

Until Death Do Us Part

Applied Knowledge Transfer Lessons from The Pallium Project

Thinking Creatively - Tools & Strategies Panel
Research Transfer Network of Alberta Conference

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The Pallium Project
le projet Pallium



Working Together to Improve the Quality
of Living and Dying in Canada
Travailler ensemble pour améliorer la
qualité de la vie et de la fin de vie au
Canada



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- The objective of this panel presentation is to present an applied example of a Community of Practice transformed into knowledge-building communities AND to share model elements of strategies and the tools to support being more effective and responsive in everyday clinical practice.
- This talk is a “35,000 foot” high-level overview. If you are interested in more information about the theoretical/conceptual foundations please see the appended reading list. We also have a 45 minute synthesis video of our Phase II initiative called The Pursuit of Possibility. It is a report back to our stakeholders which is based on Health Canada, Population Health’s guide for participatory evaluation. A peer-reviewed article called *A Generative Response to Palliative Service Capacity in Canada (on the reading list)* and our Phase II operations report are available on the English language side at www.pallium.ca
- In the context of Knowledge Transfer, my colleague Gary McPherson of the Canadian Centre for Social Entrepreneurship has suggested the Pallium Project is one well-documented instance of an initiative serving an important social/societal function and one which is “taking research to the street.”
- The term Pallium is a Latin word which means to cloak or shelter. We used this to describe how the “guiding aspiration statement” underlying The Pallium Project is to develop networks, tools and resources that ultimately help to cloak patients and families with comfort and support while living with a life-threatening or life-limiting illness (note – since 2002, this would include periods of bereavement in the Canadian hospice palliative care model that I will discuss shortly).



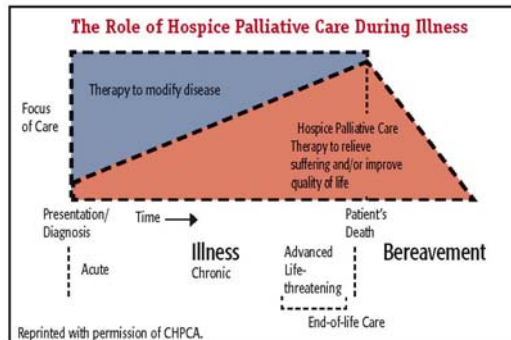
History

- Concept formation in 2000
- Improve care of the dying irrespective of where they live
- Phase I: 2001-2002 (\$250 K)
 - Coordinate scarce educational resources in western Canada
 - Collaborate amongst academic programs/community champions
 - Communicate with colleagues to reduce duplication of efforts
- Phase II: 2004-2006 (\$4.3 M)
 - Demonstrable improvements in access, quality and system capacity

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- The concept for the Pallium Project emerged over a series of discussions between colleagues from the Institute for Professional Development (IPD) at the University of Alberta and Dr. Jose Pereira, then an Assistant Professor in the Division of Palliative Medicine at the University of Alberta. All had been involved in rural outreach education for clinical professionals prior to being linked in April 2000.
- The initial focus was on barriers that rural and remote health care providers faced in developing their skill sets to care for persons who were dying in their local communities throughout western and northern Canada.
- Our initial funding was a \$250,000 contribution from the National Projects category of the Rural and Remote Health Innovations Initiative (RRHII), a Population Health-based one-time fund of Health Canada. We focused on 8 project activities to help do the “3 C’s” and you can see those in the slide as tasks of coordination, collaboration and communication to address this need of improving care of the dying irrespective of where they live. Lots of focus on foundation building and trying to better understand how to improve services by understanding major responsibilities and tasks in practice.
- We recently completed a second phase of work from 2004-2006. For the HPC community in Canada, this was akin to “winning the lottery” (reference to theme of conference). It was the largest one-time Government of Canada investment in HPC capacity to-date. A lot of people focused on specific tasks and provided significant in-kind contributions. We estimate (conservatively) that \$3 dollars of activity from other systems/organizations was leveraged for every \$1 of Health Canada funds invested as part of the \$4.3 million contribution from the National Envelope of the Primary Health Care Transition Fund (PHCTF).
- Currently completing a Phase III Feasibility Study (by late 2007/early 2008)
- Top picture – Dr. Pereira & myself at first stakeholder launch in winter 2001; middle picture – local opinion leaders/clinical champions in a DACUM workshop (Jan 2002); Dr. Pereira receiving Queens Golden Jubilee Medal (reference the essential role of a credible clinical champion especially during formation/incubation periods).

