	Ryan, Barnett, Cott, Dalziel, Gutmanis, Jewell, Kelley, Liu, and Puxty.	Canada	The study conducted a knowledge-to-practice process to increase the capacity and skills of newly created family health teams and longer standing Community Health Centers caring for frail seniors.	Mixed methods	Focus groups; Survey/questionnaire; Other: Workshops	Administrators/Managers; Nurse; Physician; Occupational Therapist; Pharmacist; Physiotherapist; Social Worker; Other: health promoter/navigator	187	In Family Health Team's (FHTs), solo primary care physicians agree to collaborate and serve a roster of enrolled patients together with a team of allied health professionals. FHTs join more long-standing community health centers (CHCs), in which physicians are salaried members of interprofessional teams focused on hard-to-serve communities. Both are intended to provide a more holistic, team-based approach to primary care. These elements of primary care reform promise a significant impact on the care of frail seniors who require a team approach to care.	Administrator; Operations management; Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Social worker; Other: health promoter/navigator	Frailty	Mixed urban/rural

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Enacting Fall Prevention in Community Outreach Care.	2014	Shaw, Connelly, and McWilliam.	Canada	The purpose of this study was to explore the meaning of the experience of enacting fall prevention among members of an interprofessional geriatric outreach team.	Qualitative research	Interviews (individual)	Nurse; Occupational Therapist; Physiotherapist; Social Worker	6	The geriatric-specific community outreach team affiliated with a large rehabilitation hospital in Ontario, Canada. On this team, outreach practitioners were provided with referrals primarily from family physicians, and were then responsible for completing a comprehensive geriatric assessment of physical, mental, and social well-being.	Nurse; Occupational therapist; Physiotherapist; Social worker	Falls risk	Urban
Identification of Implementation Strategies Using the CFIR-ERIC Matching Tool to Mitigate Barriers in a Primary Care Model for Older Veterans.	2023	Shin, Montano, Adjognon, Harvey, Solimeo, and Sullivan.	United States	The study aimed to identify barriers to GeriPACT implementation and strategies to address these barriers using the Consolidated Framework for Implementation Research—Expert Recommendations for Implementing Change (CFIR-ERIC) Matching Tool.	Qualitative research	Survey/questionnaire	Administrators/Managers; Nurse; Physician; Occupational Therapist; Pharmacist; Physiotherapist; Dietitian; Social Worker; Other: Psychiatrist/geropsychiatrist, psychologist, physician assistant and health technician.	197	The Geriatric Patient-Aligned Care Team is a patient-centered medical home for older adults with complex care needs that provides specialized primary care to Veteran patients with multiple chronic conditions.	Administrator; Nurse; Pharmacist; Dietitian; Social worker; Other: Geriatrician, a registered nurse care manager and a mental health provider	Other specific chronic illness (eg diabetes, COPD, cancer, hypertension, heart disease)	Other: Unknown



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Interdisciplinary frontline teams in home-based healthcare services-paradoxes between organisational work structures and the trust model: a qualitative study	2023	Slåtveen, Wibe, Halvorsrud and Lund	Norway	This study aims to explore how organisational work structures influence the delivery of interdisciplinary home-based healthcare services (trust model).	Qualitative research	Interviews; Focus groups; Observation	Administrators/Managers; Nurse; Occupational Therapist; Physiotherapist; Other: Healthcare worker and Purchase unit employee	10 (interview) 25 Focus Group	The community interdisciplinary team is implementing a trust model which is reorganising home care services to be delivered by smaller interdisciplinary front-line teams with the purpose of creating more flexible and individually tailored services for older people.	Operations management; Nurse; Occupational therapist; Physiotherapist; Social worker; Other: other healthcare professionals and purchaser unit employee.	Older people and their caregivers who are receiving home-based healthcare services.	Mixed urban/rural
Evaluation of Technology Use in an Inter-Disciplinary Patient-Centered Health Care Team.	2019	Smaraodottir and Fensli.	Norway	This paper presents an evaluation on the technology support in a patient-centered health care team providing services to elderly people with chronic conditions and multi-morbidities in the transition from hospital to a home setting.	Qualitative research	Interviews (Individual); Observation	Nurse; Physician; Occupational Therapist; Physiotherapist; Older person; Family carer/Informal carer; Other: Technician	23	The patient-centered health care team was physically placed at a university hospital that was divided into two locations and financed by both municipalities and the hospital trust fund. The team was established to support elderly people with chronic conditions and multi-morbidities in the transition from hospital to a home setting, also including other patient groups that could benefit from the services.	Administrator; Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Other: Research staff	Other specific chronic illness (eg diabetes; COPD, cancer, hypertension, heart disease)	Urban

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It makes you feel more like a person than a patient': patients' experiences receiving home-based primary care (HBPC) in Ontario, Canada.	Smith-Carrier 2017	Smith-Carrier, Sinha, Nowaczynski, Akhtar, Seddon, and Pham.	Canada	The purpose of this study was to explore the experiences of patients accessing HBPC delivered by interprofessional teams, and their perspectives on the facilitators and barriers to this model of care in Ontario, Canada.	Qualitative research	Interviews (individual)	Older person	26	The home-based primary care team is characterised by (i) the provision of ongoing home-care services and primary medical care through a fully integrated interprofessional care team, led by a primary care provider; (ii) regular communication among team members to create care plans (based on multidimensional geriatric assessments at intake) that allow patients to remain in their homes with a high quality of life (QoL) by maximising their independence and function; (iii) after-hours availability for urgent issues; and (iv) a focus on reducing hospital admissions and emergency department (ED) visits.	Administrator; Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Dietitian; Social worker; Other; Care navigator, programme Co-ordinator, home care co-ordinator, geriatrician, psychiatrist, team co-ordinator	Frailty	Urban

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'It's not just the word care, it's the meaning of the word... (they) actually care: Caregivers' perceptions of home-based primary care in Toronto, Ontario	2018	Smith-Carrier, Pharm, Akhtar, Seddon, Nowaczynski, and Sinha.	Canada	The purpose of this study was to explore unpaid caregivers' perceptions of and experiences with home-based primary care programmes in Toronto, Canada.	Qualitative research	Interviews (individual)	Family carer/ informal carer	14	The team consists of health-care providers who work together with the patient and her/his family and/or care-givers to formulate an individual care plan that would ensure the ongoing monitoring and treatment of the patient's medical concerns, as well as the coordination of home and community care services that enable the patient to live safely at home.	Nurse; Occupational therapist; Physician; Pharmacist; Dietitian; Social worker; Other: Personal support worker	Frailty; Dementia; Other specific chronic illness (eg diabetes, COPD, cancer, hypertension, heart disease)	Urban
A systematic process for creating and appraising clinical vignettes to illustrate interprofessional shared decision making.	2014	Stacey, Brière, Robitaille, Fraser, Desroches, and Légaré.	Canada	The study aimed to create and appraise theory-based vignettes for illustrating an interprofessional approach to shared decision making (IP-SDM) for health professionals.	Mixed methods	Survey/questionnaire; Other: Workshop	Administrators/Managers; Nurse; Physician; Occupational Therapist; Physiotherapist; Dietitian; Social Worker; Other: Clinical Ethicist	29	The team was a home care team.	Administrator; Operations management; Nurse; Occupational therapist; Physician; Physiotherapist; Dietitian; Social worker; Other: Clinical Ethicist	Other: Unknown	Urban
Implementation of a Workflow Initiative for Integrating Transitional Care Management Codes in a Geriatric Primary Care Practice.	2018	Steckbeck, McBain, Terrien, Isom, Stadler, Stahl, and Batsis.	United States	The study aimed to establish a formal process to integrate a Transitional Care Management service.	Other: Descriptive study	Patient records/charts; Other: Meetings	Administrators/Managers; Nurse; Physician; Other: flow staff	Unknown	The team is responsible for transitional care management for patients following an acute hospital or nursing home discharge to the home-based community setting.	Administrator; Nurse; Physician; Other: Care managers and flow staff.	At risk of hospitalisation (risk not specified)	Rural

