

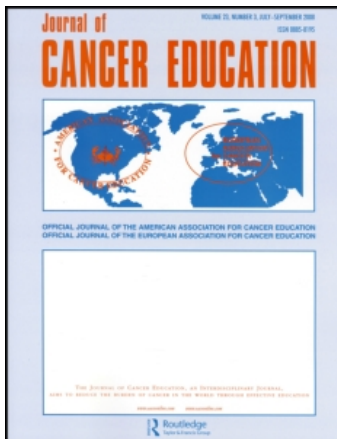
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### An Overview of the ACE Project—Advocating for Clinical Excellence: Transdisciplinary Palliative Care Education

Shirley Otis-Green <sup>a</sup>; Betty Ferrell <sup>a</sup>; Maren Spolum <sup>a</sup>; Gwen Uman <sup>b</sup>; Patricia Mullan <sup>c</sup>; Reverend Pamela Baird <sup>d</sup>; Marcia Grant <sup>a</sup>

<sup>a</sup> City of Hope/Beckman Research Institute, Duarte, CA, USA <sup>b</sup> Vital Research, LLC, Los Angeles, CA, USA <sup>c</sup> University of Michigan Medical School, Ann Arbor, MI, USA <sup>d</sup> Community End-of-Life Consultant, Arcadia, CA, USA

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# An Overview of the ACE Project—Advocating for Clinical Excellence: Transdisciplinary Palliative Care Education

SHIRLEY OTIS-GREEN, MSW, LCSW, ACSW, OSW-C,  
BETTY FERRELL, RN, PHD, FAAN, MAREN SPOLUM, BA,  
GWEN UMAN, RN, PHD, PATRICIA MULLAN, PHD,  
REVEREND PAMELA BAIRD, AA, MARCIA GRANT, RN, DNSC, FAAN

**Abstract**—*Background.* Excellence in palliative care demands attention to the multidimensional aspects of patient and family suffering, yet too few psycho-oncology professionals report adequate preparation in this vital area. *Methods.* A total of 148 competitively selected psychologists, social workers, and spiritual care professionals participated in intensive educational courses to enhance their palliative care delivery, leadership, and advocacy skills. Extensive process and outcome evaluations measured the effectiveness of this educational program. *Results.* To date, 2 national courses have been completed. The courses received strong overall evaluations, with participants rating increased confidence in defined palliative care skills. *Conclusions.* The initial results of this innovative National Cancer Institute-funded transdisciplinary training for psycho-oncology professionals affirm the need and feasibility of the program. See the Advocating for Clinical Excellence Project Web site ([www.cityofhope.org/ACEproject](http://www.cityofhope.org/ACEproject)) for additional course information.

The aim of the Advocating for Clinical Excellence (ACE) Project is to improve the delivery of palliative care through an intensive advocacy and leadership training program for 300 psycho-oncology professionals (psychologists, social workers, and spiritual care professionals). Competitively selected participants attend 1 of 4 training sessions (75 at each session) and a follow-up reunion conference. Nationally recognized faculty mentor participants in leadership and advocacy skills. The curriculum provides psycho-oncology professionals with strategies to become more effective change agents for enhanced palliative, end-of-life, and bereavement care within their institutions. This article

provides an overview of the National Cancer Institute (NCI)-funded ACE Project curriculum with initial evaluation data from the first 2 courses.