Hospice Palliative Care (HPC)



10 year, consensus-based model released by CHPCA in 2002 holds that Hospice Palliative Care is appropriate for any patient and family living with a life-threatening illness due to any prognosis at any age and when they are prepared to accept care



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- So, in Phase I (2001-2002) we were reacting opportunistically to field reports, some published needs assessment work, etc.
- By 2003, when we responded to a Health Canada invitation to take our competitive Letter of Intent to a full proposal for the Primary Health Care Transition Fund, we were in the early days of understanding the 2002 *Model to Guide Hospice Palliative Care Based on National Principles and Norms of Practice*.
- This is a model that... (reference text on slide).
- This is a useful and strategic model for responding to the changing reality that in the course of 100 years we have gone from short lives, quick deaths to much longer life spans with much longer periods of progressive decline leading to death (starting to think about organizing services and knowledge according to 3 major decline trajectories)....key references are in suggested readings.
- This is a graphical representation of a Canadian consensus model which is codified in a 103 page document. It is the same model upon which the Canadian Council on Health Services Accreditation (CCHSA) has based the Hospice Palliative Care indicators (see <http://cchsa.ca/default.aspx?page=58&cat=27>)
- So, starting around 2004 our knowledge-building activities become very focused with a documented commitment to Health Canada to be strategic and aligned with the *Model to Guide Hospice Palliative Care*. This is one set of critical strategic filters for decision-making, resource allocation and relationship/partnership development.



Approach

- University-community engagement best practices
 - Respectful two-way engagement
 - Working together on practical, needs-based tools, resources, issues
 - Balance evidence-based practice with practice-based evidence
- Population health orientation
 - Family as the unit of care
 - Broad definition of team
- Primary-care providers & family caregivers are, and seen to be, “knowledge managers” for care in a “shared care” delivery model



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- A few comments about our approach to knowledge-building and transfer.
- We use the principles of University-Community Engagement. Much of this discourse is rooted in recent US experience of the Kellogg Commission on the Future of State and Land Grant Universities. It focuses on the accountability of public universities to the publics/citizens who largely “foot the bills” for public institutions/infrastructure.
- The focus of these practices (reference 3 subpoints first bullet)
- What makes the project dynamic of academics and rural/PHC champions work, in large part, has been the respect for the tension between evidence-based practice and practice-based evidence. Not everything that is done, validated and published within an academic health sciences context is accessible/available in rural and remote settings. Lots of local innovations/“work arounds.”. Need to remain in a position of curiosity and filter as “is this safe, ethical, effective (may not meet accountability criterion as not studied/published)?... lots of potential inputs for rural health services research in HPC clinical efficacy.
- Pop Health orientation – patient is important, but we are equally concerned with experience/health status of family caregivers and primary-care professionals [e.g., risk manage family unit health status/risk of own chronic illness as a result of care provision; risks of complicated grief/bereavement and focus on caregiver burnout/compassion fatigue (e.g., esp LTC/CC residential settings)].
- Ref last bullet – don’t expect primary-care providers or family members to be experts in Palliative Care, but to be aware enough to formulate good clinical questions/act; see flags that impact patient safety/comfort; reduce risk of harm (e.g., opioid induced delirium due to PHC/ family over-medicating... appears to be quite common).
- Pictures... work is always about improving care for patients and families (ref top and middle) AND team-based within a primary-care context of HPC as knowledge manager..



View of Knowledge

- Hybrid of Constructivism and Scientific Positivism (paradox)
 - Evidence-based (e.g., DBCT), but
 - Knowing is “sense making”
 - Sense making is always social
 - The core is fundamentally relational
- Focus is getting things done with and for people to a desired end
- Acquired in context, informed by beliefs, feelings and values
- This view of knowing always has an ethical and moral dimension



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- Understanding our view of knowledge is important to understand design of knowledge-building activities and resulting products.
- Ref first bullet – comfortable with the paradox that we are using a hybrid of Constructivism and Scientific Positivism. Respect RCT as “gold standard” in health sciences research/evidence, but also recognize that knowledge-building and use is fundamentally social in nature and about “sense-making” in context(s).
- The reality is that practitioners construct understanding or meaning by making sense of their experiences and fitting those experiences and own ideas about said experience into a reality that they construct and which is dynamic.
- Responsive knowledge-building has an end and sharp focus. In Phase II, its been about improving access, quality and building longer-term delivery system capacity.
- Because we are dealing with a whole systems approach to assessment and management within a *Model to Guide Hospice Palliative Care*, its essential we think about knowledge-building in (see third bullet).
- Last bullet – ref Don Schön (Educating the Reflective Practitioner, 1987)...*“In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solutions through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lies the problems of greatest human concern. The practitioner must choose. Shall he remain on the high ground when we can solve relatively unimportant problems according to prevailing standards of rigor, or shall we descend to the swamp of important problems and non-rigorous inquiry?”*



