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For more information please contact:

Advertising: Cheryl Lee

cheryl@mccronehealthbeat.com

Toll Free – Ph 1.800.727.0782

Publisher: Jan Henry, McCrone Publications

jan@mccronehealthbeat.com

Letters & Articles: Jay Sherwood

jay@mccronehealthbeat.com

Graphic Design: Jackie Vogt

design@mccronehealthbeat.com

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9768 – 170 Street, #319

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Ph: 780.413.9342 Fax: 780.413.9328

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Despite the current state of our country's economy and reports of increased unemployment in various sectors, Canada continues to face labour shortages amongst most of the health disciplines. According to the Canadian Nurses Association there were over 250,000 registered nurses working in 2008, constituting by far the largest professional group serving the health care systems in Canada. Nursing and health care add to the "productivity and economic prosperity of our nation" (CNA, p.1).

In August 2008, before the current crisis in the global economy became so apparent, the CNA presented a brief to the House of Commons Standing Committee on Finance. In the brief, CNA noted that economic activity in the health sector contributes about 10 percent to Canada's GNP and employs 10 percent of the Canadian workforce. It is also noted that the federal health minister has promised to make fundamental changes to the system based on targeted investment in four areas namely: research; improved collaboration between jurisdictions; technology and health human resources. CNA offered recommendations to the committee related to investment in three areas. These are: science and innovation; information and communications technology (ICT) in the health sector; and, health human resource infrastructure. All three have an impact on basic and continuing health professional education.

Science and Innovation

Over a hundred years ago nursing education in Canada was largely based on an apprenticeship model that met the needs of hospitals for labour and in many instances, the needs of physicians. Fast forward to 2009, and the majority of new graduates from programs to prepare registered nurses have a baccalaureate degree in nursing. This has made nursing a university-based professional discipline with a research-based, scientific practice. A significant federal investment in nursing research was in 1999 with the announcement of the Nursing Research Fund of 25 million dollars. The fund has led to a growth in doctoral programs in nursing from none in 1990 to 15 in 2008. Doctoral programs

Nursing Education and Strengthening the Economy in Canada

Editorial: by Jennifer (Jay) Sherwood, BScN, MEd.

significantly generate new knowledge through their heavy research component. As well, the Canadian Nurses Foundation funded over 160 nursing research projects between 2003 and 2007, gaining an additional \$4.7 million from other partners.

There are numerous examples of care innovations resulting from nursing research projects. The one cited in the brief notes that a study by a research team led by a nurse compared the cost, time and efficacy for visits to nursing clinics to those of home visits through community care access centres. From the study findings it was estimated that 10 percent of Canadians could be treated in less time for less cost with greater efficacy at nursing clinics. Applied across the Canadian health care systems it was estimated that 146 full time registered nurses could be redeployed to other places in the systems where there were shortages while realizing a cost saving of approximately \$10 million in lower cost visits.

While the Nursing Research fund will end in 2009, it has been shown to be an effective infrastructure investment. Continuation of such an investment in nursing research would result in continuing innovation in health care, making the system stronger, better and more effective.

Information and Communications Technology in the Health Sector

Although it is acknowledged that the benefits of applying ICT to the health sector are numerous, it is estimated that the health sector is 25 – 30 years behind other sectors in the economy. The most obvious benefits are in the provision of care, while less obvious are in the provision of education to health professionals. Both basic and continuing education programs for registered nurses are increasingly using distance education strategies in whole or in part of the overall program. Distance strategies make education more accessible to nurses and include both ICT and non ICT components. For example, in some distance programs, individual students may be required to travel to a common site located far from the hosting university, while others may be offered exclusively by electronic methods.

In its brief, CNA states that by the 2006-2007 school year, 37 out of 131 baccalaureate nursing

programs were offered electronically in whole or in part. As well, in another document on the CNA website it is indicated that there are three master's programs that are completely offered by distance and at least three doctoral programs use some distance strategies. A number of universities use distance methods in at least some courses in post-basic RN baccalaureate programs. Investment in ICT will result in making world class nursing education accessible to all who qualify.

Health Human Resource Infrastructure

Over the last few years there has been concern that we are not producing enough health professionals to meet our growing demand for health services. First, those over 50 are overrepresented in the health workforce and new graduates are not being produced to successfully replace retiring staff; and, second, technological innovations require constant change in skill sets. Investment in health professional education to prepare new members of health professions is a necessary strategy to address growing demands but equally important is a strategy to meet the life long learning needs of those in the workforce. The modern and evolving roles for health professionals will increase the demand for learning opportunities both in and outside of the workplace.