## BACKGROUND

Deficits in psychosocial-spiritual care continue to emerge including substandard pain and symptom management, poor access to services, high caregiver burden, disparities in care, and communication deficits across the continuum of care.<sup>1-5</sup> Patient and family psychosocial and spiritual needs continue to be unreliably addressed,<sup>6-7</sup> and inconsistently delivered.<sup>8-10</sup>

Quality palliative care can best be delivered in a collaborative environment integrating a bio-psychosocial-spiritual model by skilled medical, nursing, and psycho-oncology professionals.<sup>11-18</sup> The complex interplay of physical, psychological, social, spiritual, existential, medical, financial, and social burdens experienced by those diagnosed with cancer make a team approach imperative.<sup>19-21</sup>

Integration into a cohesive and effective team requires skillful leadership, collaboration, coordination, and communication. Several authors have attempted to outline the necessary

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Address correspondence and reprint requests to: Shirley Otis-Green, MSW, LCSW, ACSW, OSW-C, Senior Research Specialist, City of Hope, 1500 East Duarte Road, Duarte CA 91010-3000; phone: (626) 256-4673, ext. 62783; fax: (626) 301-8941; e-mail: <[sotis-green@coh.org](mailto:sotis-green@coh.org)>.

components of effective teams in psycho-oncology.<sup>22-25</sup> Teams exist along a continuum from unidisciplinary (several members within a single discipline), to multidisciplinary (typically a reactive model with ad hoc membership that uses a consultation format), to interdisciplinary (members are identified as working together proactively but often without shared leadership and decision-making authority), to transdisciplinary (in which members create a shared team mission, benefit from role overlap, and have integrated responsibilities, training, and leadership).<sup>26</sup>

The transdisciplinary model emerged from the hospice model in which all staff are expected to have competence in collaboration, an ability to assess for pain and distress, and an appreciation of the diverse concerns that might impact care.<sup>27</sup> Although there is significant role overlap, skilled colleagues who provide more specialized services within each discipline's scope of practice are vital to more comprehensively address patient and family needs.

Specialization as a palliative care psycho-oncology professional requires mastery of core competencies.<sup>28-36</sup> The National Comprehensive Cancer Network created algorithms for distress management<sup>37</sup> and palliative care<sup>38</sup> that have been adopted in many institutions. However, the algorithms' success relies on institutional infrastructure with teams of skilled personnel in place to implement the recommendations. Achieving success depends on a cadre of skilled practitioners who recognize the tremendous religious, spiritual, ethnic, and cultural diversities in cancer populations and the importance that these variables play in serious illness.<sup>39,40</sup>

Too few psychologists, social workers, and spiritual care professionals have been trained to negotiate the complex political climate to maximize their responsibility as advocates for institutional change. Currently, few palliative care education opportunities exist.<sup>41</sup> The challenge is not only to educate future professionals but, more urgently, to address the training needs of those currently in practice.

The ACE Project curriculum addresses these complex challenges by offering didactic information regarding improved palliative care core competencies and experiential exercises designed to promote personal commitment to change. The ACE Project supports experienced psycho-oncology professionals in reclaiming their role and responsibility as system advocates for improved palliative and end-of-life care within their network of influence. Faculty integrate examples of their own change efforts within each presentation to illustrate successful examples of policy and institutional change.

## ACE PROJECT—CURRICULUM DESIGN

Although ACE builds on successful programs such as EPEC: Education for Physicians on End-of-Life Care,<sup>42</sup> ELNEC: End of Life Nursing Education Consortium,<sup>43</sup> and DELEtCC: Disseminating End-of-Life Education to Cancer Centers,<sup>44</sup> the ACE Project is unique in its transdisciplinary approach and its focus on psycho-oncology professionals.

Transdisciplinary education provides an opportunity for shared learning for enhanced team functioning.<sup>27</sup>

Another unique aspect of the design includes a reunion conference reuniting the 300 participants and faculty to reinforce change efforts and share lessons learned. The conference provides a venue to display and discuss advocacy efforts, highlighted by poster presentations. Participant posters will be displayed and grouped by theme, with recognition given to outstanding examples of goal achievement. This provides participants with an opportunity to demonstrate leadership among their peers as they convey progress made toward their goals.

