6.2: Background- Why the Need for Interprofessional Collaboration

Primary Health Care

The urgent need for the implementation of primary health care throughout the world was given international recognition at the World Health Organization (WHO) conference in Alma-Ata, USSR in 1978. Primary health care was described as “a community-based health care service philosophy that is focused on illness prevention, health promotion, treatment, rehabilitation, and identification of people at risk” (Howse & Grant, 2015, p. 132). The Canadian Nurses Association (CNA) issued a position statement strongly supporting the five essential principles of primary health care: “accessibility, active public participation, health promotion and chronic disease prevention and management, the use of appropriate technology and innovation, [and] intersectoral cooperation and collaboration” (CNA, 2015, p. 1). Collaboration and teamwork across the professions and health care sectors are required to meet the five principles inherent within the primary health care service philosophy adopted at Alma-Ata. These principles are the catalyst for interprofessional and inter-sectoral health care collaboration in the provision of comprehensive health care to the public.

Figure 6.1.1 Public Health Nurse in Action
Providing Primary Health Care: Complex Client Needs and the Shift to Care in the Community Sector

Worldwide, the population of persons over the age of 65 is growing, and in most developed countries the increase is most striking in those aged 80 and older (Kwan, Chi, Lam, Lam, & Chou, 2000). The demographics of Canada are changing rapidly. The population of seniors in Canada is expected to grow from 3.5 million people in 1996 to an estimated 6.9 million by 2021 (Statistics Canada, 2015). By 2021, approximately 18.7 per cent of the population will be over the age of 65 (Health Canada, 2010). In 2014, seniors accounted for approximately 14 per cent of the population and 40 per cent of hospital resources (CNA, 2016). As the population grows older, the incidence of chronic illness will also rise (Government of Canada, 2015). Accordingly, the ability to respond to the health needs of older persons in a clinically (professional) and fiscally responsible manner has become a critical challenge of the current health care system (Canadian Institute for Health Information, 2010; Hirdes, Ljunggren, et al., 2008; Kwan et al., 2000). As stated by Leung, Liu, Chow, and Chi (2004) “even though aging is not synonymous with frailty, elderly people are major consumers of health care” (p. 71).

Moreover, Bernabei, Landi, Onder, Liperoti, and Gambassi (2008) and Hirdes, Ljunggren, et al., (2008) suggest that health care systems are increasingly confronted with older clients who are: affected by complex interactions of physical, social, medical, and environmental factors; receiving multiple and frequently interacting medications and treatments for an array of clinical conditions; and often limited in terms of financial resources and support systems to meet increasing health needs.

Even though current health systems have evolved to provide sophisticated acute care, these systems continue to be challenged by complex geriatric clients with chronic medical, psychological, and social needs. The responsibility for their care, once the domain of the hospital and long-term care facilities, has shifted to the community (Bernabei et al., 2008). A systematic review of the literature documenting outcomes from home-based primary care (HBPC) programs for homebound older adults indicated that “specifically designed HBPC programs . . . can reduce hospitalizations and long-term care admissions while improving individual and caregiver quality of life and satisfaction with care” (Stall, Nowaczynski, & Sinha, 2014, p. 2249). Community health services play an increasingly prominent role in the health care system with the aim of minimizing inappropriate hospitalizations and/or admissions into long-term care (Gray et al.,

Special attention must be paid to the Canadian Indigenous senior population. Many have complex health needs, but live in areas where it is more challenging and expensive to provide care. In 2006, almost 5 per cent of Indigenous people were aged 65 or older (Health Council of Canada, 2013). The social conditions on many reserves reflect the historical and political neglect that Canada has shown toward people of Indigenous ancestry (see Native People Social Conditions). Many Indigenous seniors are “isolated and struggling due to multiple factors in their lives and communities; they need more intensive support than non-Aboriginal seniors” (Health Council of Canada, 2013, p. 28). In addition, they may be intimidated by the institutionalized health care system. This intimidation may be attributed to care provider approaches similar to those described in a recent research study in which Indigenous patients “reported stories of bullying, fear, intimidation and lack of cultural understanding” (Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, K., 2014, p. E1). Health care providers who incorporate culturally appropriate practices into their care provide a welcoming environment that encourages the use of health care services by Indigenous people.

