Hindawi
Health & Social Care in the Community
Volume 2024, Article ID 3504396, 9 pages
https://doi.org/10.1155/2024/3504396

Research Article

Development of a Conceptual Framework for Adult Community Rehabilitation Policy, Planning, Care, and Research: A Multimethod Qualitative Approach

Kathryn M. Sibley,[1,2] **Ruth Barclay**,[3] **Juliette Cooper**,[4] **Jeanette Edwards**,[5] **Lorna W. Guse**,[6] **Leanne Leclair**,[4] **Alan Katz**,[1,7] **Alexandra M. B. Korall**,[2] **Jacquie Ripat**,[4] **and Kathleen Zawaly**[1]

[1]*Department of Community Health Sciences, Max Rady College of Medicine, Rady Faculty of Health Sciences, University of Manitoba, 750 Bannatyne Avenue, Winnipeg, Manitoba, Canada*
[2]*George & Fay Yee Centre for Healthcare Innovation, Rady Faculty of Health Sciences, University of Manitoba, 379-753 McDermot Avenue, Winnipeg, Manitoba, Canada*
[3]*Department of Physical Therapy, College of Rehabilitation Sciences, Rady Faculty of Health Sciences, University of Manitoba, 771 McDermot Avenue, Winnipeg, Manitoba R3E 0T6, Canada*
[4]*Department of Occupational Therapy, College of Rehabilitation Sciences, Rady Faculty of Health Sciences, University of Manitoba, 771 McDermot Avenue, Winnipeg, Manitoba R3E 0T6, Canada*
[5]*Shared Health, 1502–155 Carlton St, Winnipeg, Manitoba R3C 3H8, Canada*
[6]*College of Nursing, Rady Faculty of Health Sciences, University of Manitoba, 89 Curry Place, Winnipeg, Manitoba R3T 2N2, Canada*
[7]*Department of Family Medicine, Max Rady College of Medicine, Rady Faculty of Health Sciences, University of Manitoba, 750 Bannatyne Avenue, Winnipeg, Manitoba R33 0W2, Canada*

Correspondence should be addressed to Kathryn M. Sibley; kathryn.sibley@umanitoba.ca

Received 28 September 2022; Revised 20 June 2023; Accepted 6 January 2024; Published 25 January 2024

Academic Editor: Helen Skouteris

To address recognized gaps in community rehabilitation service coordination and advance delivery of rehabilitation services for adults living outside of institutions, we have developed a conceptual framework to inform the design of community rehabilitation policy, planning, care, and research. Employing a multimethod qualitative approach, we developed a draft framework based on a document review as well as interviews with community rehabilitation service and system providers, older people receiving community rehabilitation services, and family caregivers. We then consulted with community rehabilitation service and system providers, older adults, and family caregivers to revise the framework. We identified 194 relevant documents and 30 programs, and we analyzed interview data from 29 service and system providers as well as 6 dyads of older persons and family caregivers. We developed a definition of community rehabilitation and identified 11 components for the draft framework, which was presented to 16 participants for consultation. We used their feedback to revise the terms and definitions for the 11 components. We organized the final set of components into two categories: principles (culturally safe; equity-focused; evidence-informed; person and family-centred; restorative) and organization (appropriate; coordinated; continuity; evaluated; stepped; team-based). The contextualized, action-oriented conceptual framework for adult community rehabilitation (CFACR) is supported by older people, family caregivers, and community rehabilitation health system providers. Continued work to refine and validate the components in more population groups and contexts will facilitate implementation and application of the CFACR.

1. Introduction

As global life expectancy increases [1], more adults are living with health conditions for temporary or extended periods of time [2]. These health conditions can negatively impact function, independence, and participation in the community [3]. Individuals often require support from health and social care systems and/or from family or friends acting as caregivers [4, 5]. Although the level of support needed may require relocation to an institutional setting, people consistently express a desire to live at home as long as possible [6]. Supporting people in maintaining health, well-being, and quality of life are priorities for health and social care systems around the world; however, systems face challenges in responding to these complex needs while managing costs [7]. Services and programs that support people who live in their community can address individual preferences and health system goals.

Numerous services can be delivered to help people attain and maintain function in homes and community settings, supporting independence and reducing the need for institutionalization [8] For example, rehabilitation is a specialized domain of health care that focuses on improving, maintaining, or preventing loss of function [9]. Rehabilitation interventions include managing self-care, improving mobility, providing adapted equipment, modifying the environment, and reestablishing social connections [10, 11]. The provision of rehabilitation services in community settings improves patient outcomes in a cost-effective manner [12–14]. Restorative care and reablement are complementary approaches, typically offered through personal care or home care teams, which aim to support people to maintain functional independence in activities of daily living by doing these *with* rather than *for* a person [15]. While some systems have distinguished rehabilitation from reablement and restorative care, recent work emphasizes their shared goals and features, placing these approaches on a continuum [8].