Enabling Strategies

- Community of Practice approach
 - Collaborations of people who share specific interests and practices working together to advance their specific area of practice
- Project Portfolio model
 - 70 subproject/initiatives portfolio
 - Negotiate specific interests and release time for development
 - Clarity on start/end times (ideally)
 - Clarity about expected outcomes
- Practical definitions of Access and Quality to guide the work

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- What are some of the key enabling strategies which emerged?
- In Phase II this project really started to look and feel like a Community of Practice.... but CoPs are not enough... had to intentionally support transformation into a knowledge-building community. If you are interested in learning more start with Etienne Wenger's 1998 book (on suggested reading list).
- Ref second bullet – We used a project portfolio approach... enabled wide range of collaborators to become engaged in pieces of capacity-building work of most interest to them AND enabled those persons to negotiate release time with supervisors/org as an “investment of time.” This supported the “in kind” contributions and reinforced concept that we both “expend” time and “invest” time. Working in context of Pallium Project is an investment in the future based on the concept that “many hands make light work.”
- This has influenced our work to making resources/outcomes/deliverables/products accessible using a broadly-based pan-Canadian licensing model. Our intellectual property is converse of a “traditionalist” approach – Our first order of concern is rights access and last priority is ownership. Key when public investment is involved (many levels of government, one level of taxpayer; dealing with at least 13 major delivery systems in Canada). We view the Project as steward of these resources for the many.
- Last bullet – Access is largely about empowering primary-care providers (skills intensive/not capital intensive; addressing traditionally marginalized communities AND quality uses a practical focus based on Michael Rachlis' thought leadership about engaging quality improvement along three lines of underuse, misuse and overuse of health care delivery system resources.
- Pictures... Top – LEAP course development team mix of local clinical champions and expert academic clinicians (March 2004); middle Aboriginal instructional video (Feb 2004); bottom – daughter and father in cognitively-impaired driving KT resource dev.



Enabling Strategies

- Diffusion of Innovation test
 - Can it work?
 - Does it work?
 - Will it make a difference?
 - Does client system has receptor capacity to support change?
 - If not, what critical success factors have to be addressed/built?
- Pareto test
 - Which 20% of interventions will give us 80% desired changes?
- Open clinical/care operations to a range of supportive knowledge development skill sets

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• We use a variation of Rogers (ref suggested readings) model for Diffusion of Innovation and use the following five questions to guide knowledge building (ref first bullet above).

• Practical examples of “receptor capacity” challenges – chronic short staffing/can’t get release time/back fill; foreign trained physicians not well-oriented to Canada/ “dropped in” to many communities with little practical preparation; management team who view palliative care as “the death service” for last few days/weeks of life. Sometimes it is more mundane such as no DVD player within a facility or lack of high-speed internet access to support broadband deployment.... Need work arounds (e.g., Audio CDs,/ship DVD-based instructional resources with a “give away” DVD player, etc.).

• We also use a Pareto principle test about what to do because in HPC capacity-building resources are extremely scarce (e.g., money, time, skilled clinical expertise, programmatic leadership only in a few centres and often principally urban-based).

• Lots of persons with complementary skills see becoming involved with HPC as “rocking chair” work (i.e., when retired in the rocking chair can I look back and say I did sometime that made a difference for people)... as a result we have developed a rich multidisciplinary “supplier” network of persons highly skilled in project management; law; instructional media development; document design/publication; publishing; and new media/channel management.

• Pictures... Top (Nancy Brook, former head writer for ACCESS Television works with Dr. Romyne Gallagher on instructional videos; Middle - Harvey Popowich, a highly-accredited broadcasting technician post-produces media products; Bottom - Dr. Ron Spice, Calgary Health Region, explains some key concepts to rural primary-care colleagues during a Regional Weekend Course.