At least one million Canadian seniors are currently living with a mental illness (CNA, 2011). Neill, Hayward, and Peterson (2007) argue that there is a dire need to provide access to wellness care that supports healthy aging, noting that “the population of individuals over 60 is expected to increase to almost two billion internationally by 2050” (p. 425). However, clients of all ages suffer with chronic mental health issues. These individuals can be among the most disadvantaged groups in Canada. They are often living with multiple intersecting health and societal issues that potentiate reliance on a range of services (Schofield et al., 2016).

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**Research Note**


**Purpose**

The purpose of this project was to provide a profile of caregivers of home care clients with neurological conditions. The study also examined prevalence of caregiver distress and the association between neurological conditions and other client and caregiver characteristics with distress.

**Discussion**

The study population included home care clients in Winnipeg, Manitoba and the province of Ontario. Neurological conditions included in the study were Alzheimer’s disease and related dementias, multiple sclerosis, amyotrophic lateral sclerosis, Parkinson’s disease, Huntington disease, epilepsy, muscular dystrophy, cerebral palsy, traumatic brain injury, spinal cord injury, and stroke. Home care client characteristics and caregiver characteristics were collected and analyzed for each neurological condition. Risk factors associated with caregiver distress were identified.

**Results**

Many home care clients were found to have one or more of the neurological conditions (38.8 per cent to 41.9 per cent).
Caregiver distress was twice as prevalent among caregivers of clients with neurological conditions (28.0 per cent). “The largest associations with caregiver distress were the amount of informal care hours provided in a week and the MAPLe algorithm, an indicator of a client’s level of priority for care” (p. 350). Huntington disease was the neurological condition most strongly associated with caregiver distress. However, clients’ clinical characteristics and the number of informal care hours were more strongly associated with caregiver distress. The provision of formal home care services from the community reduced caregiver stress.

Application to practice

Many informal caregivers providing care to these clients with neurological conditions experience distress. Multi-component support strategies are required for informal caregivers of the complex clients.

A report by the Commission on the Future of Health Care in Canada (Romanow, 2002) advocated for a strengthening of the Canadian health care system by inclusion of post-acute care, palliative care, and mental health home care services under a revised Canada Health Act, with these services covered by Medicare. In turn, Shamian (2007) stated:

If policy makers are serious about ensuring the sustainability and quality of our health care system they must turn their attention to the role that home and community care plays. Failing to do so will result in a fragmented, weakened health care system. (p. 296)

A heightened and fundamental role of community services in the provision of health care across Canada is required to meet the growing number of clients in the community with complex and chronic medical, psychological, and social needs. As institutions have downsized and/or closed, the acuity and chronicity of client care has escalated in the community, both in home care and community mental health. Furthermore, the client’s and the family’s desire to remain in the home and to be cared for in the community has become a significant factor as client- and family-centred care evolves.

Yet this brings challenges for the clients, their families, health care providers, and the health care system. How can the complex needs these clients experience be optimally met, keeping quality, safety, and efficiency in mind? How do we as nurses ensure a client- and family-centred approach? How can we as health care providers optimize recovery, wellness in chronicity, and prevention as we provide care in the community?

Complexity, Community Care, and Collaborative Practice: The 3 “C’s”

The increasing prevalence of chronic conditions in Western societies and ensuing need for non-acute quality client care bring the need for collaborative practice to the fore (Xyrichis & Lowton, 2008). Xyrichis and Lowton (2008) suggest that multidisciplinary teamwork will lead to an integrated approach to population health promotion and maintenance, while improving the efficacy and outcomes of client care.