**Table 2** (continued)

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Using information communication technology in models of integrated community-based primary health care: learning from the iCOACH case studies.	2018	Gray, Barnsley, Gagnon, Belzile, Kenney, Shaw, Sheridan, Nij, and Wodchis.	Other: New Zealand and Canada	The study draws on data from an international study of integrated models, exploring how ICT is used to support activities of integrated care and the organizational and environmental barriers and enablers to its adoption	Qualitative research	Interviews (individual)	Administrators/Managers; Nurse; Physician; Pharmacist; Dietitian; Social Worker; Other: Physician assistants, and personal support workers	137	The teams are part of integrated community-based primary health care models across three jurisdictions, Ontario and Quebec in Canada and New Zealand.	Operations management; Nurse; Physician; Pharmacist; Dietitian; Social worker; Other: Physician assistants, and personal support workers	At risk of hospitalisation (risk not specified)	Mixed urban/rural
Implementation of the Geriatric Patient-Aligned Care Team Model in the Veterans Health Administration (VA).	2018	Sullivan, Eisenstein, Price, Solimeo, and Shay.	United States	The study describes the implementation of a specialty primary care medical home (PCMH) model called Geriatric Patient-Aligned Care Teams (Geriatric PACT) in the Veterans' Health Administration (VA) that is focused on serving older complex patients.	Cross sectional study	Survey/questionnaire	Administrators/Managers; Nurse; Physician; Occupational Therapist; Pharmacist; Physiotherapist; Dietitian; Speech and Language Therapist; Social Worker; Other: Clerical associate, physician assistant, nurse aide and a chaplain	44	Geriatric PACT provides frail, elderly patients and their caregivers access to the most appropriate care for their health care needs through a single point-of-contact for geriatric primary care.	Administrator; Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Psychologist; Dietitian; Speech and language therapist; Social worker; Other: Clerical associate, nurse aide and a chaplain	Other: Elder veterans with complex needs.	Urban

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The IMPACT clinic: innovative model of interprofessional primary care for elderly patients with complex health care needs.	2013	Tracy, Bell, Nickell, Charles, and Upshur.	Canada	The article describes the pilot evaluation of the Interprofessional Model of Practice for Aging and Complex Treatment model.	Other: Descriptive article	Survey/questionnaire	Nurse; Physician; Occupational Therapist; Pharmacist; Physiotherapist; Dietitian; Social Worker; Older person	32 Family Health Sites and 42 patients.	The primary objective of the IMPACT (Interprofessional Model of Practice for Aging and Complex Treatments) team was to design and evaluate a new interprofessional model of care for community-dwelling seniors with complex health care needs. A secondary objective was to explore the potential of this new model as an interprofessional training opportunity.	Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Dietitian; Social worker	At risk of hospitalisation (risk not specified)	Other: Unknown
Health TAPESTRY: co-designing interprofessional primary care programs for older adults using the persona-scenario method.	2019	Valaitis, Longaphy, Ploeg, Agarwal, Oliver, Nair, Kastner, Avilla, and Dolovich	Canada	The purpose of this paper is to explore how a modified approach to the persona-scenario method was used to co-design a complex primary health care intervention (Health TAPESTRY) by and for older adults and providers and the value added of this approach.	Persona-scenario method	Workshops	Nurse; Physician; Occupational Therapist; Pharmacist; Older person; Other: Patient navigators, representatives from community care providers and volunteers	70	Health TAPESTRY (Teams Advancing Patient Experience: Strengthening Quality) is a primary care innovation aimed at promoting optimal aging for Canadians through the integrated use of: trained community volunteers, technology, interprofessional primary care teams, and community engagement to support system navigation.	Administrator; Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Psychologist; Dietitian; Community/Social service provider; Other: System navigator, volunteers and a volunteer coordinator.	Other specific chronic illness (eg diabetes, COPD, cancer, hypertension, heart disease)	Urban

**Table 2** (continued)

Title	Year of pub	Authors	Country in which the study was conducted	Aim of study	Study design	Methods for data collection	Which of the following population groups are contributing data to the study?	Total number of participants	Aim or purpose of the team	Which of the following roles are represented in the team?	Description of the older population serviced by the team	Team Setting
Examining Inter-professional teams structures and processes in the implementation of a primary care intervention (Health TAPESTRY) for older adults using normalization process theory.	2020	Valaitis, Cleghorn, Dolovich, Agarwal, Gaber, Manning, Oliver, Parascandalo, Ploeg, and Risdon.	Canada	This paper examines the implementation of Health Advancing Patient Experience: Strengthening Quality in relation to interprofessional teamwork including volunteers.	Qualitative research	Interviews (individual); Focus groups; Observation	Administrators/Managers; Nurse; Physician; Occupational Therapist; Pharmacist; Physiotherapist; Dietitian; Older person; Other; Psychologist, system navigator, volunteers and a volunteer coordinator.	96	Health Teams Advancing Patient Experience: Strengthening Quality [Health TAPESTRY] is a primary care intervention aimed at supporting older adults that involves trained volunteers, interprofessional teams, technology, and system navigation.	Administrator; Nurse; Occupational therapist; Physician; Pharmacist; Physiotherapist; Psychologist; Dietitian; Community/Social service provider; Other: System navigator, volunteers and a volunteer coordinator.	Other specific chronic illness (eg diabetes, COPD, cancer, hypertension, heart disease)	Urban
Community mental health teams for older people in England: Variations in ways of working.	2018	Verbeek, Worden, Wilberforce, Brand, Tucker, Abendstern, and Challis.	UK	This study portrays integrated community mental health teams in 2009 against which subsequent service provision may be compared.	Cross sectional study	Survey/questionnaire	Other: Unknown	376 Community Mental Health Teams	Community mental health teams (CMHTs) for older adults are a specialist service for psychiatric support in later life.	Operations management; Nurse; Occupational therapist; Physician; Physiotherapist; Psychologist; Dietitian; Speech and language therapist; Social worker; Other: Psychiatrist and support worker.	Mental health	Mixed urban/rural
Membership and management: structures of inter-professional working in community mental health teams for older people in England.	2013	Wilberforce, Tucker, Abendstern, Brand, Glebel, and Challis.	UK	This paper aims to provide a thorough examination of community mental health teams' membership and management arrangements.	Cross sectional study	Survey/questionnaire	Other: Unknown	376 community mental health teams	Community mental health teams (CMHTs) for older people are a specialist service meeting the mental health needs of later life. Their precise remit depends on other locally available community services, such as memory clinics, specialist, domiciliary care, and/or care home outreach services.	Nurse; Occupational therapist; Physiotherapist; Psychologist; Dietitian; Speech and language therapist; Social worker; Other: Support workers and assistant social care workers.	Mental health	Mixed urban/rural



**Table 3** Grey literature purposively identified to support programme theory development and translation to the Irish community health service model for older people

	Title	Year of publication	Organisation/authors	Country	Summary
1	Operational Guidance for Older Person Community-Based Multi-Disciplinary Teams	2021	National Integrated Care Programme for Older Persons, HSE	Ireland	Guide for clinical leaders and healthcare professionals: Ensure consistent implementation of the Older Person Service Model, fostering interdisciplinary collaboration for optimal outcomes
2	Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment	2016	National Clinical Programme for Older People (NCPOP)	Ireland	Practical guide for healthcare professionals, promoting thorough assessments for frail older patients, ensuring equitable access to geriatric expertise
3	The practice of collaborative leadership Across health and care services	2023	Nicola Walsh, Stephanie de Sarandy, The King's Fund	UK	Report: England's integrated care systems need collaborative staff, emphasizing shared leadership for creativity and effectiveness
4	Integrated care for older people Guidelines on community-level interventions to manage declines in intrinsic capacity	2017	WHO	Geneva	Promotes lifelong well-being, identifies early declines in intrinsic capacity, provides guidance for managing declines, and enhances primary care services
5	Guidance on person-centred assessment and pathways in primary care: Handbook	2019	Integrated Care for Older People (ICOPE), WHO	Geneva	The handbook aids community health workers in implementing ICOPE recommendations, offering pathways for managing health declines in older individuals, and integrating personalized care plans

Programme for Older People (NCPOP) [29] to support the implementation of specialist older person interprofessional teams into the national service model for older people and the capability development of healthcare professionals working in these teams. The panel also identified a King's Fund report on the practice of collaborative leadership that provided insight from the perspectives of healthcare leaders on developing capabilities for collaborative team-based working [30]. Furthermore, two WHO Integrated Care for Older People (ICOPE) reports provided guidelines for healthcare professionals for person-centred care planning with older people in community or primary healthcare settings [1, 31].

