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COMFORT$_{TM}$ SM Communication: Outcomes of a National Train-the-Trainer Palliative Care Communication Course for Oncology Providers

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Abstract

Background: With increasing support for the integration of palliative care and standard oncology, communication training programs are needed to teach oncology nurses and other providers about palliative care communication. Variance in cancer setting and availability and scope of palliative care programs warrant the need for a train-the-trainer course format to standardize teaching content and practice.

Objectives: The purpose of this study is to report the outcomes of COMFORTTM SM Communication for Oncology Nurses, a train-the-trainer communication course supported by the National Cancer Institute (R25CA174627) to educate oncology nurses about palliative care communication to improve patient-centered communication and cancer care.

Methods: Oncology nurses (n=355) who attended the two-day course received instruction on how to teach communication, the curriculum for teaching palliative care communication, and support for developing outcome goals following the course. This study used 6- and 12-month follow-up data from nurses who provided feedback on the progress of these goals.

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Findings: Nurses taught an additional 9,720 interdisciplinary oncology providers, conducted needs assessment of communication processes, initiated institution-wide palliative care communication training, and partnered with palliative care teams. Barriers to completing outcome goals included a lack of institutional support, specifically an absence of leadership, financial backing, and dedicated time.

Keywords

communication education/training; nursing; oncology; patient-centered care; palliative care

Introduction

Increased diversity in diagnoses, multi-morbidity, and chronic illness add to the complexity of cancer care and demand the involvement of palliative care to ensure that patients' goals, preferences, and wishes are at the forefront of care planning (Aldridge & Bradley, 2017). Palliative care is specialized team-based care that focuses on relief from the symptoms and stress of illness (Get Palliative Care, 2019). Oncology associations support the integration of palliative care into standard oncology care. Palliative care in oncology improves quality of life and survival (Bakitas et al., 2017; Temel et al., 2010) and reduces symptom burden, financial burden, and emergency department visits for symptom management (Hallman & Newton, 2019). Despite these benefits, the number of cancer patients needing palliative care far exceeds the number of palliative care providers available (Szekendi et al., 2018).

As there are not enough palliative care providers to sustain the integration of palliative care concurrent with usual oncology (Bakitas et al., 2017), the presence of palliative care can be increased by non-palliative care providers, such as oncology nurses, who can engage patients and families in palliative care conversations (Szekendi et al., 2018). With an increasing focus on patient-centered and value-based healthcare, oncology nurses are ideally positioned to expand access to palliative care and more consistently deliver cancer care that honors patient and family preferences (Dailey, 2016; Szekendi et al., 2018). Effectiveness reviews demonstrate that palliative care can improve patient and family satisfaction and experience of care; reduce days in the hospital; reduce 30-day re-admissions, and, especially towards the end-of-life, reduce total spending (Center to Advance Palliative Care, 2018, February 28).

The COMFORTTM SM Communication for Oncology Nurses training program is a NCI supported project (R25CA174627) which educates oncology nurses to improve support and resources for communication training in palliative care communication. COMFORT is an acronym that represents the seven basic principles of palliative care communication (Wittenberg-Lyles, Goldsmith, Ferrell, & Ragan, 2012). The purpose of this article is to present outcomes of the training program.

Background

Oncology nurses currently participate in multidisciplinary teams that often coordinate palliative care, and some palliative care programs include an oncology nurse practitioner (Hallman & Newton, 2019), however, nurses report feeling uncertain about their role within

palliative care conversations (Tartaglione, Vig, & Reinke, 2018). Nurses are commonly excluded from the delivery of a cancer diagnosis (Bowman, Slusser, & Allen, 2018) and have not been prepared to provide patient and family education about palliative care (Harden, Price, Duffy, Galunas, & Rodgers, 2017). Few oncology nurses feel adept at facilitating discussions about palliative topics, receiving little to no education about palliative care communication (Tartaglione et al., 2018; Wittenberg, Goldsmith, Buller, Ragan, & Ferrell, 2019).

