An Interprofessional Approach to Strengthening Home and Community Care
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Background

The Ontario government has outlined its commitment to develop a health care system that puts patients first (1). Furthermore, the Ministry of Health and Long Term Care (MOHLTC) has made home and community care a priority for improving our health care system (2). In 2015, the MOHLTC released a report titled *Patients First: A Roadmap to Strengthen Home and Community Care.* This paper calls for a transformation in the way we deliver care at home and in the community, and highlights pressing issues that need to be addressed in order for our health care system to be able to deliver integrated, quality care, closer to home.

As Ontario's population ages, home and community care is becoming increasingly important and in greater demand. From the patient perspective, robust home and community care increases comfort and overall quality of life (2). From a health care system perspective, home and community care frees up hospital beds for those who need them, reduces pressure on emergency rooms and has the potential to save money (3). As a consequence of expanding home and community service in Ontario, there has been a 42% increase in hospital discharge to home care service and 32% decrease in long-term care wait (4). Despite recognition of the importance of home and community care, only 6% of the Ontario health budget (2013-14) was dedicated to providing these services (4). While progress is being made, home and community services can be inconsistent, insufficient and hard to navigate (5). We need to continue to increase access to services for those who need them most, and ensure services are delivered in an integrated manner.

Position statement

Improvements in home and community care services requires an interprofessional, integrated approach in order to achieve quality care that is person-centred and closer to home.

Recommendations

Recognizing that improvements in home and community care services requires an interprofessional, integrated approach we recommend the following:

1. Recognize unpaid caregivers as an integral part of caring for people in the community and at home, and expand caregiver support.

As an interprofessional team of student health care providers, we recognize the valuable role each profession plays in order to provide the best care for our patients. We also recognize the essential role that unpaid care providers, such as family, friends and neighbours, play in providing home and community care. Our health care system relies heavily on unpaid caregivers who support individuals to stay in their homes (6). Within the context of an aging population and an environment of fiscal restraint, it is important that the integral role these individuals play as part of the care team is recognized. In doing so, it is also important to acknowledge and help combat caregiver distress. As health care providers we need to continue to listen to this group of care providers, and understand how they can be

better supported. For example, efforts must be taken to relieve the physical, financial and emotional stress placed on them. As outlined in the MOHLTC report titled *Patients First: A Roadmap to Strengthen Home and Community Care* we strongly back efforts to expand caregiver supports. Furthermore, we recommend implementation of interprofessional strategies to improve modifiable factors on the experience of burden (7). This includes improving respite care by increasing the number of spots available and the duration of adult day programs for adults living in the community (8). Lastly, we support the Ontario government's expansion of compassionate care leave from six to 26 weeks (9).

2. Better integrate home and community care services into the health care continuum.

We recognize the importance of all health care providers working together to provide the best care for patients. As outlined in the MOHLTC report titled *Patients First: A Roadmap to Strengthen Home and Community Care* we support testing an innovative approach to bundled care to improve coordination between hospital and home care. We also recognize that planning for home and community care services are not currently done in an integrated manner with all health services, as they are planned by separate entities. We are in support of transferring responsibility for home and community services from Community Care Access Centres (CCACs) to the Local Health Integration Networks (LHINs) in order to improve the integration of service planning (5). However, we recommend that the role of case managers continue, especially during this transition. Case managers support the autonomy of their clients and coordinate multidisciplinary care across the health care system (10).

3. Leverage information technology to ensure collaborative, integrated home and community care amongst all care providers

Interprofessional teams require strong information technology networks that enable information sharing, planning and decision-making, as well as communication amongst team members. As discussed in "Patients First: A proposal to strengthen Patient Centred Health Care in Ontario" (5), health care providers would greatly benefit from improved information systems that track the care patients receive across various parts of the health care system. A robust information technology network would help care providers meet the needs of their patients as they move throughout the system, both in hospital, and in the community and home.

Conclusion

Interprofessional care is central to effective home and community care delivery that puts patients' and caregivers' needs first. We have seen successful efforts to integrate providers and services to strengthen home and community care in Ontario. As an interprofessional group of students we advocate for recognition of unpaid caregivers as partners in providing care, continued efforts to integrate services and the use of technology to enhance communication across the health care system.

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