To address the educational and other human resource infrastructure issues the CNA is recommending a National Human Resource Infrastructure Fund that would cover the essential elements that are needed to train and develop additional health providers and leaders as well as providing for continuing education to meet the needs for changing skill requirements of those currently in the workforce.

In the conclusion of the brief, CNA claims that "...underinvestment in health sector infrastructure will risk poor performance not only in the health system but also in the national economy more widely." (CNA, p.5) To maintain the "Canada Advantage" by making Canada a better place by assuring high quality health care, registered nurses need the

See Editorial page 7

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The British Columbia Institute of Technology (BCIT) has been educating BC's health care workers for over 40 years, partnering with the province's health authorities to ensure graduates meet and exceed the industry's need for skilled workers. BCIT's School of Health Sciences programs aim to create job-ready graduates for the health care and research fields, meeting demands for a healthier community now and into the future.

BCIT programs are expedited, offering entry-to-practice training in much shorter timeframes than traditional undergraduate degree programs. For example, the three-year Bachelor of Science in Nursing (BSN) program was launched last year with the intent to get skilled registered nurses into the workforce sooner. Many BCIT programs are offered as two-year diploma programs, allowing students to get the applied training they need in a short time frame.

There is a wide variety of courses and programs available, from introductory to advanced professional development training. Flexible education formats, including part-time studies and distance education, are also available for select programs, including Cardiac Sciences, Medical Imaging, and Health Care Management. Simulation equipment and clinical training provides practical skills for students on the leading-edge of health care training. With the hands-on approach to training and condensed program formats, BCIT is leading the way in applied training and excellence in patient and client care.



Looking towards the future of practice, a new vision was developed in 2008 for advancement and an education plan was put in place to excel academic programming. The vision is:

"Advancing provincial practice in health sciences through recognized graduates"

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See BCIT page 7




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Health Professional Education: Its Relationship to Collaborative and Interdisciplinary Practice

by Jennifer (Jay) Sherwood, BScN, MEd.

One of the major foci of the Canadian First Ministers' Health Accords (2000 and 2003) was a commitment to appropriate planning and management of health human resources. Apart from determining numbers and types of health human resource personnel the First Ministers, taking information from both the Kirby and Romanow reports (and others that went before them) focused on Primary Health Care and the need for innovative delivery strategies for patient care and collaborative, interdisciplinary practice. They saw that changing the way that health professionals are educated by promoting interprofessional education for collaborative patient centered practice is one key to primary health care renewal and to recruiting and retaining a stable and well prepared health workforce in Canada.

The idea of collaborative practice is certainly not a new one. Like many good ideas in health care and elsewhere, it has taken a long time (and numerous pilot projects, unreported initiatives and the like) for the focus to become a driving force in

resource planning for health care delivery. On Health Canada's website www.hc-sc.gc.ca/hcs-sss/hrh-rhs/strateg/interprof/index-eng.php there is a section on Health Human Resource planning. It is from this section that I have obtained most of the following for this editorial. Collaborative Patient-Centered Practice is defined by Health Canada as being the type of practice where there is active participation by all health disciplines relevant to a patient's care. In some ways it is not unlike the team approach that most of us practiced formally and informally in years past. As a concept it has been fleshed out to include continuous communication, active participation in clinical decision making and true respect built in for the disciplinary contributions of all health professionals. Interprofessional education, the interdependent concept, is defined as "occasions where two or more professionals learn from and about each other to improve collaboration and the quality of care."

As one component of the Health Canada's health human resource strategy a 304 page

research report of the interprofessional education initiative, Interprofessional Education for Collaborative Patient-Centered Practice, has been prepared. In the overview of the report and the initiative itself, it is noted that the concepts of "collaborative patient centered practice" and "interprofessional education" are interdependent. While the interdependence is illustrated in the description of the conceptual framework underlying the report, they are treated both separately and together. My purpose in this short editorial is to focus on interprofessional education.

