

Knowledge Translation for Cancer Control in Canada: A Casebook

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Collaborative Palliative Care Practice Project: Mentorship Program for Interprofessional Primary Healthcare Teams

Cancer Care Ontario, Toronto, ON
Ms. Esther Green, Dr. Deborah Dudgeon

LESSONS LEARNED

- **Mentorship takes time and structure helps to facilitate.** This was accomplished through setting designated times for activities such as videoconferences, shadowing a colleague or designated learning sessions.
- Palliative care education was the prime focus to support primary care providers (family physicians and nurse practitioners) to enhance their knowledge and skill in managing patients requiring palliative care. But mentors and mentees wanted to spend more time on learning mentorship; and although it was a module in the education program (added to LEAP), they wanted more time spent on understanding and applying mentorship concepts. **In future initiatives we recommend that time be built into the curriculum and experience to fully understand and apply the mentorship concepts.**
- **Technology is useful to support mentorship.** What worked well was the use of videoconferences to connect mentors and mentees; in some instances, newsletters and case studies were available electronically as well and these were worthwhile resources. Nonetheless, **more use of technology might have been useful to support ongoing mentor-mentee relationships.**

PROJECT OVERVIEW

The *Collaborative Palliative Care Practice Project* was aimed at building regional supportive relationships between interprofessional primary health care teams (i.e., family physicians and primary health care nurse practitioners - mentees) and palliative care experts (palliative care physicians and advanced practice nurses as well as registered nurses with palliative care training/experience - mentors). The intended outcome was increased palliative care knowledge and skills, and enhanced collaborative practice for both the mentees and the mentors. Mentors and mentees participated in an intensive 14 hour palliative care/collaborative practice educational session. This was followed by a period of mentorship activities to enhance competence and comfort with managing the problems of symptomatic patients.

The *Collaborative Palliative Care Practice Project* was highly successful as it improved the knowledge and skills of family physicians and nurse practitioners in the care of cancer patients with palliative and end-of-life care needs. The project also improved the collaboration between primary health care teams and palliative care expert teams.

PROBLEM

The need to enhance primary care providers' knowledge and skills in P/EOLC has been well-documented. This need is particularly acute for primary care nurse practitioners, as most

report virtually no formal training in caring for this challenging patient population (as per local needs assessment). While most family physicians acknowledge the need for more training in P/EOLC, some confess that is not a high priority for their personal continuing professional development (CPD) because it is perceived as a small and infrequent component of their practice.

BARRIERS

The literature describes many educational initiatives in P/EOLC which target practicing physiciansⁱ or nursesⁱⁱ, with some designed to be multiprofessional^{iii,iv}. However, programs that target primary care teams (i.e. an interprofessional group who work together regularly, as opposed to a collection of individuals of various professions who may or may not have any regular clinical connection) are very rare. All P/EOLC education programs emphasize the importance of teamwork, but usually through general statements rather than a practical approach grounded in an explicit theoretical framework. Well-developed CPD programs regarding interprofessional collaborative practice (IPCP) exist, but are not linked to clinical palliative care content^v.

SOLUTION

Palliative and end-of-life care is increasingly being delivered by interprofessional primary healthcare teams. In Ontario, interprofessional primary healthcare has been formalized in recent years with the development of structured Family Health Teams consisting of family physicians, primary care nurse practitioners, and other allied health professionals who assume joint responsibility for their patients' care^{vi}. The degree of interprofessional collaboration required for optimal functioning of these teams is beyond that which most healthcare professionals experienced in their training^{vii,viii}. The growth of team-based care has spurred demand for CPD programs that address collaborative practice.