Service Dynamics

- Palliation reality-check!
 - Old pathway: No more we can do...
 - Emergent: Help to live well until death (which can be many years)
- “Hidden Curriculum”/socialization
 - Historically: *“You’re successful if you cure, you’re a failure if you don’t”*
 - Reality check: *“Oh, yeah and 100% of your patients are going to die, sooner or later!”*
- Delivery system is largely about cure, HPC is focused on healing
- So, much complexity and wicked problems in ↑ access and quality

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- A few comments about the service dynamics upon which this knowledge-building work takes place. This work is largely change management oriented and is as much about the work of the “heart” as it is about the “head.” Lots of attitudinal issues.
- Ref first bullet - *Model to Guide Hospice Palliative Care* aligned with changing population and new reality of “long death” with complex, multiple issues. Focus is on helping patients and families live well until death. We are talking about a supportive, thoughtful, compassionate and responsive approach linked to a “whole system” model of care.
- Ref second bullet – Those who are educators maybe familiar with the concept of “hidden curriculum.” What has been, and largely remains, the underlying value message in our medical schools and to a lesser extent in other health sciences education programs? (ref second bullet subpoints). This sets up the potential for terrific dissonance given a reality that current epidemiology suggests very few of us will die peacefully in our sleep of old age at 95 y.o.
- Also, our delivery systems have largely evolved to deal with shorter term trauma, tend to be fundamentally reactive and have episodic management.... Hospice Palliative Care is largely about “healing,” is focused on managing well across many settings of care, requires skills and cooperative team approach of many disciplines and is fundamentally relational. Different model of care requires different approaches, resources.... This requires significant consideration in knowledge development.
- Pictures – Top (Dr. Jose Pereira, project co-founder responds to a question during an interactive teaching-learning Regional Weekend Course session; Middle (two Saskatchewan-based RN local leaders debate a point during evaluation process); Dr. Evan Adams, Director, UBC Aboriginal Health Program leads a workshop session for Building Response Care for Aboriginal Clients and Families in northern B.C.).

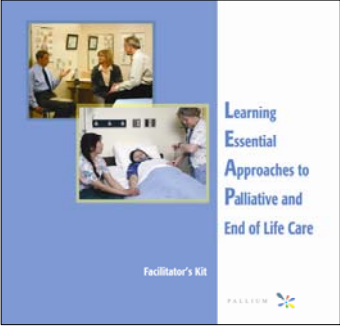


Outreach Education


- 957 primary-care professionals in 40 outreach education courses
- Create opportunity for Family Physicians, Registered Nurses and Pharmacists to learn in context
- Practical response to supporting inter-professional education
- Create “safe space” for persons to critically reflect on their practice/ consider unlearning/relearning
- Create links to specialty/referral-level colleagues who facilitate from LEAP Facilitator Kit

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- The next several slides focus on some model approaches to knowledge-building that could be “process transferred” to many other clinical capacity applications.
- We used a specialized form of outreach education which Dr. Pereira and some colleagues had been demonstrating in the form of a pharmaceutical-company sponsored retreat for rural family physicians (pre-Phase I and Phase II).
- In Phase I we had prototyped a hand full of courses and had a basic model for outreach education. It was designed on the assumption that several challenges to effective local clinical management were due to people who needed to work together not having the opportunity to understand each other as individuals, in disciplines and across disciplines.
- Created a small-group (max 25) inter-professional education experience where specialist/ referral-level colleagues went “out” to community-based settings and facilitated a 13 contact hour foundational course using the Learning Essential Approaches to Palliative and End-of-Life Care courseware (which is a model discussed in the next slide)
- In a 24 month period we engaged 957 physicians, RNs, pharmacists and others in a weekend course experience in four western provinces and the Yukon territory.
- In the Regional Weekend Course model (Friday evening, Sat, Sun) “hidden curriculum” issues of liberation of past assumptions, local/regional teamwork, service improvement issues were explored with a focus in enhanced access and improved quality locally.
- We also offered customized outreach education on a partnership-basis in British Columbia, Saskatchewan, Manitoba, Nunavut and Northern Ontario using variations of the outreach education model.
- Pictures – A HPC clinical nurse leads a uni-disciplinary small group break out session; An RN explains a point during the Friday evening (Creating Context module); RN colleagues listen carefully to a physician making a point (all Richmond, B.C., Jan 2006).



The top image shows the cover of the 'Learning Essential Approaches to Palliative and End of Life Care Facilitator's Kit'. The cover is blue and white, featuring two small photographs: one of a group of people in a meeting and another of a healthcare professional with a patient. The text on the cover includes 'Learning Essential Approaches to Palliative and End of Life Care' and 'Facilitator's Kit'.



The bottom image shows a group of people sitting around a table, looking at a laptop screen. They appear to be in a meeting or training session, reviewing instructional materials.