Interprofessional education needs to happen both before and after licensure to practice. At the undergraduate level, the timing of interprofessional education is important. It is thought that students in all disciplines need a thorough grounding in their own disciplines before engaging in interprofessional learning activities, suggesting that it occur at the senior levels of professional programs. Continuing education, both for academic credit (e.g. at the graduate level) and non-credit is imperative for the practice of collaboration across the continuum of patient care. There are three broad goals for providing interprofessional education. These are:

- Socializing health care providers in working together in shared problem solving and decision making...;
- Developing mutual understanding of, and respect for, the contributions of various disciplines; and
- Instilling requisite competencies for collaborative practice.

More specifically the objectives of inter-

professional education and collaborative patient-centered practice initiative outlined in the Overview mentioned are:

- Promoting and demonstrating the benefits of interprofessional education for collaborative patient-centered practice;
- Increasing the number of educators prepared to teach from an interprofessional perspective;
- Increasing the number of health professionals trained for collaborative patient-centered practice before, and after entry-to-practice;
- Stimulating networking and sharing of best educational approaches for collaborative patient-centered practice; and
- Facilitating interprofessional collaborative care in both education and practice settings.

A major part of interprofessional education is the fostering of practice settings where successful collaboration amongst professionals is part of the culture of care. In settings such as these, professionals will demonstrate a shift in attitudes from professional autonomy to interdependence, be able to clearly communicate their professional knowledge and skill to other professionals and will demonstrate a respect for the contributions of each discipline as it relates to particular aspects of patient care. These professionals, competent in collaborating, will act as role models and provide experiences for both pre and post licensure students, help them learn to work collaboratively. Developing collaborative practice settings where none exist requires formal competency training for health professionals on how to collaborate meaningfully and organizational and system change to focus on collaborative practices.

In a vision of interprofessional education a focus on developing teaching processes to
See *Health Professional Education* page 5



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Colorectal cancer is the third most common cause of cancer death among men and women. Approximately 150,000 new cases of colon (large intestine) cancer are diagnosed and more than 56,000 people die from this disease in the U.S.

Who is at Risk?

Colon cancer can occur in persons of any age, but it is most common in those over the age of 50.

What are the Symptoms?

If you have symptoms of colonic disease (for example, rectal bleeding, bloody stools, abdominal pain, change in bowel habits, anemia, or weight loss) you should seek medical attention immediately and likely undergo a colonoscopy. However, please remember that most patients with early colon cancer or colon polyps have no symptoms or signs of disease. That is why routine screening for these disorders is so important.

Most colon cancers arise from large intestinal polyps that progress from small bumps on the lining of the bowel to larger polyps that finally develop into invasive cancer. This process

takes up to 10 years in most people. Therefore, there are many opportunities to intervene medically before a polyp becomes cancer.

Methods of Screening for Colon Cancer

For both men and women at average risk, screening should start at age 50 year. For those with a family history of colon polyps or colon cancer, screening should start at age 40 or even earlier. Two approaches to screening are currently recommended.

One approach is to test the stool for blood every year and perform a flexible sigmoidoscopy every five years. The other approach is to examine the entire colon with a colonoscopy every 10 years. Colonoscopy is likely to detect close to 100 percent of polyps or cancers.

Latest Treatment for Colon Cancer

The sooner colon cancer is found, the less likely it is to be invasive, and the more likely that the patient will be cured of cancer and survive. One such advance is the ability to remove cancerous lesions of the colon using minimally invasive surgical techniques. Laparoscopic colectomy, as compared to traditional open surgery which requires a long

abdominal incision, dramatically reduces recovery time and helps patients return to normal activities quickly. The surgical team at the University of Maryland uses small incisions and telescopes to remove a diseased segment of the colon and then sews together the two ends of the colon. Laparoscopic colectomy has

been widely accepted for the treatment of benign colon diseases for nearly ten years. A recent study published in the New England Journal of Medicine demonstrated that the laparoscopic techniques are as effective as open surgery in treating colon cancer.

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develop the competencies necessary for current and future health professionals to work together is required. It is thought that if students in health professional programs and health professionals in practice develop the competence through formalized training that the potential for change in workforce patterns will be enhanced. Competence development in health professionals is not enough. There is a need for change in organizational processes and those at the individual team level for collaboration to be sustained and grow. The elements of collaboration need to be understood, promoted and sustained throughout the continuum of health professional learning, within the workforce of health professionals and the organizational environment in which they practice. The traditional "silo-like" practices among health professionals will not change by mastering the competencies alone.