### Programme theory refinement

Context-mechanism-outcome configurations (CMOCs) were generated from the extracted data and brought to stakeholder consultations for refinement of the programme theories. Consideration was given to the disaggregation of mechanisms to ascertain the resources which are offered by the intervention and which are enabled by contexts, and how the experience of these resources changes the reasoning of the team members. This disaggregation is recommended by Dalkin et al. [32] to support the operationalising of programme theory by policymakers and system designers. Following consultation with the stakeholder groups, the CMOCs were categorised into seven programme theories. The realist programme theories are presented as CMOC statements that support IPC in interprofessional community care teams for older people. They highlight the resources that foster favourable contexts and reasonings that lead to positive outcomes related to IPC and associated with improvements in health service delivery and older person care.

### Programme theory A: professional identity and growth

This programme theory is concerned with a strong professional identity and growth with a clear understanding of team member roles as critical to establishing effective interprofessional teamwork. This was supported by 17 studies retrieved from the systematic search [33–49], three sources of grey literature [28–30] and from two stakeholder groups (1 and 2).

In contexts where teams are given the opportunity for dedicated 'professional space', regular team meetings where every team member has an equal opportunity to participate and a structured framework for a common assessment (resource), team members are enabled to articulate their professional perspective on patient cases and their contribution to care (context). Dedicated space, common assessment frameworks and regular team meetings create conditions for team members to have

an enhanced appreciation of each other's role as well as expose them to functional areas that are less familiar to them, fostering positive team relations through increased intra-team dialogue (reasoning), which in turn strengthens professional identity and growth to deliver effective IPC aligned to a common purpose. These outcomes promote satisfaction within the team and for the client receiving care. This programme theory is depicted in Fig. 2.

### Supporting evidence

Duner's study [34] involving two care planning teams for older people explains that role clarity enables 'disciplines taking on tasks of other professions' without perceiving a 'blurring of professional boundaries'. In turn, it was reported that effective IPC can lead members to feel 'more security in one's professional role' and deepen an understanding of one's role through understanding the role of other team members. Smith-Carrier et al. [33] found that role clarity enables 'much richer ideas in terms of strategies because different team members bring their different perspectives, training and creativity'.

The HSE multidisciplinary team operational guidance document [28] recommended weekly team meetings for case discussions, noting that this can be a mechanism for sharing disciplinary expertise, experience and skill sets for all team members, supporting collaborative problem solving and organising services around user needs. Slåtveen et al. [49] found that a discrepancy in work structures for different professional roles resulted in unequal capacity across team members to attend interdisciplinary team meetings hindering IPC. In their evaluation of team structures and processes, Valaitis et al. [47] highlighted the benefit of team meetings for improving interprofessional team collaboration and providing a greater understanding of clinicians' roles and skill sets:

*For me, a neat thing is the inter-professional team and seeing what everybody else has to offer or bring to the table, looking at a patient and having a fresh set of eyes look at a patient's chart from different angles. [...] As a clinician in the team, seeing what everybody else does and appreciating that; how much added benefit it can bring to a patient versus just one person looking at a patient or the same person looking at that patient's chart all the time (47 page 9).*

Role clarity was shown to support the development of a group identity within interprofessional teams. The King's Fund report on the practice of collaborative leadership [30] noted the importance of developing a shared purpose and team identity to promote a

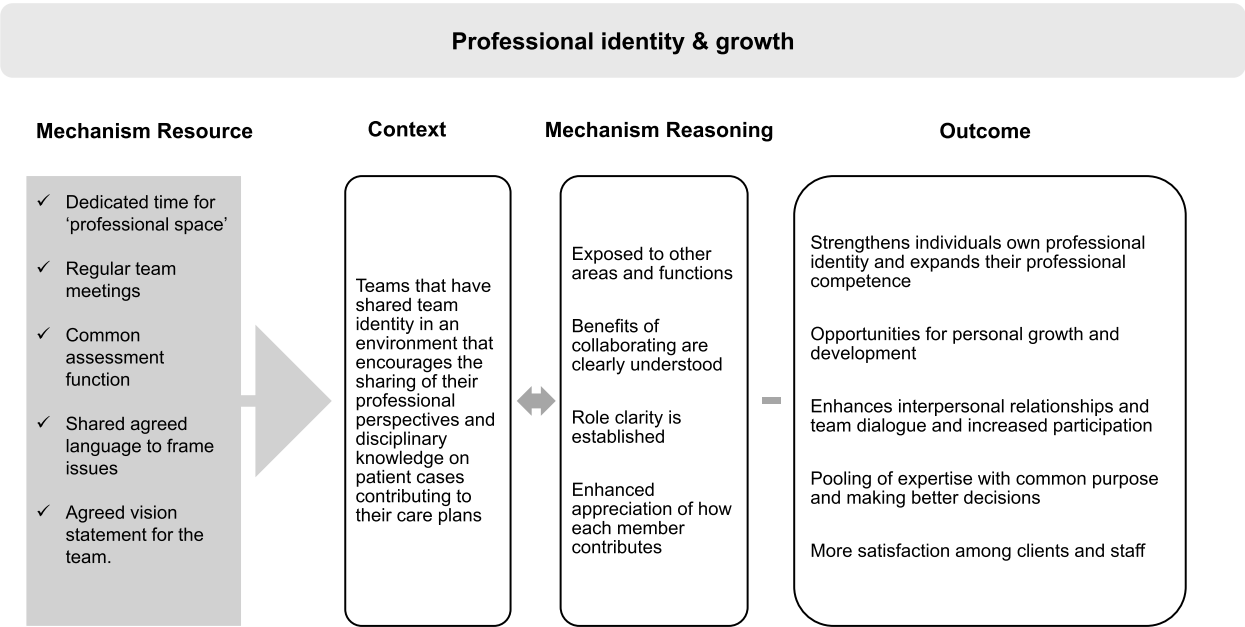


Fig. 2 Professional identity and growth

common frame of reference for team members to reconcile their disciplinary perspectives with a shared group purpose and identity:

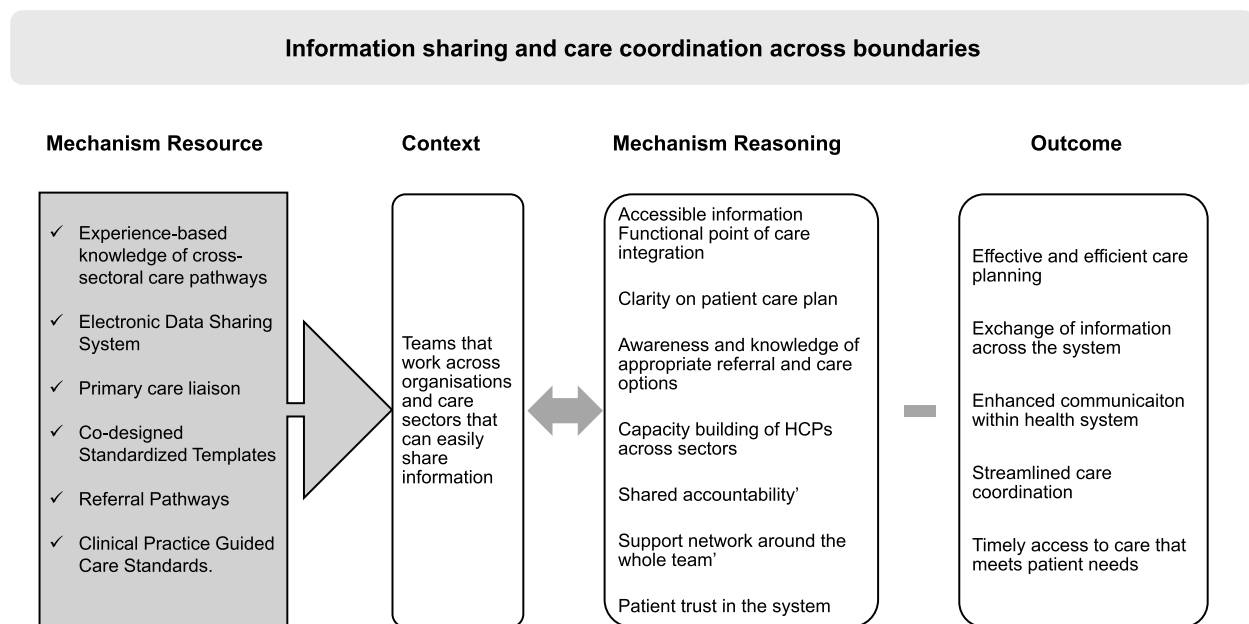
*it is important to identify the benefits of collaborating and develop a clear shared purpose. Once agreed, the shared purpose needs to be communicated clearly, and actively used with different groups. Developing a shared group identity may also strengthen participation. Developing a shared language to frame some of the key issues can also be useful and avoid any misunderstanding. (30 page 26)*

The HSE operational guidance for older person multidisciplinary teams [28] noted that resources for common team assessment such as the InterRai Clinical Assessment Tools could expose team members to functional areas that they are less familiar with, improve intra-team dialogue, reduce professional silo working and facilitate teams to develop a common purpose. This was further supported by the NCPOP Specialist Geriatric Team Guidance [29], which noted that ‘the team has an identity that is separate from the identities of individual team members...the skills of multiple disciplines working together in coordinated patient/family-focused care teams are needed to elicit different aspects of the patient’s and family’s illness experience’.

**Programme theory B: information sharing and care coordination across boundaries**

This programme theory focuses on information sharing and care coordination across professional boundaries within teams and across organisational boundaries. It was informed by 14 studies retrieved from the systematic search strategy [34, 35, 37, 39, 41, 44, 50–57], one source of grey literature [28] and two stakeholder groups (1, 2 and 3).

Teams delivering care to older people require working conditions that foster accessible information and guidance sharing across care sectors (context). These contexts are not easily established, requiring experience-based knowledge among team members of local cross-sectoral pathways of care for older people as well as an electronic data-sharing system with standardised templates to guide referral and care transitions, which the team may communicate through a primary care liaison function (resources). When these resources are available to teams, they facilitate working across the health system with the required knowledge of appropriate referral routes and care options. Furthermore, it enables more efficient ways to plan care across sectoral providers with shared accountability for care delivery. In addition, these resources build healthcare professionals’ capabilities to refer to the teams and share discrete case management approaches (reasoning). For the team, it improves teamwork, enhances communication, and streamlines care coordination, providing practical, timely care planning



**Fig. 3** Information sharing and care coordination across boundaries

and care delivery for an older person. These outcomes are critical characteristics of effective interprofessional working. This programme theory is depicted in Fig. 3.

#### Supporting evidence

The studies illustrated with practical examples the complex nature of IPC for older person care that involves integration across care sectors within community and hospital contexts. Valaitis et al. [47] recommend careful 'planning and implementation' with 'mechanisms for enhanced communication and strategies to ease workflow challenges'.

While teams cited a shared ICT system as a critical resource, many were operating with multiple electronic systems, leading to duplication of work [37, 53]. Standardised templates for referral should detail appropriate referral pathways and ways to request a referral, but in reality, teams have reported that this practice is often not standardised [50]. Daub [35], based on an extensive team evaluation, advocated the 'co-creation of care plans' as an enabler of 'shared accountability' across care sectors, leading to the development of a 'support network around the whole team'. The HSE MDT Operational Guidance document [28] noted the potential impact of a dedicated primary care liaison function, which would build capacity around the team across primary care sectors through consultation, education and advice or guidance on referral and management of older people. This type of resource, referred to as a 'system navigator' was also

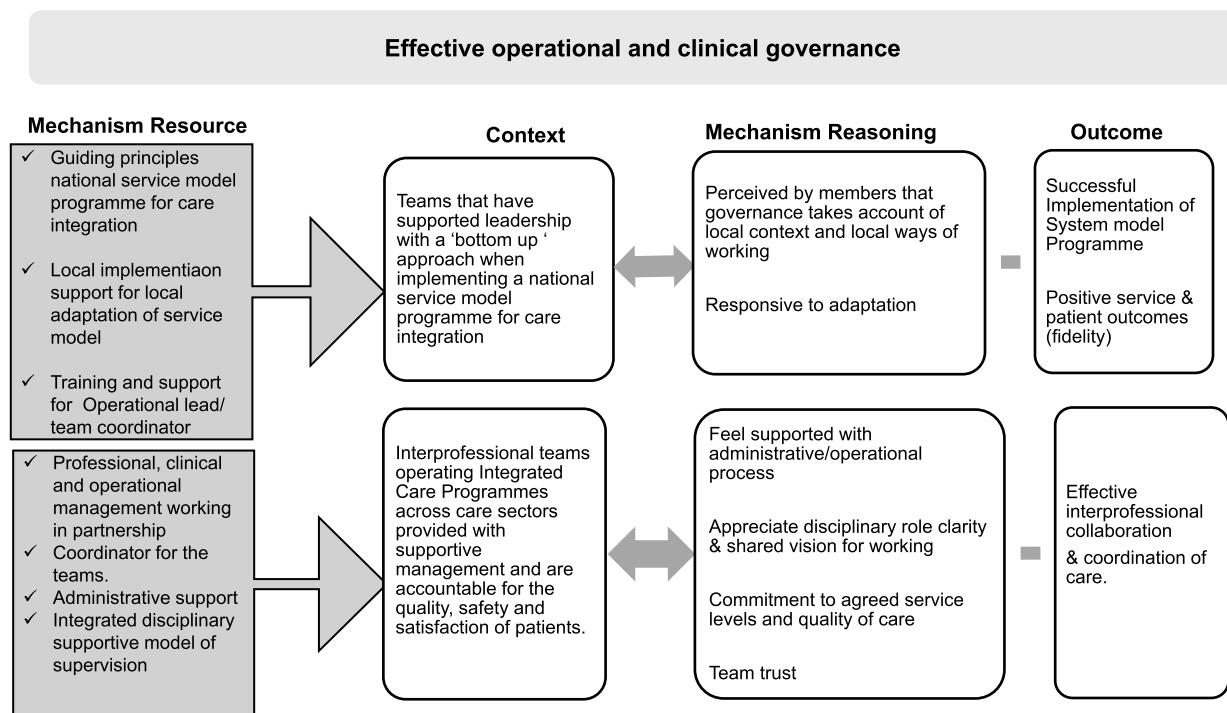
highlighted in the evaluation conducted by Elliot et al. [50].

#### Programme theory C: effective operational and clinical governance

This programme theory focuses on effective governance to support teams and IPC and is informed by 13 studies retrieved from the search strategy [33, 35–38, 41, 43, 49, 51, 55, 58–60] two sources of grey literature [28, 29] and three stakeholder groups (1–3). This programme theory with two CMOCs is depicted in Fig. 4.