Codify the Norm

- LEAP – Modularized courseware result of blind peer review and practitioner community input
- Agree to what safe, effective, accountable and ethical practices are and stick with it
- Thoughtful design of print and multi-media to enable learning, “un”learning and change
- Instructional resource for the skilled HPC practitioner
- Used throughout Canada; in 17 Canadian medical schools

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• I call this model approach “Codifying the Norm.” In this model colleagues from western and northern in Canada went through an evolutionary 4 year process of negotiation, prototyping/use, testing, evaluation, multiple editions and revisions leading to an 11 module courseware package called Learning Essential Approaches to Palliative and End-of-Life Care (LEAP). It is packaged with multi-media presentations and instructional video segments.

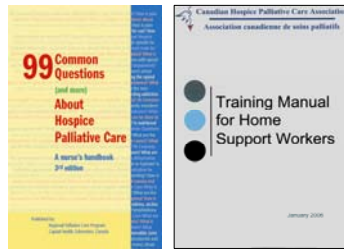
• Ref second bullet – This courseware codifies the evidence and community discourse about the “essential” clinical management of end-stage care in the community as guided by safe, effective, accountable and ethical practice. Aherne also refers to this as a “Tim Horton” approach to learning resources in that licensed use supports standardization of approach/reduction of variation (i.e., A “Double, Double” is always the same no matter where you are in Canada or Kandahar!).

• Ref third bullet – Considerable thought about instructional design and presentation to support local change management and service improvement is embedded in design and codified within the “kit.” The focus is on making it easy to use and follow for the busy palliative care clinician with educational duties.

• Ref fourth bullet – An accessible license model makes LEAP a “turn key resource” for busy clinicians with instructional responsibilities. Shipped with a CDR that has ready to copy participant materials; support of a Blackline Master Certificate to enable legal, local duplication of copyright participant materials/mounting of e-materials for e-instruction/web-based learning, etc.

• Pictures – Top (LEAP kit cover); Bottom (local champions critically review “rough cut” footage of instructional videos as part of a major Facilitator Orientation (Aug 2004).

Going to Scale



- “Leap frog” local innovations by bringing new resources/networks/quality processes
- Negotiate resource distribution arrangements
- Refocus development learning curve on new issues/platform for “knowledge sharing”
- Find partners to support knowledge sharing without distracting from clinical service core focus


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- Many HPC programs and services have great local innovations. The challenge in “going to scale” from local-level innovations to national level resources include relationships/networks, distribution, resource fulfillment, expertise in publishing, clinical editorship, accommodating local variation, etc.
- Going to scale is one strategy to “leap frog” knowledge development learning curves for other locales and add additional value.
- Ref second and third bullets - Several examples of Going to Scale and/or modification in the form of redevelopment of existing resources for larger markets occurred in Phase II. One is the *99 Common Questions (and more) about Hospice Palliative Care: A Nurses Handbook (3rd Edition)* is one sub-project done using this model. The Pallium Project supported a major editorial review, national blind review editorial process and technical assistance in linking the copyright owner (Capital Health) with the Canadian Hospice Palliative Care Association to support national resource distribution and fulfillment through the CHPCA Marketplace (one stop shop).
- A similar process, modified with community development participation, was done to reinterpret and redevelop *A Caregivers Handbook: A Guidebook for End-of-Life Care* for Inuit family caregivers in Nunavut.
- Ref fourth bullet – There is a trap for clinical programs that develop really good resources that others external to the organization want... they can end up as de facto publishers and several programs report committing significant (and often publicly subsidized) program admin/secretarial resources to supporting resource fulfillment and distribution activities. Arrangements such as The CHPCA Marketplace create a “one window, one stop shop” for quality HPC resources using inventory consignment and other distribution models. How one supports distribution for knowledge sharing is a critical consideration given potential costs, real and opportunity costs of program staff time. Increasingly this may be some what less of an issue as e-distribution models evolve (e.g., e-book, tool downloads, etc.).