However, it is well-recognized that existing organization of rehabilitation (and of health and social care services more broadly) outside of institutions such as hospitals is disjointed and fragmented, with no coordinated system informing the provision of these services [16, 17]. The absence of a coordinated approach on which to inform community rehabilitation and reablement system design is associated with poor care continuity [18], where services may be duplicated in some areas while gaps persist in others, resulting in functional decline and poor outcomes [19–22]. A conceptual framework may serve to inform planning and decision making for multiple aspects of community rehabilitation and restorative-based supports. Frameworks refer to a structured overview of descriptive categories and related constructs that presume to account for a phenomenon [23, 24]. For example, the International Classification of Functioning and Disability (ICF) [25] has long provided overarching conceptual guidance in rehabilitation. While there is an important general framework for rehabilitation at the individual level, the ICF does not address system design. Conceptual frameworks for specific rehabilitation contexts or jurisdictions have been proposed [26, 27], however they draw largely on concepts from secondary sources, not from primary sources.

To address recognized gaps in community rehabilitation service coordination and advance delivery services outside of institutions, our goal was to develop a conceptual framework that can be used in community-based rehabilitation policy design, planning, care, and research. While developed in the context of one Canadian system, the resulting framework can be adapted and refined for other jurisdictions.

2. Methodology

2.1. Context. This study was conducted in Winnipeg, Manitoba, Canada, between 2017 and 2019. Winnipeg is Manitoba's only large urban centre (population >750,000), and 14.7% of residents are aged 65 years and older [28]. The provincial government funds health care through supports from federal transfer payments in a single pay or universal coverage health insurance system [29]. Services are administered through five geographically organized health regions and a provincial health authority. Some publicly-funded community rehabilitation services may be offered through outpatient programs (e.g., day hospital and primary care) or through home care programs to select clients [30]. Private rehabilitation services also exist.

2.2. Conceptual Foundations. We drew on pragmatism, a philosophical position that aims to use research findings to solve practical real-world problems [31]. We further applied an integrated knowledge translation approach, which engages research users throughout the research process [32, 33]. Our team included a provincial health system leader (JE), who identified the need for a guiding framework for community-based rehabilitation integrated with restorative care as part of a major provincial health system transformation initiative.

2.3. Design. We used a multimethod qualitative approach (Figure 1), consistent with published recommendations for developing a conceptual framework [34]. These recommendations emphasize mapping data sources; categorizing data; identifying, categorizing, and integrating concepts; synthesis and resynthesis; and validating the conceptual framework. The study received institutional research ethics approval from the University of Manitoba Health Research Ethics Board and operational approval from participating health authorities and service delivery sites.

2.4. Data Sources

2.4.1. Document Review. We searched peer-reviewed academic literature with Ovid MEDLINE (Appendix 1) in collaboration with an academic librarian to identify (i) established definitions for community rehabilitation; (ii) existing models and frameworks for community rehabilitation and rehabilitation care delivery; and (iii) ongoing community rehabilitation programs across Canada.

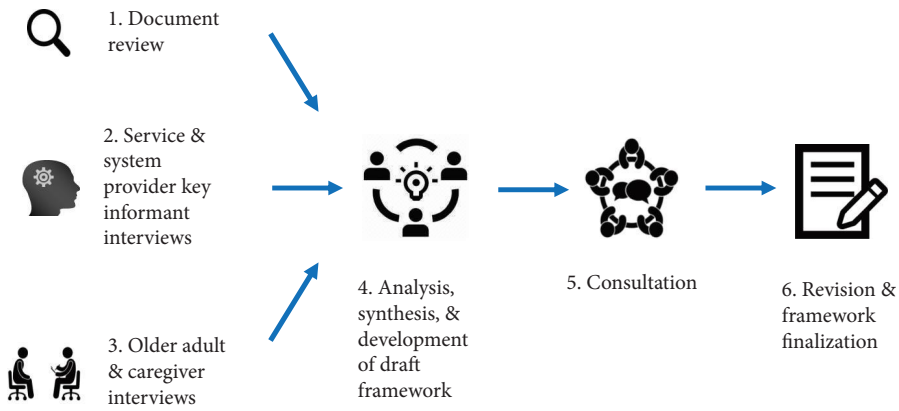

Figure 1: Framework development process.

Two investigators (JC, LL) screened and identified articles. We also conducted a purposive web search to identify Canadian reports, policy documents, and descriptions of programs and services related to rehabilitation, community care, and restorative care. We extracted program characteristics and identified additional definitions, models, and programs through snowballing.

2.4.2. Community Rehabilitation Service and System Provider Key Informant Interviews. We conducted semistructured interviews with community rehabilitation service and system provider key informants working in Winnipeg. Individuals working in a policy, management, or frontline service delivery role in coordination and implementation of community rehabilitation were eligible. Purposive and snowball sampling was used to identify potential participants. Interviews explored the goals, processes, strengths, and opportunities of existing community rehabilitation services. Full details of data collection are available [30].