Integrating palliative care into oncology requires healthcare providers to engage in sensitive communication about diagnosis, discuss factors influencing treatment decision-making, relay and mediate communication among family members, and provide psychosocial counseling about difficult topics. Palliative care conversations are contextual, dependent upon the type of healthcare system, size and nature of the palliative care program available, clinical setting, and the availability of resources (Hui, Hannon, Zimmermann, & Bruera, 2018). Palliative nursing is grounded in a holistic philosophy aimed at providing comprehensive care for the physical, spiritual, psychological, and social needs of patients and families during serious or life-threatening illness. The National Consensus Project domains of quality care describe the central role of compassionate, patient-centered communication in palliative care (National Consensus Project for Quality Palliative Care, 2018). Similarly, the COMFORT model provides an expansion of nurse communication tools to support team-based, interprofessional care. New communication skills emerge when oncology nurses are trained and participate in the delivery of palliative care, leaving them feeling personally and professionally fulfilled (Feldenzer, Rosenzweig, Soodalter, & Schenker, 2019). Nurses with improved knowledge, attitudes, and behaviors about palliative care report having more conversations about palliative care with patients and families (Harden et al., 2017). High levels of communication comfort and skill make nurses feel more equipped to deliver effective goals of care conversations (Szekendi et al., 2018).

Still, most cancer centers do not offer communication training programs for nurses (Wittenberg et al., 2019) and there are limited opportunities for oncology nurses to receive palliative care communication training (Weber, Sulstarova, & Singy, 2016). Programs that are available are often limited to lecture and discussion formats (Harden et al., 2017) and it can be difficult for organizations to provide released clinical time in order for nurses to attend communication skill training. With no standard practice model for the integration of oncology and palliative care (Hui et al., 2018), palliative care communication training programs for nurses are needed to define standardized teaching content and practice for palliative care in any clinical setting (Harden et al., 2017). Thus far in the research, nurse communication skill training includes self-reported post-training outcomes such as confidence and comfort to determine if the program was successful without considering applied use and integration of this knowledge (Banerjee et al., 2017).

One viable option for expanding communication training that accounts for the wide variance in the scope and nature of palliative care programs and cancer care settings (e.g., community hospitals versus large academic cancer centers) is the train-the-trainer format. A train-the-trainer model of dissemination utilizes master trainers to prepare others to implement communication training, thereby allowing on-site ‘communication champions’ to teach

colleagues and implement process changes aimed at improving patient-centered communication specific to the clinical setting and availability of resources. Much like simulation-based communication education, train-the-trainer programs are informed by current evidence, are validated via rigorous outcome data, and are successfully measurable beyond the training site (Blackmore, Kasfiki, & Purva, 2018).

In terms of communication training, there is a gap in our understanding about whether those trained in a train-the-trainer course actually train others and implement recommended changes to communication processes. Research is needed to learn about outcomes following a train-the-trainer communication course to discern barriers and successes. The purpose of this study is to examine the outcomes of a train-the-trainer program utilizing oncology nurses to provide palliative care communication training. A train-the-trainer communication course is the first step toward expanding and enhancing education about palliative care communication for oncology nurses who serve as frontline providers.

Methods

COMFORTTM SM Communication for Oncology Nurses is a train-the-trainer course funded by the National Cancer Institute (R25) that provides nationwide communication training to improve patient-centered communication in cancer care. Specific details about the course learning objectives, design, and curriculum have been reported elsewhere (Wittenberg, Ferrell, Goldsmith, Ragan, & Buller, 2017). Oncology nurses applied in two-person teams from the same institution, responding to advertising through their organization, and a competitive selection process was conducted by the authors based on background, statement of interest, projected goals, and geography. Course participants received a print and digital training manual that included PowerPoint slides for each of the seven COMFORT modules that included speaking notes and ways to evaluate communication after training.

During the two-day course nurses developed three outcome goals. These goals were generated from ideas that emerged during discussion and networking and included specific strategies for institutional implementation. Participants were contacted at 6- and 12-months post training and asked to indicate the progress of each goal by state of completion (100% completed, 50% or more completed, 50% or less completed, stalled, or not started) and to provide a brief description of progress toward the goal. Participants were also asked to report on the number and discipline of those they had trained, which program modules were used, and to rate the perceived usefulness of the modules and training manual on scale of 1 (not useful) to 10 (very useful). Follow-up assessment was determined to be exempt under the institutional review board at the supporting institution.

Data Analysis

Outcome goals were separated into completed and not completed categories. Goals were identified as completed if participants reported at least 50–100% completion of the goal. Goals were identified as not completed if participants reported less than 50% completion, goal stalled, or not started. Goals that were identified as completed were coded into one

mutually-exclusive category developed from an initial analysis of pilot data, with no new categories emerging (Wittenberg, Ferrell, Goldsmith, & Buller, 2016).