There are two CMOCs within this programme theory. The first focuses on facilitating the initial establishment of interprofessional teams. It identifies teams that operate a 'bottom-up' leadership approach (context) supported by guiding principles of a national service model and operational leadership (resource), which generates a supportive and enabling governance model for adaptation to local ways of working (reasoning). This promotes team commitment, likely to generate a successful service model implementation (outcome).

The second CMO relates to the alignment of professional, clinical and operational governance to support the sustainability of interprofessional working as standard practice. It identifies the need for continued supportive management for teams (context) with stable resourcing for operational governance, clinical supervision, and administration support (resource). This enables team trust and capability to deliver effective IPC within the team and the broader health system.



**Fig. 4** Effective operational and clinical governance

### Supporting evidence

The studies identified the adaptation of models of care and the need to fit into local contexts and 'local ways of working' as critical to developing the capability of teams to deliver IPC. The requirement for national and organisational support to nurture and resource 'bottom-up initiatives' was emphasised as critical to implementation success [35, 49, 60].

The research undertaken by Janssen et al. [38] highlighted the negative impact on teams that do not have senior management support. These teams reported feeling as if they were 'standing alone' and 'afraid to discuss challenges and resources with their management'. Elbourne et al. [51] noted the importance of senior leadership promoting team autonomy, whereas 'autocratic leadership' was found to disempower team collaboration.

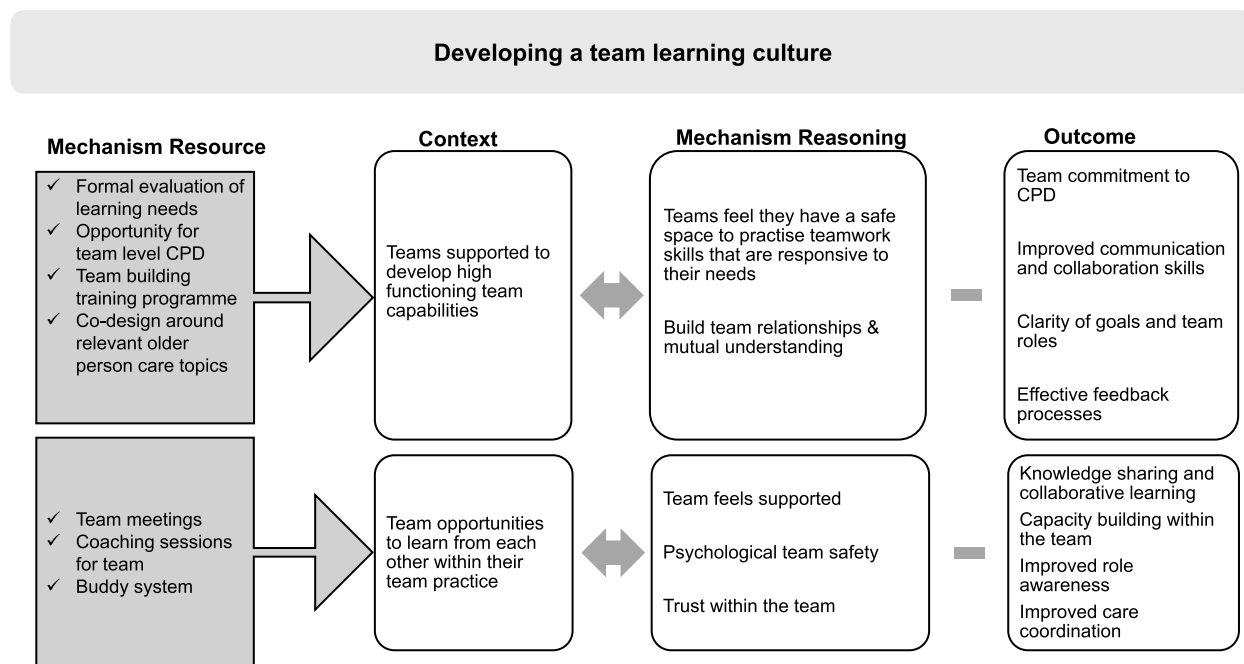
The importance of alignment of professional, clinical and operational sources of governance and management is supported by the HSE Operational Guidance Document [28] for the creation of a culture of team commitment to agreed service levels and quality of care. Slåtveen et al. [49] identified the need for flexibility and autonomy over resources (especially time) from senior management to provide the individual team members with the 'professional space for maneuvering' to create

interprofessional patient-centred approaches to care planning. Autocratic operational management styles with rigid resource allocation were reported as limiting 'professional development for interdisciplinary working and generating a sense of pressure to deliver services within a given timeframe' (49 page 5).

### Programme theory D: developing a team learning culture

This programme theory is concerned with developing a learning culture within the programme that enables IPC through supportive structures and educational opportunities. The theory is supported by 14 studies identified through the systematic search strategy [34, 37–39, 41, 43, 47, 57, 61–66], two sources of grey literature [28, 29] and two stakeholder groups (1 and 2). The programme theory with two CMOCs is depicted in Fig. 5.

The first CMOC explains how teams develop high-functioning capabilities (context) through formal evaluation of learning needs, team-level CPD and team-building opportunities integrated with relevant clinical topics (resources). These contextual conditions provide teams with a safe space to practice teamwork skills that align with their needs and build team relations and trust (reasoning). The positive outcomes are team commitment



**Fig. 5** Developing a team learning culture

to professional development, improved communication, teamwork skills, clarity of goals and team roles.

The second CMOC focuses on developing IPC competencies through complementary learning opportunities within the team practice (context). These can be formal or informal opportunities using team meetings, team coaching and buddy-led support (resource). This team environment generates a sense of support, psychological team safety and trust (reasoning), enhancing knowledge sharing, collaborative learning, team capacity building, role awareness and care coordination (outcomes).

#### Supporting evidence

The research led by Shaw [41] found positive results in developing interprofessional collaborative skills when a clinical topic, i.e. 'fall prevention programme' is integrated with team training. Team skills training varied across the studies, but the most effective approaches are integrated and interactive, including role play, case studies, games, team building exercises [63, 64] and interprofessional clinical vignettes [61].

Hjelle [62] evaluated 'interdisciplinary teams' experiences of delivering a reablement programme and identified 'formal and informal exchange of information and knowledge in interdisciplinary collaboration...as essential for all the team members', and they emphasised the need for resources to provide the 'structural factors' required for such formal and informal education. Informal learning strategies included 'sounding board' meetings with

the opportunity to share learning [38] supplemented with coaching, mentoring or supervision [34, 47, 66].