2.4.3. Older Adult and Family Caregiver Interviews. Over a 3–6-month period, we conducted three semistructured interviews with dyads comprising a community-dwelling individual aged 65 or older and receiving community rehabilitation services in Winnipeg and a family caregiver. Participants were recruited through randomized mailing or posters in assisted living facilities. Interviews explored (i) experiences of community rehabilitation service use in relation to the older person's functional abilities and changes over time; (ii) community and/or family support received; and (iii) participation in the community. Full details of data collection are available [35].

2.5. Analysis and Development of a Draft Framework. We first analyzed each data set separately with conventional content analysis and then integrated our findings through directed content analysis [36]. Integration involved grouping the data into broad topic-oriented categories (current strengths of community rehabilitation, challenges, and opportunities for future). Next, we discussed key elements that define community rehabilitation and agreed on principles for developing a framework through informal consensus. From this, KMS generated a draft definition of community rehabilitation and compiled a list of framework components. We created a descriptive summary definition and explanation for each framework component. To justify inclusion of each component, we mapped supporting data from the document review and interviews to each component. To be included as a component, evidence from at least one interview data source and one secondary source identified in the document review were required. We then reviewed and revised draft definitions, framework components, and supporting documentation over multiple rounds until we reached agreement on a draft framework. We used an audit trail to maintain records. Our team meetings and discussions encouraged reflexivity.

2.6. Consultation. We consulted community rehabilitation service and system providers, older people receiving community rehabilitation services, and family caregivers who participated in the interviews to review and seek feedback on the draft framework. Purposive sampling was used to identify participants. We conducted a focus group with community rehabilitation service and system providers and interviews with older adults and family caregivers. We presented background information and our draft definition of community rehabilitation, shared preliminary findings from each data source, and presented the draft framework. Facilitated discussion then explored the draft framework's strengths, weaknesses, gaps, and/or unnecessary elements. Participants were encouraged to suggest potential revisions to framework components, component titles, and definitions. We shared a hypothetical case scenario (Appendix 2) and explored with the participants how the framework components could manifest in a real person. All discussions were recorded and transcribed verbatim.

2.6.1. Revision and Framework Finalization. We used directed content analysis to analyze consultation discussions with a focus on revising the draft framework. Addressing comments from feedback systematically, we discussed potential revisions until informal consensus was reached. KMS

then revised the draft framework as recommended by the team. A communications professional reviewed and revised component definitions. KMS, in consultation with the communications professional, drafted a visual representation of the framework. The team approved the final framework components, definitions, and visual representation.

3. Results

3.1. Draft Framework. We considered data from 194 papers, 30 Canadian programs, 29 community rehabilitation service and system providers, and 6 older person and family caregiver dyads. We defined community rehabilitation as *rehabilitation services for people living in their homes or continuing place of residence, developed in partnership with clients and families, designed to optimize function and reduce disability, and delivered by an interdisciplinary team*. Our draft framework included 11 components. We based explanatory definitions for the components on published sources identified from the literature search and, where necessary, additional targeted searches. Draft framework components, definitions, evidence sources, and synergies are reported in Appendix 3.

3.2. Consultation and Revision. Feedback was provided by 12 service and system providers, 2 older people, and 2 family caregivers. Overall feedback was positive, with participants noting that the framework was comprehensive, and the components were important and appropriate. Comments from participants were related to the language used for both component names and explanatory definitions, requesting clarification in some cases or suggesting alternate terms in others. Participants highlighted inconsistencies and general issues with explanatory definitions. No components were either identified as irrelevant or recommended to be removed from the framework. Three concepts were proposed as additional components. Following our review of the feedback, we retained all component names and revised our definitions. We grouped components in two overarching categories: *Principles* and *Organization*. We defined principles as *fundamental norms, rules, or values that represent what is desirable and positive for a person, group, organization, or community and help it in determining the rightfulness or wrongfulness of its actions* [37]; in the case of this framework, principles represent value-based features of community rehabilitation. We categorized five components as principles: *culturally safe*; *equity-focused*; *evidence-informed*; *person and family-centred*; *and restorative*. We defined organization as *structural and process features related to delivery or implementation of community rehabilitation*. Six components were categorized as organization: *appropriate*; *coordinated*; *continuity*; *evaluated*; *stepped*; *and team-based*. Components within a category have been organized alphabetically in descending order, with no relative value attached. No new components were added; we considered the three proposed components either related to existing components or not action oriented.

3.3. Revised Framework. We refer to the revised framework as the conceptual framework for adult community rehabilitation (CFACR). Components are described in Table 1. In developing a visual representation of the CFACR (Figure 2), we included our definition of community rehabilitation at the core of the framework.

3.3.1. CFACR Components: Principles

(1) Culturally Safe. The need for community rehabilitation to be culturally safe is acknowledged, in recognition of the Manitoba and Canadian contexts of colonial legacies. As both a system and as individuals working within a system, there is a need to critically reflect, acknowledge, analyze, and address power imbalances, institutional discrimination, and colonial relationships to advance therapeutic encounters. Our concept of culturally safe community rehabilitation care is adapted from the Manitoba Quality and Learning Framework (MQLF) [38] and aligned with key informant comments that identified health inequities among potential recipients of community rehabilitation and raised questions about how systemic racism plays a role.