Codify Wisdom/ Emerging Practice

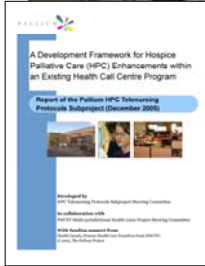
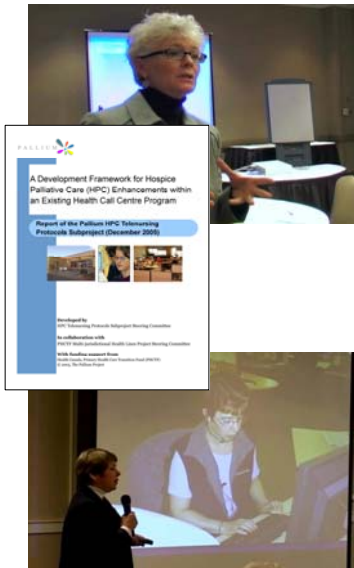


- Many senior practitioners near end of health delivery career
- Many have helped invent their respective fields/practices
- Create incentives/opportunities to document, validate, codify, prototype, refine and share
- Support knowledge exchange through relationship/networks
- Integrate mentoring/coaching for an emerging generation

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- The next model could also be considered as part of organizational and system staff succession and transition planning strategies.
- I have called it “codifying wisdom” and emerging practices, particularly related to “new and emerging professions” (NEOs) or specialized areas with context-specific knowledge.
- Ref second and third bullet – HPC Spiritual Care professional practice is a relatively young discipline and was not well-documented in Canada. HPC S/C providers could not easily explain their contributions and unique value within their teams/organizations. A first step was to establish that foundation. We worked with Regina Qu’Appelle Health Region to release Rev. Dan Cooper who in turn developed a pan-Canadian collegial process to start documenting, validating, codifying, prototyping, refining and sharing HPC Spiritual Care knowledge. This resulted in a DACUM (Developing A Curriculum) chart of the Major Areas of Responsibility and Major Tasks for the HPC Spiritual Care Provider and a 400 plus page modularized kit called *Developing Spiritual Care Capacity for Hospice Palliative Care*.
- We had a similar process with a recently-retired First Nations Elder (unbenounced to us at the time who was living with terminal cancer) who was a long-time cultural helper with the Whitehouse General Hospital. She played a critical leadership and mentoring role with our Aboriginal Relations Advisor in refining our Aboriginal courseware and developing a set of instructional video segments to support knowledge transfer about providing responsive HPC with Aboriginal clients and families.
- Pictures – Top (Rev. Dan Cooper in a CAPPE accredited Clinical Pastoral Education [CPE] “learning lab” with students [summer 2005]; Bottom – Gaye Hanson (Aboriginal Relations Advisor) video documents Olga Anderson’s (First Nations Elder) experiences and insights at Yukon College [February 2004].

Multi-jurisdiction learning/sharing



- Pilots/demonstrations tend to be underutilized elsewhere
- Create applied case-studies with detailed model element descriptions/draft protocols, etc
- Codify as “development framework” toolkits
- Publish processes, learnings and enable conditions for replication (e.g., licensing, resource sharing, bartering)

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- The next model approach acknowledges that there are many levels of government in Canada but only one level of taxpayer. Meaning that pilots, demonstrations or established models in one province could also be “leap frogged” and adapted to other jurisdictions. We did it in the application of Hospice Palliative Care Telenursing Protocols within an Existing Call Centre (e.g., see *Canadian Nurse*, May 2007 edition for Fraser Health/BC Nurse Line experience).
- Ref second and third bullet – We have used a model where we designed a “Development Framework” approach to documenting, codifying and extending one jurisdiction’s experience for adaptation to other jurisdictions. The model is supported by applied case-studies involving clinical experts and documenting model elements, baseline protocols for adaptation, etc.
- Ref fourth bullet – This model relies on a number of conditions. It requires support from the local jurisdictions (e.g., prov/territory/RHA) to enable the sharing of I.P.), it requires legal/business planning support to address liability risk management and indemnification issues as well as sometimes “bartering” or the possibility that “if we share this with you, perhaps you will share some of your local innovations in another area with us.”
- Pictures – Top - Carolyn Tayler, Director of End-of-Life Care for Fraser Health (BC) briefs stakeholders about the project and the process at a post-national conference consultation workshop (September 29, 2005); Bottom – Velda Clark, Director of Palliative Care Services and founding director of the Saskatchewan Health Line does a presentation on health call centres informed by the Saskatchewan experience during the Pallium Project’s, Service Development Institute (November 2004).