Another pan-Canadian body that is studying the issues in health human resource planning is the Health Council of Canada. In the summer of 2005 it released a report on health human resources. Part of the report focused on the professional regulatory issues inherent in professionals' scopes of practice. The report was based on a closed door conference that the Council held to discuss the issues in health human resources as they relate to health care reform in Canada. According to the July 22, 2005 newsletter Health Edition, published by Merck Frosst Canada Ltd., the report would contain a strong plea to address scope of practice and education issues so that the phrase "having the right provider at the right place" would take on real meaning. Michael Decter, Chair of the Council at the time said that the need to have health and education working together to support collaborative practice is a major component of resource planning. More specifically he was quoted as saying "If we hope that the incoming health care professionals will work collaboratively then we should be doing more to train them collaboratively."

Since 2005 almost every University in Canada that offers health professional education has had some focus on interprofessional education at both the basic and continuing levels.

For those of you who are interested in learning more about inter-professional education and collaborative practice try putting the keywords "interprofessional education collaborative practice" into your favourite search engine. As well, background papers/presentations and final report from the conference held on health human resource planning by the Health Council of Canada are available on its website www.healthcouncilcanada.ca.



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by Jennifer (Jay) Sherwood, BScN, MEd.

This column highlights a sample of the information that has arrived since the last issue of HEALTHbeat. All of this comes from press releases, lists and other such things that are available on the Internet. Apart from editing, I am passing it along to you as it comes to me.

Be advised, HEALTHbeat does not endorse or otherwise support any of the products, new ideas etc.

Did you know that...?

MONTREAL, PQ – An internal audit at the McGill University Health Centre found that only one in four doctors (25%) wash their hands between patient visits. Nurses do a better job, but their rate of compliance is still

only 40 to 50 percent. Lack of handwashing has been identified as a major factor in the spread of germs in hospital settings.

WINNIPEG, MB – A special review of all patient deaths in Winnipeg hospitals last year uncovered 27 new cases where patients died as a result of an unintended medical error. Quality control officials with the Winnipeg Regional Health Authority reviewed all 2,577 deaths in hospitals in 2008 to see if any patients died as a result of a systemic or medical error.

CHICAGO, IL – At the recent Radiological Society of North America (RSNA) conference, Cerner Corp., of Kansas City, Mo., showed an innovation in the area of electrocardiogram

(ECG) systems. The company claims to be the first in the world to integrate ECG data into the electronic health record using the DICOM imaging standard.

OTTAWA, ON – Health Canada has approved Avastin® (bevacizumab), in combination with paclitaxel chemotherapy, for the first-line treatment of patients with metastatic HER2-negative breast cancer. The approval, under the policy of Notice of Compliance with Conditions, is based on results of a phase III study (E2100), which showed the combination of Avastin and paclitaxel nearly doubled the chance of progression-free survival in patients with metastatic breast cancer compared to paclitaxel alone.

22,400 women were diagnosed with breast cancer and approximately 5,300 died from the disease.

OTTAWA, ON - Health Canada has cleared the Therakos™ Cellax™ Photopheresis System, an effective form of treatment to relieve symptoms of cutaneous T-cell lymphoma, such as cracking, scaling, redness and swelling of the skin, that are unresponsive to other forms of treatment. Patients benefit from this integrated system that uses extracorporeal (outside the body) photopheresis, an innovative cellular therapy, by reducing their treatment times and extracorporeal blood volume while minimizing their risk of infection and cross-contamination.

TORONTO, ON – The electronic Child Health Network (eCHN), together with Ontario Minister of Health and Long-Term Care David Caplan and representatives from The Hospital for Sick Children, recently celebrated the 10-year anniversary of eCHN, Canada's first province-wide electronic patient record system.

With this indication, Avastin is now approved to treat the two most prevalent cancers in Canada: Breast and Colorectal. Avastin is also the second biologic therapy for women with advanced breast cancer made available by Roche in Canada, following the revolutionary treatment Herceptin.

Breast cancer is the most common cancer among Canadian women. In 2008, an estimated



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sustained support of federal government investment.