The *Collaborative Palliative Care Practice Project* is the first CPD program (to our knowledge) intended for interprofessional primary healthcare teams designed to explicitly address both collaborative practice and clinical palliative care learning objectives. Addressing both P/EOLC and IPCP within the same educational initiative holds potential advantages from the perspectives of both primary care participant teams and palliative care faculty. Participant teams can address two areas of learning need simultaneously, benefit from the team-building inherent in shared educational experiences, and network with both similar primary healthcare teams and their local palliative care consultant team. Palliative care mentor teams have the reciprocal opportunity to foster connections with local primary care providers while reaching two groups previously underserved by P/EOLC educational initiatives: primary care nurse practitioners, and family physicians who would not be interested in a typical intensive palliative care CPD program, but who are interested in developing skills in IPCP.

The aim of the *Collaborative Palliative Care Practice Project* was to build regional supportive relationships between primary health care teams and local palliative care experts that would result in increased competencies in both P/EOLC and IPCP. Interprofessional teams of palliative

care experts (palliative care physician and nurse consultants) functioned as program facilitators (mentors) for participant teams (mentees) in their local region. Following an intensive educational intervention, Learning Essential Approaches to Palliative and End-of Life Care (LEAP) and a module on Collaborative Practice designed specifically for this project the program incorporated a follow-up mentorship period intended to build on the new relationships and knowledge^{ix*}. The *Project* was implemented in phases, each consisting of planning-implementation-evaluation cycles occurring over the span of approximately one year. Each phase received independent ethics approval from each participating institution's research ethics board. Phase 1 and 2 are complete; we have received funding for Phase 3, which is underway. In each phase, there was expansion of sites into LHINs across Ontario. The project is a great example of knowledge translation (KT) between palliative care and primary health care teams. The project used an interactive KT model oriented to meeting the assessed knowledge needs of primary care practitioners, supported through case studies (raised by the primary care groups), clinical shadowing and ongoing mentorship.

EVALUATION

Measures & Data Collection: A mixed methods strategy was utilized to assess both process (e.g., Did the program proceed as planned?) and outcomes (e.g., Did the program have the desired effect on participants?). Process data collected included the number of mentors and mentees participating by region and the number of CPCP education courses. Outcome data were obtained from three instruments: the LEAP Knowledge Quiz, the Collaborative Palliative Care Practice Program Inventory and the Interprofessional Collaboration Survey.

In addition to the above quantitative measures, qualitative data were collected from both mentees and mentors through focus groups conducted after the completion of the mentoring phase. Mentees and mentors participated in separate focus groups. The focus group question guide centred on the mentorship aspect of the program and was primarily intended to offer insights into how this facet of the program contributed to the outcomes observed. The first two phases of this pilot project involved a combined total of 23 mentors (17 physician and 15 palliative care nurse specialists) and 129 mentees (51 physicians, 30 nurse practitioners, 39 other nurses and 9 other health care professionals) in six regions of the province.

Results: The results from the evaluation of the initial two phases are preliminary and a manuscript is in preparation, therefore, the results cannot be disseminated or shared until after the publication has been released.

RESOURCE IMPLICATIONS

All phases of the project were funded by the Ministry of Health and Long-Term Care of Ontario. The first phase from the Interprofessional, Mentorship, Preceptorship, Leadership and Coaching Fund and the second and third phases from HealthForceOntario's Interprofessional Care/Education Fund. Funding covered costs of travel and accommodation and replacement costs for mentors, venue and food, supplies, accreditation and videoconferencing, facilitators in each region and a research associate.

HOW THE PROJECT ADVANCES THE QUALITY OF CANCER CONTROL

Patients with cancer experience problems with symptoms throughout the course of their illness. This project is designed to improve the ability of nurse practitioners and family physicians to manage cancer patients' symptoms. The model serves to improve the collaboration between the expert palliative care teams and the primary healthcare teams so if cancer patients have symptoms that are difficult to control, the primary teams can receive expert mentorship/consultation to help resolve the problem. Overall, working together between primary care and acute specialized care improves the quality and safety of care delivered to cancer patients and support for their family caregivers.

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^{ix*} **The members of this initiative include the following:**

Lakehead University

- Mary Lou Kelley, MSW, PhD, Director, Centre for Education & Research & Aging & Health (CERAH), Professor, School of Social Work & Northern Ontario School of Medicine, Lakehead University, Thunder Bay