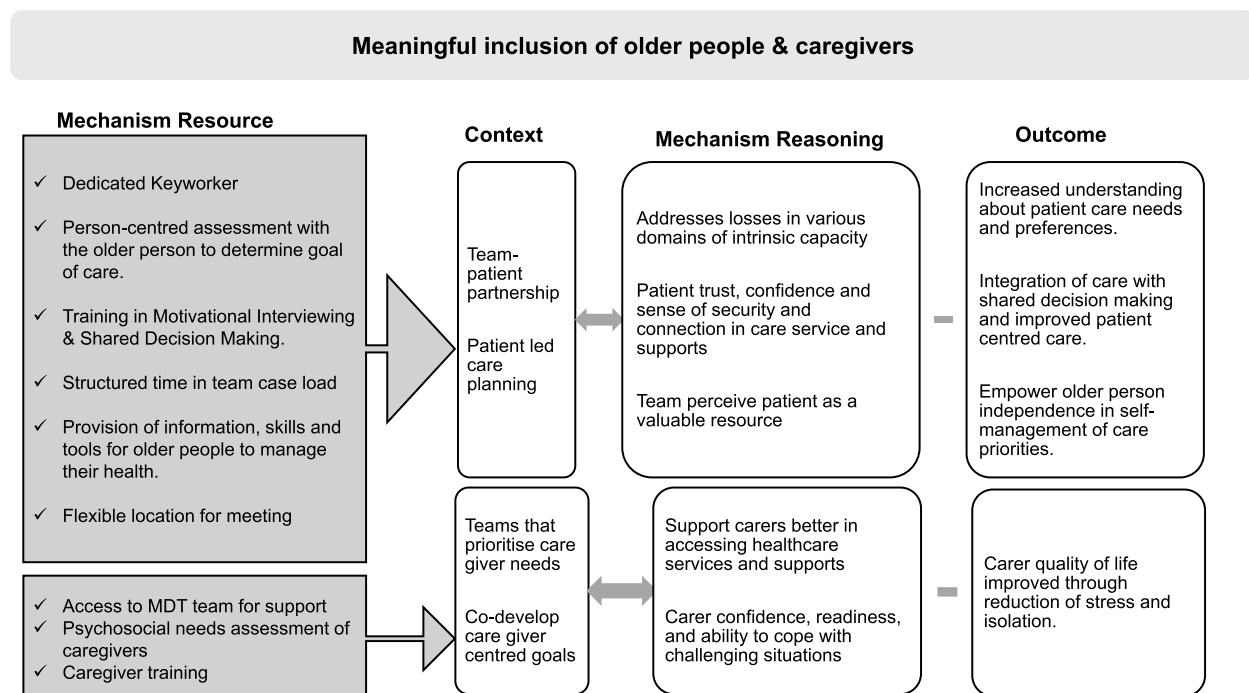
The HSE MDT, operational guidance document, noted that while operational governance and managerial processes are fundamental to the day-to-day team operations and processes, 'it is critical that multidisciplinary teams are supported to develop high functioning trans-disciplinary team capabilities and build relationships and mutual understanding of each other's roles, develop clarity of goals and effective feedback processes to maximise the impact and performance of their teams' (28 page 22).

#### Programme theory E: meaningful inclusion of older people and caregivers

This programme theory, depicted in Fig. 6 has two CMOCs that focus on the meaningful inclusion of older people and caregivers in care planning to improve IPC and care for older people. The theory is supported by 18 studies retrieved from the systematic search strategy [37, 39–42, 44, 46, 50, 51, 54, 56, 58, 59, 62, 65, 67–69], two sources of grey literature [1, 31] and two stakeholder groups (1 and 4).

The first CMOC relates to the inclusion of the older person in their care. When community teams partner a skilled key worker with a patient in a location suitable for the older person (resources) and conduct patient-led care planning (context), a sense of connection is fostered that enhances the patient's trust and sense of security in the care and supports provided (reasoning). These conditions





**Fig. 6** Meaningful inclusion of older people and caregivers

have positive consequences for the older person as their care is more integrated and relevant/appropriate to their needs and preferences and empowers them in self-care management (outcomes). At the level of the team, positive outcomes are achieved including an increased understanding of patient care needs and preferences, more integrated care planning which supports the intrinsic capacity of the older person, shared decision-making and improved person-centred care.

The second CMOC relates to the inclusion of caregivers and their care needs as essential to quality care for older people. In contexts where teams prioritise addressing caregiver needs and co-develop caregiver-centred goals and interventions as part of the older person's care, a comprehensive caregiver needs assessment is required with responsive care planning that includes access to concrete supports to relieve caregiver burden (resources). This will support caregivers to access health and social care services, which enhances their confidence, readiness and ability to cope with challenging situations (reasoning), leading to improved carer quality of life (outcome).

#### Supporting evidence

The literature highlighted resources to support meaningful inclusion in goal setting and care planning. The first relates to the capacity of team members to engage in shared goal-setting and create flexible care plans that are responsive to the older person's priorities, needs and

preferences [1]. Team members' competence in motivational interviewing [40] and shared decision-making [46, 54] were highlighted as important for patient-led care planning and goal setting. Motivational interviewing necessitates adequate time for a person-centred approach to care planning with older people [40]. Furthermore, the ICOPE guidance for person-centred assessment in primary care noted the importance of providing older people with the information, skills and tools they need to manage their health conditions and maximise their intrinsic capacity and quality of life [1].

The literature highlighted the need for team members to be flexible in where they conduct their care planning. Hoedemakers et al. [37] recommended teams to invite older people and caregivers to team meetings where this is suitable and appropriate. The literature noted that team members should be flexible in travelling to where the older person is to ensure meaningful inclusion of all older people in shared decision-making for example through home visits or identifying spaces where the older person feels most comfortable [36, 42, 44, 67].

Key workers or link workers were identified consistently in the literature as a key resource for meaningful inclusion [37, 40, 44, 50, 53, 57, 59, 68, 69]. It was argued that this resource creates a sense of connection for the patient to the healthcare staff and gives them greater confidence as they feel they have a 'safety net' to access advice and increases satisfaction with care contributing to living

well at home [40, 44, 59, 68]. The literature also reported positive health system outcomes associated with a key worker resource. These included increased coordination between teams, transparent communication processes, accessible access to care and support for older people and reduced risk of hospitalisations [37, 50, 53, 57, 69].

Several resources specific to caregivers were recommended in the literature to support specialist care teams, including collaborative interprofessional care planning [37, 67, 68] as well as a comprehensive psychosocial caregiver needs assessment with responsive interventions [1, 31, 37, 67–69]. Psycho-social interventions, training and support for caregivers, mainly when the need for care is complex and extensive, were critical recommendations in the WHO Integrated Care for Older People guidelines on community-level interventions to manage declines in intrinsic capacity [1]. In their evaluation of an integrated frailty care programme in the Netherlands, Hoedemakers et al. [37] emphasised the importance of addressing caregiver needs for effective care planning with older people:

*...the CCFE aims to unburden the informal caregiver by recognising the potential burden and ensuring adequate support to prevent drop-out of the informal caregiver and hospitalisation of the frail elderly. One of the goals of support is to ensure that the positive aspects of informal caregiving (satisfaction) outweigh the burden (37 page 6).*

#### Programme theory F: quality improvement and program development

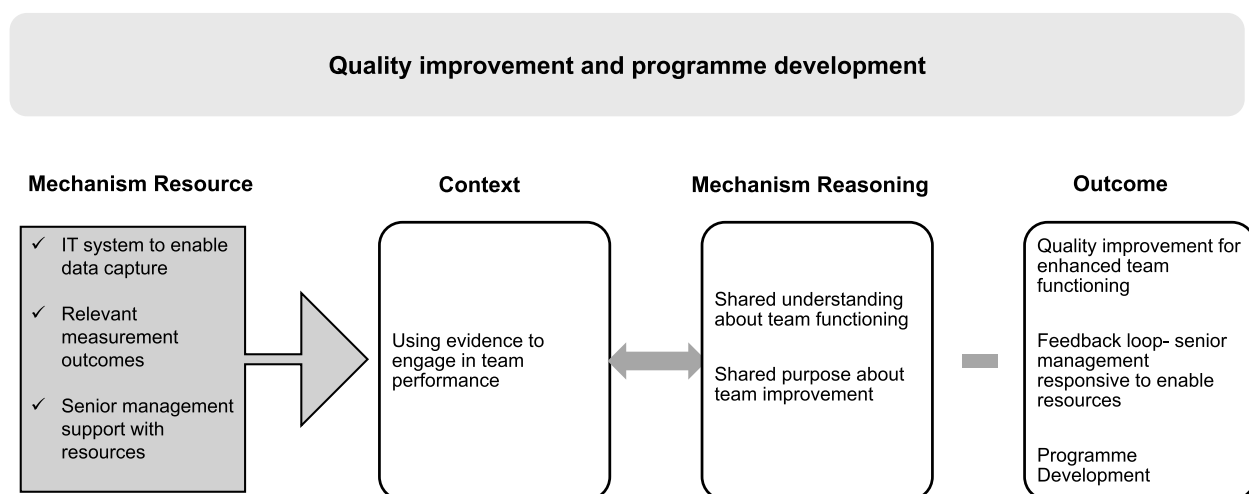
This programme theory is focused on evaluating team performance and its impact on service stakeholders to resource iterative quality improvement and to support clinical programme development. The theory is depicted

in Fig. 7 and is informed by six studies retrieved through the systematic search strategy [35, 37, 49, 53, 60, 61] and two stakeholder groups (2 and 3).