Monthly CPD Audioconference Program

Pallium Project (Phase II)

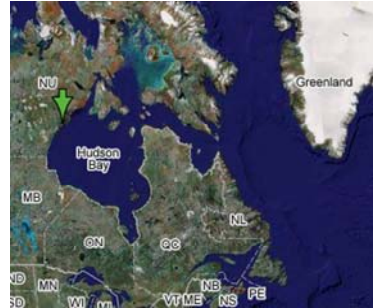
<u>Month</u>	<u>#Sites</u>	<u>#Part</u>	<u>#P/T</u>
Feb 05	32	169	06
Mar 05	50	231	08
Apr 05	66	180	08
May 05	70	241	09
June 05	58	176	09
July 05	68	217	08
Aug 05	54	158	09
Sept 05	85	259	10
Oct 05	68	147	10
Nov 05	115	430	11
Dec 05	85	247	11
Jan 06	80	258	11
Feb 06	97	405	12

- Real-time monthly opportunity to connect locally about HPC through national conduit
- Accommodates high volumes of participants
- Thoughtful programs support local change
- Audio-post - from POTS to PodCast drives content for “decision support” and local CPD

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- The next several slides highlight a POTS to Podcasting model that we pioneered within the last few years.
- The Pallium Project used a Monthly CPD Audioconference Program to support the building of Communities of Practice across provinces and territories.
- This model uses a ubiquitous technology to which most have access and know how to use (i.e., the telephone) and an event-based format at the same time every month (Fourth Thursday of the month, 12:00 MST) to create content and community. The content is later re-purposed to create reminder systems and content for mentoring/precepting/small group learning in the form of audio post-produced MP3s for “pod casting”
- We refer to this model as one which takes us from “POTS” (i.e., plain old telephone service) to PodCasting (i.e., web-based distribution of MP3 content).
- This model supports learning because the evaluation data illustrate that locally many “clusters” of small groups have formed. They either organize a “brown bag lunch” series or a local staff meeting around the sessions. They use the sessions as a platform to discuss how the particular topic applies to their circumstances locally.
- We also learned that “uptake or demand” by month is often an indicator of the difficulty or challenges that people are having with particular issues. For instance, the November 2005 session was *Avoiding Burnout and Compassion Fatigue* (Dr. Mary Vachon, Toronto) and February 2006 was *When Meds Are Not Enough: Exploring Total Pain* (a panel discussion that focused on the concept of “soul pain” or “existential suffering” as one of the dynamics that is commonly mistaken as under-treatment of physical pain).

From POTS



Health Care Staff in Rankin Inlet (north west Hudson Bay area) take in a monthly CPD audio conference session



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- In this slide we see health care staff in Rankin Inlet on the north western shore of Hudson Bay who have volunteered a picture of their local team “tuning in” for a regularly scheduled Monthly CPD Audioconference (note – this program has been suspended as of September 2006 due to Phase II funding wind down).
- It was a very popular feature for 19 months and did much to bring PHC stakeholders together (literally) from coast-to-coast-to-coast for a shared learning experience. The uptake and the role in building local and pan-Canadian community was one of the most significant unintended outcome that I personally took away from the Phase II project.

To Podcast

First at pallium.ca (Jan – May 07)

Now (Oct 07 -) at
www.palliativeinsight.net



Monthly re-broadcast of MP3 podcast on first Friday of every month at pallium.ca using a syndication model (“First Fridays”)



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- Starting in January 2007, we started a monthly podcast release at our web-site. Very basic approach of mounting MP3s and content-verified PDF files of the written transcripts.
- We are migrating to a “proper” podcasting hosting site which will be located at www.palliative.mypodcast.com. This will enable RSS-based subscription via iTunes, Yahoo, other syndication services (we had a coding error problem with the web-site design at Pallium.ca).

Conversations on Caring

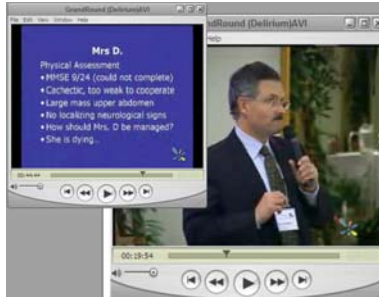


- Codify/archive Monthly CPD Audioconference sessions
- Demonstrate pod-casting & use of MP3s as educational tool
- Demonstrate potential of rounds and events to create archival legacy
- Demonstrate potential of large event to support post small group learning
- Collaborative practice linkages (e.g., Physician-in-team [June 05], Palliative Sedation [July 06])

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- We have also codified Audio CDs and MP3s in a licensed product called *Conversations on Caring*. We have different licensing and end use rights which support use of *Conversations on Caring* for Brown Bag Lunches, clinical preceptorships, etc., which are not available via the monthly podcast release.
- The first year of archived sessions are available in one easy to use binder with CDR/Audio CDs and written transcripts AND/OR with the MP3s and PDFs of the written transcripts in a single CDR. Both are distributed through the CHPCA Marketplace on an Inventory Consignment basis.