The specific aims of the 5-year, NCI-funded ACE Project are to

1. Develop a transdisciplinary palliative care curriculum and advocacy-skills training for the psycho-oncology disciplines of psychology, social work, and spiritual care.
2. Implement the curriculum through 4 training courses and a follow-up reunion conference.
3. Evaluate the impact of this training by measuring the process and the outcomes of the educational activities and advocacy efforts initiated by the participants.
4. Disseminate the findings through peer-reviewed publications, various palliative care organizations, and each discipline's professional networks.

## COURSE FRAMEWORK

Curriculum content draws on an extensive literature review, with input from project advisors, consultants, and professional peer review. The National Consensus Project's Guidelines for Quality Palliative Care provide the rationale for the curriculum's modules. Figure 1 illustrates the project's framework. The theoretical premise is that building skills in each of the 9 module areas will strengthen individual expertise and team collaboration. We anticipate that this will result in more effective delivery of care and improved outcomes in the quality of life for patients and families. A comprehensive quality-of-life model guided curriculum development.<sup>45</sup>

Teaching strategies are predicated on change concepts taken from psychology and business<sup>46,47</sup> and established adult learning theories that indicate adult learners are self-directed, possess rich life experiences, and are concerned with solving relevant life problems.<sup>48</sup> Participants are asked to bring a goal and 3 action steps they have identified as relevant to examine and refine during the course. Principles of transformational learning theory provide the basis for the skilled faculty to create an environment that inspires participants to reach these personal goals.<sup>49</sup>

A precourse evening reception provides an overview of the major concepts of the Project and an introduction to the multidisciplinary faculty. In the subsequent 3 days, participants receive ample opportunities to practice skill development through facilitated small-group discussions,

### Curriculum Modules

#### Values Based Training

- Moral Imperative
- Personal Death Awareness
- Ethical Obligation

#### Palliative Care Knowledge

- Physical Aspects
- Psychosocial Aspects
- Spiritual Aspects

#### Advocacy

- Advocacy Issues
- Transdisciplinary Team
- Effective Change

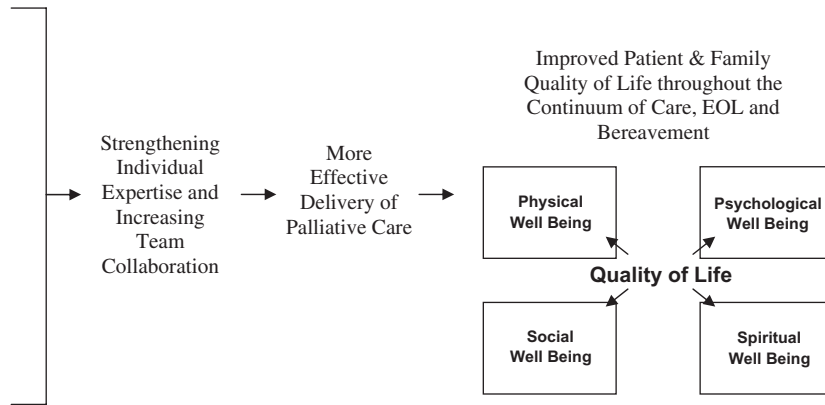


FIGURE 1. ACE Project Framework.

role playing, and experiential exercises. Teaching methods employed include lectures covering critical content, discussion sessions, and case studies. The ACE Project provides multiple resources including lecture notes, slides, music, video clips, and other educational tools. Faculty encourage guided imagery, journaling, and use of the expressive arts to stimulate reflective practice. A professional harpist integrates the use of music throughout many of the experiential exercises, and a labyrinth is available to promote reflection. Centering exercises, including narratives and rituals from various faith traditions, are offered at the opening and closing of each day's sessions.

The National Consensus Project for Quality Palliative Care<sup>9</sup> provides themes integrated throughout the curriculum:

- Family-focused perspective of care
- Advocacy as an ethical mandate for psycho-oncology professionals
- Appreciation of diversity
- Attention to vulnerable populations such as children, older adults, those with limited resources
- Authenticity in interactions
- Collaboration across the continuum of care

Essential elements of this psycho-oncology education project include strategies to improve team functioning, collaboration, advocacy for professional change, and increased pain and symptom management skills. Personal death-awareness exercises and legacy-building strategies provide practitioners with an opportunity to personalize their commitment to improve palliative care within their scope of influence. This program seeks to ignite a commitment to transform the delivery of palliative care by providing psycho-oncology professionals with advocacy skills, mentorship, and support.