In contexts where senior leadership supports teams to use evidence to measure team performance (context) through reflecting upon relevant impact measures captured by an efficient IT system (resource), it fosters a shared understanding of team functioning, a shared purpose and responsiveness to team improvement (reasoning). This leads to positive outcomes of enhanced team interprofessional functioning and ongoing resource feedback loops for quality improvement and programme development.

#### Supporting evidence

An effective IT system is a key resource for consistently capturing relevant process, impact and outcome measures. The study by Hoedemakers et al. [37] emphasises the negative impact of inappropriate measurement outcomes, which can foster doubt among team members around the integrity of the evaluation, leading to disengagement in team performance review and quality improvement and generalised discontent with a strategy to advance the programme. Slåtveen et al.'s [49] highlighted the challenge of administration consuming too much time compared with the professional assessment of patient need. They noted that the stringent application of performance measures such as time allocation for patient care can have the negative effect of forcing professionals to negotiate between user needs and the designated time frame allowed for a patient. This highlighted the importance of iterative reflection by both frontline professionals and senior management on performance measures to identify resource needs in the team.



**Fig. 7** Quality improvement and programme development

Process and outcome measurement should include indicators for teamwork, impact upon stakeholders and appropriate Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREM). In an evaluation of multidisciplinary team working, Khan et al. [53] noted that where the team did not incorporate ongoing process and outcome evaluation, they were limited in their implementation development. They argued that there is a need for assessment 'to understand why there is variation in its implementation'.

#### Programme theory G: workforce planning and retention

This programme theory includes two CMOCs depicted in Fig. 8. The theory emphasises the resources required for workforce planning and retention of healthcare professionals in the health system. The programme theory is informed by five studies retrieved from the search strategy [35, 46, 51, 58, 69], one source of grey literature [30] and two stakeholder group (2 and 3).

The first CMOC focuses on the importance of government resources to support team capability for IPC. In teams that have developed 'internal' innovation initiatives (context), which are then supported with government funding (resources), this creates a sense among the team that their capability and impact is recognised and valued and increases their confidence to further develop innovation (reasoning), leading to better service integration with consistency across services and the potential

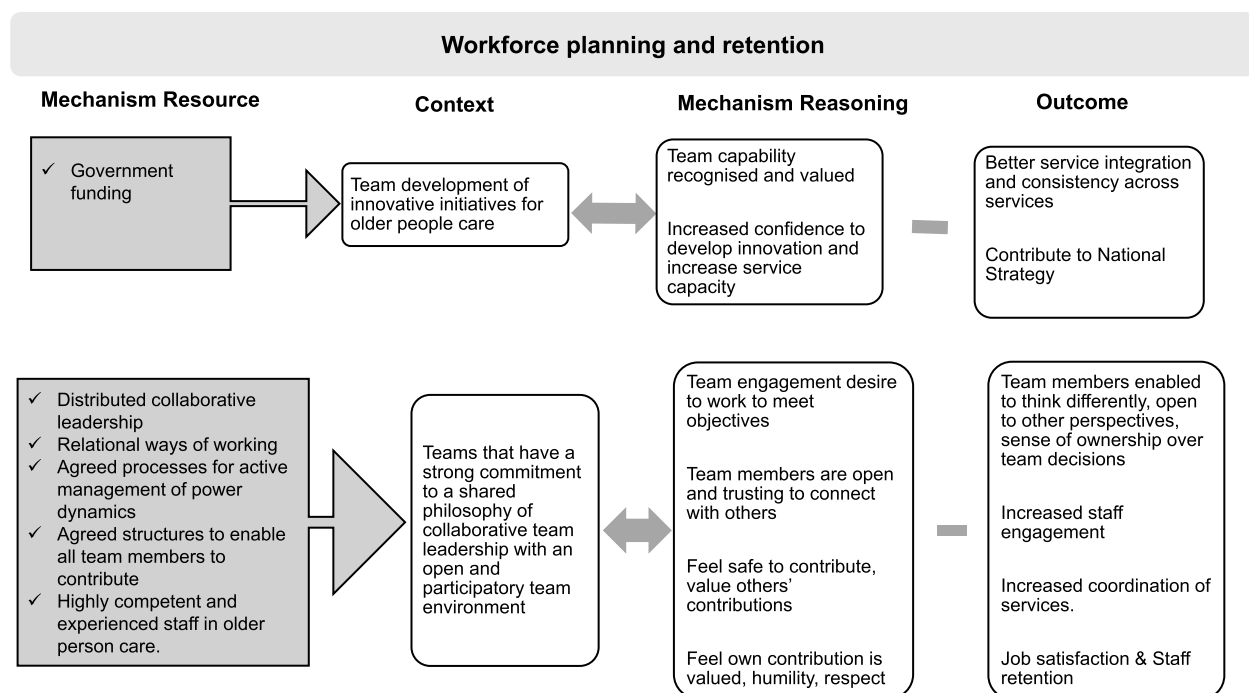
to contribute to implementation of national strategy (outcomes).

The second CMOC relates to capacity building for collaborative leadership within teams (resources) and describes a team context with a shared philosophy of team leadership and an open and participatory environment (context). This nurtures feelings of humility, trust and respect within the team, whereby team members value the contribution of others and feel that their input is valued by the team (reasoning). This leads to positive outcomes, including staff retention, engagement and job satisfaction, and a sense of ownership over team decisions where team members are enabled to think outside their disciplinary perspectives, leading to increased coordination of care (outcomes).

#### Supporting evidence

The study conducted by Garjardo et al. [69] is a supporting example of the first CMOC, where government funding supported the implementation of an internally developed dementia care programme resulting in programme sustainability.

The King's Fund Report on the practice of collaborative leadership [30] provided significant supporting evidence for this programme theory, particularly the second CMOC. The report noted the importance of creating a safe, inclusive and trusting environment to enable the collective contribution of teams through building healthy



**Fig. 8** Workforce planning and retention

relationships between team members, actively managing power dynamics and developing shared decision-making processes. This extract from the report highlights practices of collaborative leadership that enable trusting team relationships and shared decision-making:

*...bringing in and working with different views and perspectives is an important element of collaborative leadership, and this needs to be done within a safe and trusting environment so that all parties can fully participate. Diversity only has value if others appreciate the differences and are willing to explore and learn from them. It is only then that new insights or new solutions can be generated. (30 page 20).*

## Discussion

Community-centred care integration for older adults is internationally recognised as best practice in evidence, policy and health strategy [1–4, 7, 10, 14]. However, it is complex, requiring effective IPC across interprofessional teams, and challenging because of the unpredictability associated with introducing new work practices [14, 17]. This theory-driven realist synthesis advances the understanding of implementing IPC within a community-centred care integration service for older adults. The seven interrelated programme theories identify the key characteristics that promote positive outcomes in IPC implementation within community settings. They detail the complex interplay between context and mechanisms (resources and reasonings) and draw explicit attention to the dynamic and essential relationship between context and successful implementation of IPC for care integration (outcomes).

The results summarise effective IPC in contexts with external policy strategies that support operational and clinical governance (PT C) and workforce planning and retention (PT G). National programme initiatives and funding were identified as key resources to foster feasibility and consistency across services. However, the dynamics of implementation require external and internal strategies to optimise team ownership in service adaptation for the local context.

Successful IPC is fostered in teams with a strong professional identity (PT A), learning culture (PT D) and active engagement in team performance for quality improvement and programme development (PT F). Teams that operate collective leadership and participatory team involvement foster trust, contributing to staff satisfaction and workforce retention (PT G). Learning culture (PT D) requires continual evaluation of team learning needs and responsive team learning opportunities that are supported in CPD programmes.