Furthermore, community care encompasses medical, psychological, and social care, as well as health promotion and illness prevention strategies. For such an all-encompassing service to be delivered, an array of professionals and skills are required in a team approach (Xyrichis & Lowton, 2008). Neill et al. (2007) argue that a collaborative interprofessional client care model supports the comprehensive delivery of quality care through the integration of multiple professions.
Essential Learning Activity 6.1.1

Read the Canadian Nurses Association’s “Position Statement on Interprofessional Collaboration” and identify the four principles that facilitate collaboration.

Diversity among the multidisciplinary team encourages cultural relevancy, bringing creativity to comprehensive client care. Nonetheless, Naylor (2012) found there is often inadequate communication among multidisciplinary teams and insufficient engagement with the client and family members. However, Naylor duly noted that in order to interrupt patterns of high health care utilization by the chronically ill and address the negative effects of this usage on quality and costs, innovative solutions to improve professional collaboration and client and family engagement have emerged in many health care settings. An example of such an innovative solution is **telenursing**, which assists the care providers to overcome difficulties raised by geographical distance and transportation problems (Souza-Junior, Mendes, Mazzo, & Godoy, 2016). Recognition of the client perspective, along with the engagement and participation of the client and family in that client’s care planning and implementation, has led to quality care in many health care settings in Saskatchewan.

Essential Learning Activity 6.1.2

Watch this video “How does interprofessional collaboration impact care: The patient’s perspective” (7:45) by Dr. Maria Wamsley, about the client- and family-centred approach, then answer the following questions:

1. What do we mean by patient-centred care?
2. What is disease-centred care?
3. Which professionals are on a patient-centred care team?
4. Why is it important to have multiple professionals on a patient-centred team?

From the Field

*Canadian Nurse*, a publication of the Canadian Nurses Association, will often highlight a Canadian nurse in the “Nurse to Know” portion of the journal. The following quotes are excerpted from these personal profiles, where the nurse is presented with questions at the end of his or her interview. Their responses reflect the discussion in the background of this chapter, as these leaders reflect on their own experiences as nurses within the Canadian health care system, including what they see as challenges and/or changes needed.

(a) What do you like least about being a nurse?

“The lack of true teamwork in inter-professional teams.” —Marion Rattray (Eggertson, 2016, p. 37)

(b) What is your biggest regret?

“Trying to tell a resident at Massachusetts General that he was wrong and that I had a better idea. I should have just offered him cookies.” —Gina Browne (Geller, 2015a, p. 35)
(c) Name one change you would like to make to the health system.

“I’d increase services such as youth centres and food and clothing banks that promote community health and well-being.” —Julie Francis (Geller, 2013, p. 35)

(d) Name one change you would like to make to the health system.

“I would remove all borders.” —John Pringle (Cavanaugh, 2013, p. 35)

(e) What is the best thing about your current job?

“Having the autonomy to make a tangible difference in people’s lives.” —Helen Boyd (Jaimet, 2013a, p. 35)

(f) Name one change you would like to make to the health system.

“I’d enhance services for those living with addictions and mental health issues.” —Helen Boyd (Jaimet, 2013a, p. 35)

“That it’s not such a ‘system’; it should be about what’s best for the patient.” —Hazel Booth (Jaimet, 2013b, p. 33)

“I’d reduce fragmentation in health-care services.” —Angelique Benois (Geller, 2015b, p. 27)

“I would like to see more use of integrated health-care information systems to improve care coordination and reduce duplication and redundancies.” —Manal Kleib (Geller, 2014, p. 37)

These notable reflections are a snapshot from the many exemplary nurse leaders (frontline and administrative) across Canada. They speak to the importance of the centrality of the client and family; seamless care from one service to another; collaboration and teamwork; and community care and systems integration to optimize care, safety, and efficiencies.