(2) Equity-Focused. This principle supports the removal of obstacles to accessing community rehabilitation services and provision of services to those with the greatest needs. It requires fair and just access to services that reduce preventable and avoidable differences in health outcomes. Key informants discussed principles of equity influencing access to community rehabilitation in many forms, including financial barriers and transportation barriers. Published models (e.g., [38, 39]) recognize equity and equitable access.

(3) Evidence-Informed. The need for community rehabilitation to be evidence-informed aligns with contemporary health care standards. We define evidence informed as distilling, disseminating, and applying best available evidence from research, context, and experience and using that evidence to inform and improve community rehabilitation practice and policy [40]. The concept reflects an evolution of the commonly used term *evidence-based*, recognizing the complex nature of real-world health care and decision making, clinical expertise, and client preference [41]. Key informants, older people, and family caregivers discussed the need to align care with current evidence, and consultation participants endorsed the definition as accurate and comprehensive.

(4) Person and Family-Centred. There was strong support from participants for a focus on the needs of the people receiving care in community rehabilitation. Based on this, we define person and family-centred care as partnering with clients and their families to design and provide care that is holistic, culturally safe, acceptable, respectful, and responsive to individual preferences, needs, and values. In choosing the term *person- and family-centred*, we were informed by previous published work [42] and adapted our definition from the MQLF [38]. The specific term used to denote the individual receiving care varied across all sources,

Table 1: Conceptual framework for adult community rehabilitation (CFACR).

Category	Component	Definition/explanation
Principle	Culturally safe	Critically reflects, recognizes, analyzes, and addresses power imbalances, institutional discrimination, and colonial relationships in the context of community rehabilitation care to advance therapeutic encounters
	Equity-focused	Supports all people reaching their full health potential and are not disadvantaged from attaining it or accessing health services because of socially determined circumstances
	Evidence-informed	Distills, disseminates, and applies the best available evidence from research, context, and experience and uses that evidence to inform and improve community rehabilitation practice and policy
	Person- and family-centred	Partners with clients and families to design and provide care that is holistic, culturally safe, acceptable, respectful, and responsive to individual preferences, needs, and values
	Restorative	Works to attain and maintain the highest level of function possible by doing *with* a person, rather than doing *for* a person
Organization	Appropriate	Community rehabilitation services are provided in the most suitable setting for providing safe, accessible, and timely care aligned with individuals' needs and potential to achieve rehabilitation goals
	Coordinated	Care is organized between the community rehabilitation team and other care providers across the continuum of care. Clients and family are encouraged to participate in goal setting and care planning
	Continuity	A series of initiating, consistent, and concluding care events that result when a person seeks community rehabilitation services in one or more settings
	Evaluated	Consistent measurement to monitor and demonstrate health system, program, and individual outcomes that contribute to enhanced functional independence
	Stepped	The most effective and most appropriate community rehabilitation services are initiated first, adapted, and increased as needed and then reduced in a coordinated manner when an endpoint is reached
	Team-based	Includes rehabilitation professionals and support staff from multiple disciplines who work collaboratively and in an integrated way

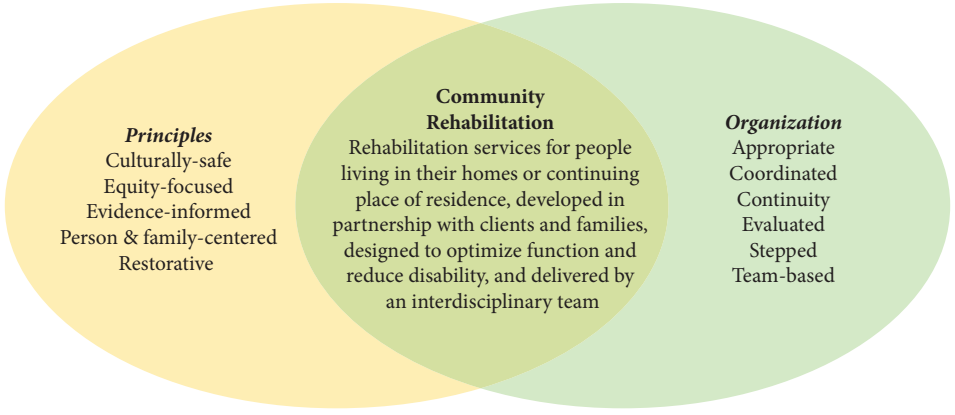

Figure 2: CFACR visual representation.

and we therefore use the term *person* wherever possible. We also recognize the complexity and fluidity of the term *family* and refer to two or more people who depend on one another for emotional, physical, and/or financial support [18] and consider members of a family as self-defined.

(5) Restorative. The principle of restorative community rehabilitation care was championed at the launch of the study by our knowledge user and was subsequently reinforced by key informants, older adults, and family caregivers. Restorative care is defined as care practices that work to attain and maintain the highest level of function possible by doing with a person, rather than doing for a person (adapted from [43]). Key informants noted the empowering nature of a restorative approach, and older people discussed how they worked with care providers to problem-solve to perform activities of daily living, such as showering and cooking.