Just-in-Time Grand Rounds



Sample JIT Grand Rounds in MP4 format for Apple Video iPod®

- Capture quality live-events and deploy via broadband web, mobile/PDA (.wmv/.mp4) and MPEG2 (DVD) for small groups
- Driver 1 - Respond to the challenge of extreme short staffing in rural/remote Canada
- Driver 2 – Respect busy specialists time/bring specialist to a community “on-demand”
- Driver 3 – Next generation of health care providers consume media on-demand via video iPod®/MP3 players (i.e. Web 2.0)



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- We are also in the early days of experimenting/piloting the use of high-quality, video-based grand rounds that can bring live-event archives to a range of persons (e.g., students, primary-care professionals, etc.) for a variety of reasons (e.g., on-demand instruction, reminder systems, etc.) in a variety of formats (MPEG2-based DVD; hand-held device/iPod-based .WMV/.MPEG4 files; broadband, on-demand video).
- We have completed an 8 site, five province/territory pilot in Summer 2007 as part of our Phase III Feasibility Study and have some learning to incorporate into a larger series of these resources.

Social Media Deployment



Example of Pallium Project *Clinical Communication in HPC* video segment in *YouTube*[®] deployment

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- We have also mounted those instructional videos that are less than 10 minutes in running time to YouTube and those longer than 10 minutes to GoogleVideo.
- This model enables a range of options and responses that enable use of licensed video using an open source model for a variety of e-based courseware deployment and “suggested viewings” on professional education course outlines.

Some Insights



- Effective knowledge transfer is possible, but demands champions, intentionality, time and resources
- CoPs are means, not ends
 - Transform CoPs into knowledge-building communities
 - Many hands can make lighter work
 - Many minds create better outcomes
- There are many academic and delivery-system barriers/ disincentives that can work against effective knowledge transfer
- KT a critical enabler for PHC reform

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- Ref first bullet – Knowledge transfer done well will be a deliberate and strategic activity and to be successful, must be intentional and linked to goals due to the time and resources involved. Ours efforts were always tied to improved access, enhanced quality or longer-term system capacity-building for Hospice Palliative Care.
- Ref second bullet - Just because you have a CoP don't think it will generate usable knowledge. Our early experience suggests that CoPs can be means to create knowledge-building communities. Again, this is an intentional strategic choice and must be supported. The “business case” for management of participating organizations is clear... benefits of working together amortize the workload over many persons and organizations and if well-designed and managed processes are in place, can result in much better outcomes than a “go it alone approach.”
- Ref third bullet – There are many, many systemic and structural barriers and disincentives which exist to this kind of work. They include existing Salary and Tenure Review and Promotion processes within academia; culture issues about the “engagement” and “service” parts of academic cultures being poor third cousins to research and teaching (or discovery and learning in emerging lexicon); research grant administration processes; lengthy research ethics approvals; and large partner business processes (e.g., these are not health service delivery organization core businesses/lack publishing/media broadcast industries tools and processes such as distribution, co-production, rights exchange, rights sublicensing/leasings, etc., in order to support scaling in a timely, effective manner).
- Ref fourth bullet – Effective knowledge transfer through deliberative knowledge- building activities is an essential cornerstone of ongoing Primary Health Care Renewal efforts in Canada given that primary-care professionals in particular increasingly are “knowledge managers” who are expected to practice in safe, ethical, effective and accountable ways. These models could easily translate into other areas and I, for one, have been discussing their potential for chronic pain capacity-building as well as mental health in communities.



- The approach that we have taken with The Pallium Project is unconventional, it has been said to be “outside the box.” It is not without risks, but it is essential to support our fellow citizens at perhaps the most vulnerable times of their lives.
- To those of us involved in The Pallium Project this initiative has evolved beyond a dream as many hundreds of people from more than 50 health service delivery, academic, government and non-governmental organizations (NGOs) have been actively engaged. By working together we are making a noble dream into a reality.
- I sincerely thank you for the occasion to discuss The Pallium Project, specifically the “why and what” of our approach to creative tools and strategies for knowledge transfer. I again remind you that this is but a very brief “snapshot” of only some of the means and direct you and your colleagues to www.pallium.ca where we have a copy of the journal reprint I mentioned, a link to our evaluation report back video, and a detailed summary report of Phase II operations.

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