The investigative team conducted an electronic Needs Assessment Survey with potential participants in March and April 2004. A total of 360 psycho-oncology seasoned

professionals responded. The core competencies (identified from position papers by each of the 3 disciplines<sup>29,50-53</sup>) reflected in the Survey further guided module content development, which was also refined by expert consultants representing each of the 3 disciplines.

Each module includes an overview, key messages, learning objectives, a participant outline, references, exercises and case studies, and slide content. Participants receive the City of Hope Pain and Palliative Care Resource Center Index: <http://www.cityofhope.org/prc> and a syllabus and CD containing nearly 1,000 pages of resources, references, slide content, supplemental materials, case studies, and exercises. Additionally, participants receive a textbook<sup>54</sup> that highlights institutional change strategies in palliative care.

### APPLICATION PROCESS

The ACE Project was marketed electronically in each discipline's professional listservs and other organizational channels, which required the development of a Web site: <http://www.cityofhope.org/ACEproject>. Course announcements and informational flyers were distributed at professional conferences generating interest from psycho-oncology professionals, and the number of well-qualified applicants far exceeded course capacity.

Selection criteria included commitment to personal and professional change, leadership history, and recommendation from supervisors. Applicants assessed their institution's effectiveness in the provision of palliative care (to be used for process and outcome evaluation). Partnership among participants, their institutions, and the ACE Project sought to maximize an ongoing commitment to this initiative. Although many of the costs associated with attending the course were covered by this grant, institutions were asked to subsidize a portion. Supervisors signed a statement of support for participants' identified goals. Each application was scored and reviewed by the investigative team, with special attention to applicants from institutions serving

diverse populations. In recognition that there are more social workers than chaplains or psychologists currently working in oncology, participants were stratified by discipline.

## EVALUATION PLAN

Data used for the extensive evaluation plan includes information derived from the application, course evaluations, and 6- and 12-month postcourse evaluations as well as during and immediately following the reunion conference. This comprehensive evaluation plan addresses the training process and outcomes and evaluates the impact of the overall program.

Quantitative data from the applications and evaluations were entered into a data editor, audited for accuracy, and analyzed using SPSS for Windows version 15.0. Descriptive statistics were computed; and for selected questions, contingency table analysis with the  $\chi^2$  statistic was used to examine differences between participants with and without a current palliative care service. Paired *t*-tests compared ratings of core competencies before and after the training.

Participants' responses to 3 open-ended questions were typed verbatim into a database and theme coded. Themes included the target of the goal (patients, staff, the institution, etc), quality-of-life dimension being addressed (physical, psychosocial, spiritual, etc), how measurable the goals were, the clinical area (eg, hospice, acute care, etc), and the focus (education, research, clinical care, etc). In the evaluation, 2 questions were theme coded: the most meaningful and the most professionally useful aspects of training (Table 1). After coding, descriptive statistics were produced on the themes, themes were rank ordered, and sample quotes were identified to amplify the meaning of the themes. Atlas.ti software was used to code, analyze, and summarize the evaluation questions.

## COMBINED COURSE 1 AND 2 PRECOURSE DATA

Participants from the first 2 ACE courses (N = 145) came from 37 states. Participants were primarily female (80%), White (88%), social workers (54%), and employed in community hospitals (47%). Patient populations served by the participants' institutions were diverse, with, on average, 17% African American, 13% Latino/Hispanic, 5% Asian, and nearly 5% American Indians/Alaskan Natives, Native Hawaiian/other Pacific Islanders, and other races/ethnicities. Although the vast majority had advanced degrees (95%), there was a tremendous variety of educational preparedness, with spiritual care professionals holding the widest range of educational degrees and titles.