3.3.2. CFACR Components: Organization

(1) Appropriate. We describe appropriate rehabilitation care as that which provides services in the most suitable setting aligned with individual needs and the potential to achieve

rehabilitation goals. The importance of an appropriate setting was noted by older people and family caregivers, who discussed logistical challenges associated with travel to outside settings and valued benefits to the family of receiving care in home. Another published model, the NSW Rehabilitation Model of Care [39], also includes the component of an appropriate care setting.

(2) Coordinated. The need for coordinated care that is organized between the community rehabilitation team and other care providers across the continuum of care was recognized among all interview groups. Family caregivers suggested a need for greater coordination to support older adults receiving community rehabilitation services. Key informants spoke of this importance as well, proposing different mechanisms to support coordinated care such as service navigators or central intake systems. Coordination of care is also a component in the NSW Rehabilitation Model of Care [39].

(3) Continuity. Continuity refers to a series of initiating, consistent, and concluding care events that result when a person seeks community rehabilitation services in one or more domains. This component is shared with the MQLF [38]. We view continuity of care as distinct from coordinated care, with *continuity* reflecting a temporal and integrated quality and *coordinated* reflecting a structure of organization. Key informants discussed the importance of continuity in relation to fragmentation of services operating in independent silos.

(4) Evaluated. Our framework acknowledges the importance of consistent measurement in community rehabilitation to monitor and demonstrate health system, program, and individual outcomes that contribute to enhanced functional independence. Key informants noted the importance of community rehabilitation data at the client level and at the program level. Our inclusion of health system, facility or program, and individual outcome variables is informed by the World Health Organization rehabilitation data systems model [44]. Complementary items are included in published models [38, 39].

(5) Stepped. Stepped care is defined as the organization of community rehabilitation care in which the most effective and appropriate services are initiated first based on the person's readiness for restoration of previous function, then adapting and increasing as needed, and finally reducing in a coordinated manner when an endpoint is reached. This component was raised as a priority by our knowledge user during the project and was supported by key informant comments that addressed the relationship of rehabilitation with the entire continuum of care. The concept of stepped care is one that has been used globally to maximize overall access to care in the presence of scarce resources [45]. It is complementary to but distinct from *Continuity*.

(6) Team-Based. Team-based care recognizes that community rehabilitation requires rehabilitation professionals and support staff from multiple disciplines to work collaboratively and in an integrated way. The construct is analogous to *multidisciplinary care teams* in the NSW Rehabilitation Model of Care [39] and has been previously emphasized as an essential feature of community rehabilitation [46]. Key informants viewed the provision of a support team as a "luxury" within the current state of the system while, at the same time, recognizing the potential positive impact of this support on community rehabilitation services.

4. Discussion

We used a comprehensive and rigorous approach to develop the conceptual framework for adult community rehabilitation (CFACR), the first conceptual framework both specific to the unique context of community rehabilitation and integrates elements of restorative care and reablement that are relevant across health and social care. Our work stemmed from the expressed need of a health system knowledge user and integrated primary data from older people, family caregivers, and community rehabilitation health system key informants. It aligns with and is built on the strengths of existing frameworks and conceptualizations of community rehabilitation. The eleven components included in the CFACR establish an overarching vision for community rehabilitation that can serve as guidance for policy, planning, care, and research. These components can support the ongoing system transformation needed to develop services that will support and meet the needs of community-dwelling adults and their families.

The CFACR includes shared and distinct elements relative to existing frameworks. The most notable distinction is our explicit focus on community rehabilitation and integration of restorative care. The care- and context-specificity of the CFACR stands in contrast with frameworks that focus on an entire health system (e.g., [38]) or rehabilitation across an entire health system (e.g., [27, 39, 47]), allowing the CFACR to be simpler while remaining comprehensive. For example, both the larger rehabilitation system models include multiple care settings or sectors within their scope (e.g. acute, inpatient, and outreach), which, beyond the connections between settings, may look very different. A shared feature of the CFACR with these larger-scope frameworks is the use of principles that provide overarching guidance. Many principles are shared across multiple frameworks (e.g., person- and family-centred, coordinated, and team-based), although no frameworks share all identical constructs. We elected to focus on including constructs which we deemed most actionable, that is, that would be most under the purview of those working in community rehabilitation. For example, *leadership* is a component of both the MQLF and NSW Rehabilitation Model of Care and was raised in our consultation forum. We decided not to include it in the CFACR because it represented an attribute rather than a tactical rehabilitation action. However, we recognize advancing the CFACR requires leadership in community rehabilitation. Our framework also offers more specificity than the ICF and Wade's discussion of community rehabilitation. We also

note that existing rehabilitation frameworks and conceptual discussions are all at least seven years old and that the terms used in the CFACR represent the most current conceptualizations of key components (e.g., evidence-informed vs evidence-based).

