



## Interprofessional collaboration in health care teams for the maintenance of community-dwelling seniors' health and well-being in Canada: A systematic review of trials



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### ABSTRACT

**Background:** Literature suggests that interprofessional (IP) teams in healthcare may offer better and more client-centered care, but little is known about their impact on health outcomes among seniors in home care.

**Purpose:** To systematically synthesize the Canadian evidence on the effectiveness of IP health care models on the health and well-being of community-dwellers aged  $\geq 65$  y receiving home care.

**Method:** We conducted a systematic search of indexed, peer-reviewed articles reporting on community-based healthcare models that included at least two different disciplines and published between January 2005 and December 2015.

**Discussion:** A total of six trials (Ontario  $n = 3$ , Quebec  $n = 2$ , and British Columbia  $n = 1$ ) were included in the synthesis, being two fully collaborative. The synthesis suggests IP teams have greater positive effects on patient-reported measures of health (distal measures, e.g., increased satisfaction with care and quality of life) than direct measures of health (e.g., decreased visits to the emergency and hospitalization).

**Conclusion:** IP teams appear to positively impact some health outcomes. Models are, however, heterogeneous and lack of national representation, particularly from rural and remote areas.

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### Introduction

In 2015, Canada had a historical demographic shift: the number of people older than 65 equaled that of children under the age of 15, meaning 6 million or 16% of the population.<sup>1,2</sup> Almost 86% of

the total number of seniors live in the provinces of Ontario, Quebec, British Columbia, and Alberta, but the province of Nova Scotia has the highest ratio of persons aged  $\geq 65$  years to children aged 0–14 years, 1.35.<sup>1</sup> This demographic shift means increased health concerns, particularly non-communicable chronic diseases, including stroke, cardiovascular disease, and dementia, and forewarns, perhaps, an emerging long-term hospitalization epidemic and increased burden on the health care system.<sup>3,4</sup> In 2011, a Canadian report revealed that 14% of acute hospital beds were being occupied daily by patients who no longer needed specialized hospital services and would be better served in long-term care facilities (LTCF) or in their own homes, receiving rehabilitation or other medical services.<sup>5</sup> As patients transition from the acute to the chronic stage in the disease process, however, they require the collaborative expertise of multiple specialists, such as physiotherapists, occupational therapists, nurses, social workers, and dietitians while in the home.<sup>6</sup> Hence, community-based interprofessional (IP) teams can offer the necessary multitude of expertise to allow for seniors to receive adequate care in their own homes.<sup>7</sup>

**Abbreviations:** CM, case manager; CCAC, Care Community Access Coordinator; GP, General Practitioner; HCP, health care professional; IP, interprofessional; IPCT, interprofessional collaborative teams; LTCF, long-term care facilities; NP, nurse practitioner; OT, occupational therapist; PT, physiotherapist; PSW, Personal Service Worker; RN, registered nurse; SW, social worker.

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Research on IP collaborative teams (IPCT) in healthcare emerged in the 1960s and 1970s, when a more collaborative practice between the patient and the physician was encouraged.<sup>8</sup> In the last two decades, research and practice of IPCTs became more comprehensive with the inclusion of all stakeholders in the decision-making process, such as acute-care setting personnel, patients, and caregivers.<sup>9</sup> Currently, IPCTs differ from multidisciplinary teams in that professionals in IPCTs must interact frequently and collaborate for shared decision-making and care provision, while a multidisciplinary team contains professionals from different disciplines who decide on their own their share of care—in other words, they “work in silos” and do not necessarily collaborate for the provision of a client-centered care.<sup>10</sup> Hence, real collaboration in IP teams is the gatekeeper to breaking down “siloed” thinking in healthcare and enabling a culture of care that remains inclusive, comprehensive, and holistic for the care of seniors.<sup>11</sup>

A Canadian mixed-method study with 272 home care providers suggests that these professionals are willing to engage in interprofessional-shared decision-making (i.e., work collaboratively), but lack of time, poor team cohesion, and high staff turnover can be important barriers.<sup>12</sup> Furthermore, upon discharge from the acute care setting, care for community-dwelling seniors becomes disconnected and divided into sectors (healthcare, rehabilitation, and social care), further hindering the existence of an IPCT.<sup>13</sup> When barriers are addressed, IP collaboration can act as a segue to better care planning for seniors in the community.<sup>14</sup> Research has uncovered some essential traits of effective IP teams, such as cohesion and constant dialogue,<sup>14</sup> but little is known about their effectiveness in improved health outcomes for home-based community care for seniors. The purpose of this systematic review is to synthesize experimental evidence on the effectiveness of IP collaborative models in Canada on health outcomes and well-being of community-dwellers aged  $\geq 65$  y receiving home care.