Prior to attending ACE training, participants were asked to rate their perception of their institution's effectiveness on a variety of quality measures. Additionally, participants rated their proficiency on 32 core palliative care competencies on a scale of 0, not competent to 5, very competent. Participants felt most confident addressing the family as the

TABLE 1. Participants Identification of "Most Meaningful" and "Most Professionally Useful" Aspects of Course

Aspect	Sample Quotes
<b>Most meaningful</b>	
Goal refinement	<ul style="list-style-type: none"> <li>To learn that my personal experience and reflections on those experiences can help me overcome the "barriers of advocacy" and the fears I hope to move forward with my goals.</li> </ul>
Small-group discussion	<ul style="list-style-type: none"> <li>The extra time in groups gave me time to experience/think about my leadership qualities/gifts/possibilities</li> </ul>
Understanding the grief and suffering experience	<ul style="list-style-type: none"> <li>Insight into grief reactions and how they affect me both personally and professionally.</li> </ul>
Personal death awareness	<ul style="list-style-type: none"> <li>The meaningful death experience and how exhausting it is to complete and how exhausting patients may feel to talk about it.</li> </ul>
Applying our heart, head & hands	<ul style="list-style-type: none"> <li>Poem by the little girl, a concept that we are witnessing and not "fixing" suffering.</li> </ul>
Inspiration/passion for the work	<ul style="list-style-type: none"> <li>Walking in, knowing I'm among others whose passion is in advocating for patients and their families at the end of life.</li> </ul>
Networking	<ul style="list-style-type: none"> <li>Connecting with both faculty and participants in the various groups and luncheon settings.</li> </ul>
Reflection/meditation	<ul style="list-style-type: none"> <li>The beginning meditation to center myself and open up the information that followed.</li> </ul>
<b>Most professionally useful</b>	
Goal refinement	<ul style="list-style-type: none"> <li>Sage advice about partilizing what you plan to do—don't reinvent the wheel, use tools that are already developed, find people in your institution who will buy in to what you are doing, etc</li> </ul>
Ethical issues	<ul style="list-style-type: none"> <li>With regard to ethical issues, we are a moral accomplice when we keep silent</li> </ul>
Family and patient focus	<ul style="list-style-type: none"> <li>Maintaining focus on patient needs, being family centered.</li> </ul>
Transdisciplinary role/teamwork	<ul style="list-style-type: none"> <li>"None of us is as smart as all of us." Health care happens in relationships.</li> </ul>
Psychosocial aspects of palliative care	<ul style="list-style-type: none"> <li>Psychosocial pain assessment and options; the discussion on anticipatory grief and it's unique differences from grief at the time of death.</li> </ul>
Advocate/instrument of change	<ul style="list-style-type: none"> <li>Imperative to change local institution is incumbent on each participant.</li> </ul>
Resources	<ul style="list-style-type: none"> <li>The material that was provided—it was so well organized and will be useful to bring back and use in our institution.</li> </ul>

primary unit of care, collaborating with health team members, facilitating decision making at end of life, facilitating family conferences, and providing bereavement education and support (3.9 to 4.4). The lowest reported pre-course competencies were in comfort with the use of the expressive arts, translating research into practice, completing an integrated psychosocial pain assessment, basic principles of pain and symptom management, and advocating for change at the institutional level (2.3 to 3.2).

Participants developed goals that targeted staff (28%), the institution (20%), or patients and/or families (45%). Participants specified 20 different clinical areas as goals including hospital in-patients (26%), palliative care (14%), and hospice patients (12%). Of the 41% of participants who specified a traditional quality-of-life domain as a goal, the spiritual domain was the most prevalent (36%). Goals were most commonly focused on palliative care education (35%), improving clinical care (32%), and implementing organizational change (21%).