Although the CFACR was developed within a community rehabilitation context for a Canadian jurisdiction with input from older people and their families, we believe that the specific components and structure are generalizable in scope for other contexts around the world. This generalizability is supported by our incorporation of sources and references from other countries. Our goal in sharing this framework is to provide a conceptual scaffold for others to refine and build on. Health and social care system planners may be particularly interested in the CFACR as a tool for organizing services. We invite readers to review our hypothetical clinical scenario to reflect on how the CFACR might be applied in different service models. We also recognize that continued work will be required to facilitate application of the CFACR in our context and beyond. Evidence from implementation science can inform this process. Systematic approaches to implementation planning, tailored to contextual circumstances, are recommended to maximize implementation efficiency and efficacy, potential for scale up, and sustainability [48, 49]. Next steps could involve adapting the CFACR for specific contexts, exploring acceptability of the framework, and identifying specific opportunities for improvement related to individual components. Identification of barriers and facilitators to implementing each component is also required. From there, tailored solutions for each component can be developed in partnership with system leaders, adults receiving community rehabilitation services, and their families, with implementation strategies developed and rolled out. Future efforts should leverage existing reablement implementation support tools [50].

We recognize the limitations of this work. We acknowledge that our decision to take a pragmatic approach affected our outcome and that the resulting framework might have looked different if based on a different approach (such as realism). We note that the NSW Rehabilitation Model of Care that informed our framework has now been superseded by a new framework emphasizing principles to support rehabilitation care [47], although the complementary aspects of all these frameworks remain. Our conceptual framework, while general in nature, was developed in the context of health system transformation within one Canadian province, and we acknowledge that it is most relevant to our context. We also acknowledge that our activities were restricted to an urban setting and the semiurban, rural, and northern/remote settings that also exist in our province are less represented. Any application of the CFACR will vary across contexts and should be tailored to each setting. However, we believe that because the overarching components within the CFACR are foundational to health care quality, they will be widely relevant. Finally, while the framework CFACR was developed in the context of older adult experiences and needs, its potential relevance to other populations with ongoing health and social support needs merits additional study.

Two challenges have impacted our next steps after completion of the framework. First, the novel coronavirus pandemic that began in 2020 has drastically altered the health system and society. Application of the CFACR in a COVID-19 recovery era will surely evolve, both to support people living with long COVID and because home-based rehabilitation is increasingly recognized as essential [51]. Second, transitions among knowledge users working in the health system are a challenge in integrated knowledge translation work [52], and we are working to strengthening relationships with new health system leadership.

5. Conclusions

Moving forward, clinicians, clinical teams, and researchers can apply the CFACR by focusing on delivering and/or studying strategies or approaches to community rehabilitation care within one or more components of the framework. Meanwhile, health system planners and decision makers may focus across components and the entire framework to explore optimal impact. Continued conceptual and practical application of the CFACR in multiple settings and jurisdictions, especially as system transformation unfolds, will help to refine, validate, and/or evolve the concepts included in it.

Data Availability

The data that support the findings of this study may be available on request from the corresponding author (KMS). The data are not publicly available due to privacy and ethical restrictions.

Disclosure

The funding body had no role in the design of the study and collection, analysis, and interpretation of data and in writing the manuscript.

Conflicts of Interest

The authors report no conflicts of interest.

Acknowledgments

We acknowledge information support from Hal Loewen, Health Sciences Librarian at the University of Manitoba. We acknowledge research support services and expertise provided by the George & Fay Yee Centre for Healthcare Innovation, including Kerenza Plohman, Ashley Struthers, Catherine Charette, and Patrick Faucher. We also acknowledge editorial support from Karen Limbert Rempel. We thank all participants for their time and contributions to this work. This study was supported by the University of Manitoba Rady Faculty of Health Sciences Rady Innovation Fund. KMS was supported by the Government of Canada, Canada Research Chairs program.

Supplementary Materials

(1) Appendix1_search_strategy [1]. (2) Appendix2_case_study. (3) Appendix3_draft_framework_mapping. (*Supplementary Materials*)

References

[1] World Health Organisation, *GHE Life Expectancy and Healthy Life Expectancy: Situation and Trends*, Geneva, Switzerland, 2022.

[2] K. C. Roberts, D. P. Rao, T. L. Bennett, L. Loukine, and G. C. Jayaraman, "Prevalence and patterns of chronic disease multimorbidity and associated determinants in Canada," *Health Promotion and Chronic Disease Prevention in Canada*, vol. 35, no. 6, pp. 87–94, 2015.

[3] J. K. Harrison, A. Clegg, S. P. Conroy, and J. Young, "Managing frailty as a long-term condition," *Age and Ageing*, vol. 44, no. 5, pp. 732–735, 2015.

[4] I. Lilleheie, J. Debesay, A. Bye, and A. Bergland, "Experiences of elderly patients regarding participation in their hospital discharge: a qualitative metasummary," *BMJ Open*, vol. 9, no. 11, 2019.

[5] M. Sinha, "Spotlight on Canadians: Results from the General Social Survey," *Journals and periodicals*, vol. 89, 2013.