## Methods

The methodology for this systematic review encompasses a literature search, inclusion of articles and critical appraisal, and data extraction and synthesis.

### Literature search and screening

A librarian conducted an electronic literature search for peer-reviewed articles published between January 1, 2005, and April 31, 2015 in PubMed, CINAHL, Sage, JSTOR, ProQuest Central, and Web of Knowledge. The delimitation to the past 10 years ensures relevance to the current demographic and health system contexts. The search strategy included the geographical limiter “Canada” and used selected key words, either separately or in combination, related to the research question, generating a total of 11,006 articles (Fig. 1). This total initial number included original research of any design (quantitative, qualitative, and mixed-methods), as it was not known whether an adequate number of trials would be available for a systematic review. Criteria for inclusion of an article for appraisal were the following:

- Original research in a peer-reviewed journal or conference abstracts;
- Published between January 2005 and April 2015;
- Study conducted in Canada;
- Healthcare team is community-based and delivers care at home;
- IP teams were partially or fully collaborative;
- Beneficiary population was seniors ( $\geq 65$  years old) living in the community;

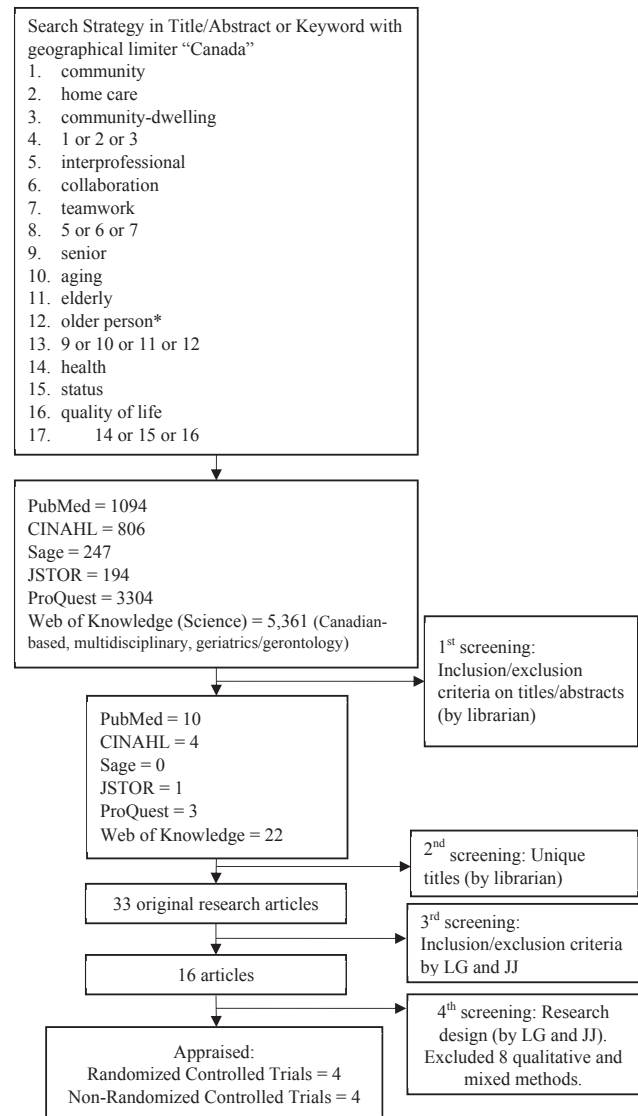


Fig. 1. Flowchart of literature search and screening process.

- Study outcomes were either the interprofessional health care team itself or any proximal measures of health (e.g. seniors' health status, visits to the emergency department) and/or distal measures (e.g. quality of care, quality of life).

As illustrated by the flowchart in Fig. 1, two screenings of titles and abstracts were carried out to exclude articles that explored IP teams in a clinical setting, in nursing homes, or in palliative care. The studies deemed non-collaborative (as detailed later) were excluded in a 3rd screening based on the full paper. At this stage, the authors noted a sufficient number of controlled trials for a systematic review. Hence, studies with a qualitative ( $n = 6$ ), mixed-method ( $n = 1$ ), and cross-sectional ( $n = 1$ ) design were excluded from this synthesis. The final sample comprised of eight controlled trials (four non-randomized and four randomized trials), which were subsequently appraised for quality.

The same search was conducted again in February 2016 to identify potential new publications issued between April and December 2015. No relevant studies were found.

This review was registered in the PROSPERO database, no. CRD42015020739.

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