IPC is effective in contexts that situate older people and caregivers at the centre of care planning (PT E). Information sharing and care coordination across boundaries (PT B) are critical to effective and efficient IPC. Inefficiency in this area was commonly reported in teams operating in health systems that lacked a comprehensive data-sharing infrastructure. The synthesised evidence identified a shared electronic data sharing system as a critical resource to optimise IPC effectiveness.

Across all seven PTs, there are explicit details of the resources required to foster favourable contexts for IPC, the changes these resources prompt in the reasonings of team members and the outcomes associated with this dynamic. The outcomes identified in the programme theory align with improvements in health service delivery and the quality of care for older people. Investing in the resources before formal implementation is a key message emerging from this review for policymakers and implementation planners. Some resources align with the compilation of implementation strategies from the Expert Recommendations for Implementing Change (ERIC) [70]. Others focus on IPC intervention development by highlighting resources that make the intervention characteristics explicit through enhanced design and packaging. These programme theories inform health programme design with evidence-informed guidance for IPC implementation, thereby supporting the World Health Organization's Integrated Care for Older People Frameworks [1, 2, 31].

The exploratory stakeholder process provided rich contingent evidence to this realist review, which was unavailable in the literature. They supported an enhanced understanding of IPC, enabling the refinement of literature-based findings with real-world experience. Stakeholders were particularly valuable for developing the outcomes within the CMOs as these causal links were underdeveloped in many of the published studies informing the review. The four stakeholder cohorts directed the scope of the evidence retrieval and analysis, ensuring that the resulting programme theories reflect the lived experience and genuine concerns of those experiencing interprofessional integrated care for older people.

The value of stakeholder consultation is exemplified by the emphasis made by our older people and caregiver stakeholders on a routine assessment of carer needs with responsive care planning. This emphasis is represented in PT E. Our consultation with the operational team leads outlined the complexity of transitioning from clinical to managerial roles in the community. Understanding of the resources required to support this transition, particularly where it involves movement from acute to community-based care, is underdeveloped in the literature [71]. The stakeholder consultations also provided the background

for PT C, which focuses on enabling operational and clinical governance. Central to this is ensuring these operational roles are supported with induction training and a vision for shared leadership across the teams, with organisational structures supporting local implementation of the service model. Policymakers and healthcare managers emphasised that the ability to share data through electronic infrastructure requires ambitious resourcing but remains a critical gap for successful IPC in health systems. Standardised referral pathways and care standards will likely require national-level support, and this underpins PT B.

In our realist review, no rival theories were developed within the resulting programme theory. This may stem from the absence of contradictory evidence in the studies we identified. However, this lack of rival theory could also reflect a limitation in our realist search strategy, as we did not explicitly search for alternative or competing theories. Future researchers should consider incorporating a deliberate search for rival theories to ensure a more comprehensive understanding of the mechanisms at play. Additionally, the absence of rival theories may be a result of the parameters of our research question, which focused on community-based care integration for older people. These models are relatively under-researched compared to hospital-based or specialist integration models, potentially limiting the availability of diverse perspectives. Furthermore, our conceptual framework for interprofessional collaboration excluded dyad or within-profession collaborations, which may have further narrowed the scope for identifying competing theories. We would recommend that future studies challenge both the conceptual parameters and the scope of research settings to explore whether alternative theories emerge under different conditions. This could enrich the programme theory and provide a more nuanced understanding of interprofessional collaboration in care integration.

#### **Application of the programme theory**

This PT will be tested, refined and validated through a realist process evaluation of IPC within four case study integrated care teams in Ireland [27]. Observations of team meetings, qualitative interviews and focus groups with community team members, older people and carers will provide data to test and expand the PT for application in the community setting in Ireland. We recommend that other researchers apply and test this programme theory to help identify practical resources and context enablers for IPC within varying health systems contexts.

Practical application and evaluation of the programme theory are required to support the implementation of international strategic commitment to enhanced

community-based integrated care for older adults. A realist approach to programme evaluation identifies practical resources and outcome measurements that can be adopted and adapted in various health systems to enable effective contexts for IPC. There is a lack of evidence to support an understanding of how staff are enabled and supported to adapt national service models to the particularities of local settings. A realist evaluation should identify the strategies employed within the system to work around implementation challenges such as staff shortage, resource constraints or the particularities of geographic and demographic conditions. These evaluations should result in practical guidance to support health systems and individual teams in transitioning to new ways of interprofessional working through professional curriculum reform, ongoing professional development, adequate system resourcing, effective governance and workforce planning.

#### **Limitations**

The evidence retrieved for this review predominantly draws from Canada and the USA and, to a lesser extent, northern and western Europe. Furthermore, we adopted a purposive approach to retrieve grey literature, which was limited in scope to sources identified by the study expert panel to support programme theory development. We have included local stakeholder evidence, including localised grey literature, to support the transferability of the programme theory generated from this synthesis to the Irish setting. This may have limitations for programme theory transferability to other health systems and to lower- and middle-income countries. Our realist search strategy focused on identifying papers that would add conceptual depth to the programme theories and is therefore limited in the extensiveness of the retrieval. For example, we included papers published in English only, and we limited our search to four databases without exploding terms. This indicates that the final number of papers retrieved for the synthesis is not indicative of the entire body of published evidence on this topic. One further limitation, broadly representative of the literature, is the relative lack of information on the resources required by healthcare professionals as they transition into specialist interprofessional community teams.

#### **Conclusions and recommendations**

This paper used a realist review methodology, combining an exploratory stakeholder process and systemically identified literature to formulate programme theory on what works for whom in fostering IPC within interprofessional community care teams for older people. Seven areas of programme theory highlight the complex, multifaceted resources that enable favourable contexts for



IPC and its associated outcomes in care integration for older people. We encourage local application of this theory with realist evaluation to identify practical resources and enablers for IPC within varying international health systems.

### Abbreviations

IPC	Interprofessional collaboration
NCPOP	National Clinical Programme for Older People
ICPOP-CSTs	Community specialist integrated care teams for older people in Ireland
IPTs	Initial programme theory
PT	Programme theory
CMOC	Context, mechanism and outcome configuration

## Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s13643-025-02862-8>.

Additional file 1. Survey instrument for CST-ICPOP members.

Additional file 2. Topic guide for stakeholder workshops.

Additional file 3. Expert panel composition.

Additional file 4. Systematic search strategy.

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### Authors' contributions

All the authors have made significant intellectual and practical contributions to the realist synthesis. DOD and CD wrote the manuscript with significant input from ÉNS and AR. All the authors reviewed and contributed to the drafting and revisions of the manuscript. DOD is the principal investigator for the study, wrote the original grant proposal and is the grant holder responsible for funding acquisition. CDev is the principal knowledge user for the project representing the NCPOP. DOD, MOS, ÉNS, AR and CD undertook the stakeholder consultations. With input from the wider team, DOD, AR and SH were responsible for the design and implementation of the search strategy as well as the initial screening. DOD, CD, ÉNS, CDev, MOS, GOD, AdB, SD and SH collaborated on the analysis and synthesis of the results. All authors have read and agreed to the published version of the manuscript.

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### Data availability

Tables 2 and 3 detail the published research evidence retrieved for this synthesis. Additional file 4 provides details of the search strategy developed and implemented for this retrieval. Additional files 1 and 2 provide the data collection tools (survey tools and topic guides to support consultations) utilised for the collection of stakeholder evidence. Redacted (anonymised) survey and field note data from the consultations are available from the corresponding author (O'Donnell) upon request.

## Declarations

### Ethics approval and consent to participate

Low-risk ethical exemption was sought for the stakeholder consultation that was undertaken to support this evidence synthesis. Exemption was granted in October 2022 by the UCD Life Sciences Research Ethics Committee (LS-E-22-138-O'Donnell).

### Consent for publication

Not applicable.

### Competing interests

The authors declare that they have no competing interests.

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