[6] D. Stones and J. Gullifer, "'At home it's just so much easier to be yourself': older adults' perceptions of ageing in place – CORRIGENDUM," *Ageing and Society*, vol. 37, no. 1, p. 219, 2017.

[7] Canadian Institute for Health Information, *National Health Expenditure Trends 1975 to 2019*, Canadian Institute for Health Information, Ottawa, ON, Canada, 2019.

[8] C. J. Poulos and R. G. Poulos, "A function-focused approach in primary care for older people with functional decline: making the most of reablement and restorative care," *Australian Journal of General Practice*, vol. 48, no. 7, pp. 434–439, 2019.

[9] World Health Organisation, *Rehabilitation in Health Systems*, Geneva, Switzerland, 2017.

[10] B. Ryburn, Y. Wells, and P. Foreman, "Enabling independence: restorative approaches to home care provision for frail older adults," *Health and Social Care in the Community*, vol. 17, no. 3, pp. 225–234, 2009.

[11] M. E. Tinetti, D. Baker, W. T. Gallo, A. Nanda, P. Charpentier, and J. O'Leary, "Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care," *Journal of the American Medical Association*, vol. 287, no. 16, pp. 2098–2105, 2002.

[12] M. R. Augustine, C. Davenport, K. A. Ornstein et al., "Implementation of post-acute rehabilitation at home: a skilled nursing facility-substitutive model," *Journal of the American Geriatrics Society*, vol. 68, no. 7, pp. 1584–1593, 2020.

[13] J. A. Luker, A. Worley, M. Stanley, J. Uy, A. M. Watt, and S. L. Hillier, "The evidence for services to avoid or delay residential aged care admission: a systematic review," *BMC Geriatrics*, vol. 19, no. 1, p. 217, 2019.

[14] E. W. Tsang, H. Kwok, A. K. Y. Chan et al., "Outcomes of community-based and home-based pulmonary rehabilitation for pneumoconiosis patients: a retrospective study," *BMC Pulmonary Medicine*, vol. 18, no. 1, p. 133, 2018.

[15] C. J. Poulos, A. Bayer, L. Beaupre et al., "A comprehensive approach to reablement in dementia," *Alzheimer's and Dementia: Translational Research and Clinical Interventions*, vol. 3, no. 3, pp. 450–458, 2017.

[16] M. Cohen, *Caring for BC's Aging Population: Improving Health Care for All*, Canadian Centre for Policy Alternatives, Vancouver, BC, Canada, 2012.

[17] W. P. Wodchis, A. P. Williams, and G. Mery, *Integrating Care for Persons with Chronic Health and Social Needs*, Institute for Health Policy Management and Evaluation, Toronto, Canada, 2014.

[18] Canadian Nurses Association, "Integration: a new direction for Canadian health care," A Report on the Health Provider summit Process, Canadian Nurses Association, Ottawa, Canada, 2013.

[19] A. P. Costa, J. W. Poss, T. Peirce, and J. P. Hirdes, "Acute care inpatients with long-term delayed-discharge: evidence from a Canadian health region," *BMC Health Services Research*, vol. 12, no. 1, p. 172, 2012.

[20] K. E. Covinsky, R. M. Palmer, R. H. Fortinsky et al., "Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age," *Journal of the American Geriatrics Society*, vol. 51, no. 4, pp. 451–458, 2003.

[21] K. E. Covinsky, E. Pierluissi, and C. B. Johnston, "Hospitalization-associated disability: she was probably able to ambulate, but I'm not sure," *Journal of the American Medical Association*, vol. 306, no. 16, pp. 1782–1793, 2011.

[22] C. Graf, "Functional decline in hospitalized older adults," *AJN, American Journal of Nursing*, vol. 106, no. 1, pp. 58–67, 2006.

[23] P. Nilsen, "Making sense of implementation theories, models and frameworks," *Implementation Science*, vol. 10, no. 1, p. 53, 2015.

[24] S. Imenda, "Is there a conceptual difference between theoretical and conceptual frameworks?" *Journal of Social Sciences*, vol. 38, no. 2, pp. 185–195, 2014.

[25] World Health Organization, *International Classification of Functioning*, Disability and Health, Geneva, Switzerland, 2001.

[26] T. S. Jesus and H. Hoenig, "Postacute rehabilitation quality of care: toward a shared conceptual framework," *Archives of Physical Medicine and Rehabilitation*, vol. 96, no. 5, pp. 960–969, 2015.

[27] Alberta Health Services, *Rehabilitation Conceptual Framework 2012*, Alberta Health Services, Alberta, Canada.

[28] D. Chateau, M. Doupe, H. Prior et al., *The Health Status of Community-Dwelling Older Adults in Manitoba*, Manitoba Centre for Health Policy, Winnipeg, MB, Canada, 2019.

[29] G. P. Marchildon, S. Allin, and Merkur, "Canada: health system review," *Health Systems in Transition*, vol. 22, 2020.