### COMBINED COURSE 1 AND 2 POSTCOURSE EVALUATION DATA

Participants indicated high satisfaction with the faculty, the syllabus, and the course overall. The overall course rating from 1, poor to 5, excellent was 4.6. Combined speaker effectiveness averaged 4.6. Modules were rated to be thought provoking (4.5) and professionally relevant (4.7), with the psychological aspects of palliative care and advocacy and change (4.8) as the highest rated modules. Overall, the course met participants' objectives (4.6).

Table 2 presents the self-rating of the 5 key skills of the ACE curriculum before and after training. At the beginning, participants rated their skills as moderately effective (overall average 3.73 on a scale of 1, minimally effective to 5, very effective), whereas at the end, they rated their skills closer to very effective (overall average 4.43). Leadership and palliative care skills increased the most (.91 and .82 points, respectively),  $P < .001$ .

Through 2 open-ended questions, participants identified the most meaningful moment as well as the most professionally

useful concept or idea for each day (Table 1). Topics rated most meaningful include personal development, group interaction, and goal refinement. The most professionally useful topics represent all 3 of the major components of the curriculum (values-based training, palliative care knowledge, and advocacy) including goal refinement, ethical issues, family and patient focus, transdisciplinary role and teamwork, psychosocial aspects of palliative care, advocacy and effective change, and an appreciation of the breadth and depth of the provided resources. Transcending the module content, participants also identified their own personal growth and the networking opportunities available as professionally useful and meaningful.

### DISCUSSION

Transdisciplinary education is by nature challenged to identify the optimal balance regarding the "sophistication" of information necessary for each discipline while recognizing the vast variety of skill levels represented between individuals. The ACE Project curriculum attempted to address this challenge through a variety of educational strategies. For example, although not specifically a "train the trainer" course, key module concepts were offered in a format that would support participant teaching and advocacy for change in their home environment. This strategy ensured that crucial core information was presented without offending participants with years of professional experience.

Another challenge in establishing a cohesive educational "tone" for the program was the wide variety of occupational roles and settings represented by the participants within each course. In addition, the types of goals participants addressed were quite diverse. The goals ranged from larger policy issues to smaller direct service concerns. Faculty facilitating goal discussions were tasked with reframing this diversity of interests and talents into a rich opportunity for increased insight and learning.

Participants' highly rated the course content, instructional activities, and course materials, suggesting that the preliminary needs assessment accurately reflected the needs and interests of the first 2 cohorts. Participants perceived an immediate postcourse positive effect on their transdisciplinary palliative care skills. Comments from open-ended questions not only reflect the strength of the curriculum, resources, and teaching methodologies but also highlight the educational benefits of transdisciplinary collaboration (via small-group interaction and participant networking).

While we await longitudinal data demonstrating the effectiveness of the training on participant goal achievement, a preliminary review of the 6-month reports from the first cohort indicate continued commitment to create meaningful institutional changes. Participants from both courses report increased confidence as change agents, a deeper resolve to develop reflective practice, and heightened attention to patient advocacy.

TABLE 2. Participants Self-Reported Changes in Key Skills Following ACE Training\*

Skill	Before		After	
	Mean	SD	Mean	SD
Leadership	3.40	0.90	4.31	0.65
Team building	3.57	0.85	4.27	0.69
Communication	4.06	0.77	4.52	0.62
Collaborative	3.98	0.76	4.60	0.55
Palliative care	3.65	1.00	4.47	0.64
Composite skills score	3.73	0.58	4.43	0.46

\*Scale: 1, Minimally effective; 5, Very effective;  $P < .001$ .

## CONCLUSIONS

Preliminary findings demonstrate the feasibility of developing a national transdisciplinary palliative care education curriculum for psycho-oncology professionals. Two remaining cohorts and a Reunion Conference are planned for this NCI-funded educational initiative, which will provide additional evaluative data regarding the overall efficacy of this model in inspiring change efforts among psycho-oncology palliative care professionals.

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