At the end of January, the Canadian Association of Schools of Nursing (CASN) issued a press release in response to the federal budget designed to help the country ride out the global economic downturn. CASN sounded the alarm bells about investing in capital projects that will get people working now, live past the current crisis and not require ongoing fiscal support while ignoring investment in nurse knowledge workers and in "infrastructure required for nursing teachers, scholars and clinicians needed now and tomorrow." (CASN, p.1). Much of what is said in the press release (which is printed in its entirety on page 6) confirms that what CNA reported in its brief to the finance

committee back in August still holds true. Investment in education for health professionals will have long term effects that will contribute to the strength of the economy while maintaining the health of Canadians now.

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BCIT from page 3

• Strategically partnering with the intent to be leaders in a collaborative, distributed, networked approach.

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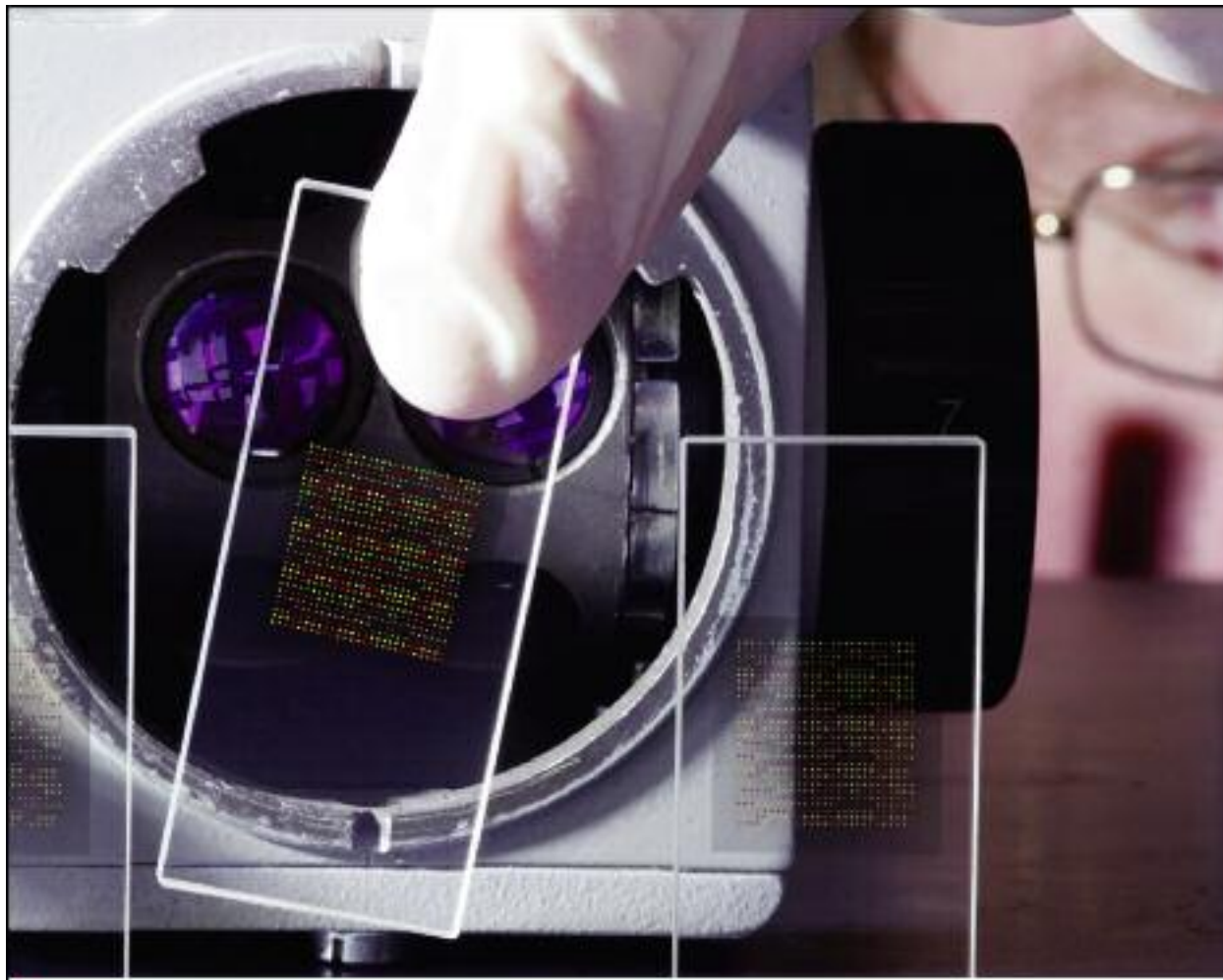
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