[30] L. Leclair, K. Zawaly, A. Korall, J. Edwards, A. Katz, and K. M. Sibley, "Exploring the delivery of community rehabilitation services for older people in an urban Canadian setting: perspectives of service providers, managers and health system administrators," *Health and Social Care in the Community*, vol. 30, no. 5, pp. e2245–e2254, 2022.

[31] V. Kaushik and C. A. Walsh, "Pragmatism as a research paradigm and its implications for social work research," *Social Sciences*, vol. 8, no. 9, p. 255, 2019.

[32] I. D. Graham, A. Kothari, C. McCutcheon et al., "Moving knowledge into action for more effective practice, programmes and policy: protocol for a research programme on integrated knowledge translation," *Implementation Science*, vol. 13, no. 1, p. 22, 2018.

[33] A. Kothari, C. McCutcheon, and I. D. Graham, "Defining integrated knowledge translation and moving forward: a response to recent commentaries," *International Journal of Health Policy and Management*, vol. 6, no. 5, pp. 299-300, 2017.

[34] Y. Jabareen, "Building a conceptual framework: philosophy, definitions, and procedure," *International Journal of Qualitative Methods*, vol. 8, no. 4, pp. 49–62, 2009.

[35] K. Zawaly, J. Ripat, L. Guse, A. Katz, J. Edwards, and K. M. Sibley, "Re-Braiding the strands of life through community rehabilitation, home care, and informal support: a longitudinal collective case study," *Canadian Journal on Aging/La Revue canadienne du vieillissement*, vol. 42, pp. 80–91, 2022.
[36] H.-F. Hsieh and S. E. Shannon, "Three approaches to qualitative content analysis," *Qualitative Health Research*, vol. 15, no. 9, pp. 1277–1288, 2005.
[37] F. Hoekstra, K. J. Mrklas, K. M. Sibley et al., "A review protocol on research partnerships: a Coordinated Multicenter Team approach," *Systematic Reviews*, vol. 7, no. 1, p. 217, 2018.
[38] Shared Health Manitoba, *Manitoba Quality and Learning Framework*, Shared Health Manitoba, Winnipeg, MB, Canada, 2019.
[39] NSW Agency for Clinical Innovation, "NSW Rehabilitation Model of Care: NSW Health Rehabilitation Redesign Project," Final report-model of care, Nsw Agency for Clinical Innovation, Nsw, Australia, 2015.
[40] D. Ciliska, H. Thomas, and M. K. Buffett, *An Introduction to Evidence-Informed Public Health and A Compendium of Critical Appraisal Tools for Public Health Prac- tice (Revised)*, Hamilton, ON: National Collaborating Centre for Methods and Tools, 2012.
[41] J. Rycroft-Malone, "Evidence-informed practice: from individual to context," *Journal of Nursing Management*, vol. 16, no. 4, pp. 404–408, 2008.
[42] C. Hsu, M. F. Gray, L. Murray et al., "Actions and processes that patients, family members, and physicians associate with patient- and family-centered care," *BMC Family Practice*, vol. 20, no. 1, p. 35, 2019.
[43] B. Resnick, L. Gwyther, and K. Roberto, *Resilience in Aging: Concepts, Research, and Outcomes*, Springer, Geneva, Switzerland, 2018.
[44] World Health Organization, *Health Information Systems and Rehabilitation*, World Health Organization, Geneva, Switzerland, 2017.
[45] D. A. Richards, P. Bower, C. Pagel et al., "Delivering stepped care: an analysis of implementation in routine practice," *Implementation Science*, vol. 7, no. 1, p. 3, 2012.
[46] D. T. Wade, "Community rehabilitation, or rehabilitation in the community?" *Disability and Rehabilitation*, vol. 25, no. 15, pp. 875–881, 2003.
[47] ACI Rehabilitation Network, *Principles to Support Rehabilitation Care-Version 1*, ACI Rehabilitation Network, NSW, Australia, 2019.
[48] I. D. Graham, J. Logan, M. B. Harrison et al., "Lost in knowledge translation: time for a map?" *Journal of Continuing Education in the Health Professions*, vol. 26, no. 1, pp. 13–24, 2006.
[49] J. M. Grimshaw, M. P. Eccles, J. N. Lavis, S. J. Hill, and J. E. Squires, "Knowledge translation of research findings," *Implementation Science*, vol. 7, no. 1, p. 50, 2012.
[50] C. O'Connor, M. Gresham, R. G. Poulos et al., "Translating reablement research for dementia practice: development of a handbook using implementation science," *Disability and Rehabilitation*, vol. 44, no. 8, pp. 1524–1536, 2022.
[51] J. R. Falvey, C. Krafft, and D. Kornetti, "The essential role of home- and community-based physical therapists during the COVID-19 pandemic," *Physical Therapy*, vol. 100, no. 7, pp. 1058–1061, 2020.
[52] A. R. Gagliardi, W. Berta, A. Kothari, J. Boyko, and R. Urquhart, "Integrated knowledge translation (IKT) in health care: a scoping review," *Implementation Science*, vol. 11, no. 1, p. 38, 2016.