A thematic analysis of reasons why goals were not completed were developed from the data, with themes representing non-mutually exclusive categories. Using an iterative process of thematizing (Glaser & Strauss, 1967; Strauss & Corbin, 1998), two members of the research team studied the data independently and used open coding to identify responses that suggested a possible theme. The researchers then met to identify, sort, and integrate themes that had been independently identified. A process of constant comparison allowed for the integration and collapsing of themes into broader associated categories. Data was re-reviewed and key categories were refined.

Finally, descriptive statistics (frequencies and means) were used to examine the distribution of institution types, numbers of discipline trained, and rating of perceived usefulness. Quantitative data were entered, audited for accuracy, and analyzed using the Statistical Package for the Social Sciences (SPSS).

Results

Three hundred fifty-five nurses from 42 states and Washington, D.C. attended one of four courses. The majority (92.7%) were female and Caucasian (70.4%), with the remaining representing: Asian (10.7%); African-American (5.9%); more than one race (3.4%); and 1% from American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and unknown cultural groups. Twenty-four individuals (6.8%) did not indicate race. Oncology nurses represented NCI-designated cancer centers (36%), community cancer centers (35%), ambulatory cancer clinics (19%), university medical centers (4%), and Veterans Health Systems (6%). A total of 164 nurse teams were represented in the data set; one team with three nurses and 12 nurse teams did not provide follow-up data.

Overall, 483 goals were coded. A 95% response rate at 12 months revealed that 61% of goals (n= 294) were completed and 39% (n=189) were not completed. Of the goals completed, 45% (n=134) were completed within the first six months of training. In total, 34 teams did not complete any goals (20%).

After attending the course, nurses completed a variety of outcome goals. A summary of these achievement goals is articulated here to demonstrate the outcomes of the training across the life of the course. The largest portion of participants pursued an assessment of the needs of their institution (25%) by collecting feedback from colleagues, patients, and patient families about communication experiences, and focused on providing training to nurse colleagues to improve communication related to palliative care. Training colleagues in communication practices and behaviors accounted for 24% of participant goals, and included outcome measures related to communication confidence and comfort with patients and colleagues. Institution-wide training involving communication processes (21%) as well as system changes (17%) to communication processes were common goals and work of COMFORT trainees, with improvements measured and discovered in team communication. Partnering with the palliative care team (8%) was also a specific initiative undertaken which

commonly included ‘palliative discussions’ and coordination in using the term ‘palliative care’ with patients and families. Finally, nurses also applied the training in other innovative ways (5%), including modifications to electronic medical records, development of brochures and flyers, and self-care events and awareness.

Vital to understanding efficacy of COMFORT is the examination of barriers impeding goal completion for the teams trained and monitored. These barriers were thematized into seven essential categories described here. 1) Financial Resources: Nurses reported that goal completion was not possible due to a lack of financial resources to pay for staff time or the development of new services, a lack of leadership support, inability to successfully coordinate and schedule needed stakeholders, organizational constraints in terms of restrictions and policy, no time to devote to goals, limited staffing, and team support could not be garnered. 2) Leadership: Changes in leadership positions, loss of providers, and institutions waiting for new hires limited or stopped goal completion for some teams. 3) Scheduling: Arranging schedules to support goal completion was unachievable due to postponed dates, presentations pending, tasks stalled, rescheduling, and meetings booked at a future time. 4) Organizational Constraints: Changes in the education department, bureaucratic restrictions, remodeling of the oncology unit, administrative changes, and the dissolution of cancer program are examples of systemic shifts that rendered some teams inoperable. 5) Time: The essential resource of time required for goal completion was unobtainable because projects took longer than expected, there was limited time for planning, lack of nurse availability due to time constraints, and staff meetings did not take place or were delayed because time was limited. 6) Staff: Personnel on leave, reduction in workforce, and dealing with staff changes stymied efforts for some. And finally, 7) Team Support: The need for further team communication training, increase in staff attendance, meeting coordination, unachieved changes in team meeting processes, lack support groups, resistant MD cooperation, and no established team were frequent barriers as well.

The seven training modules included in the train-the-trainer program were rated as highly useful as reflected by mean scores: C-Communication (8.6), O-Orientation and Options (7.9), M-Mindful Communication (8.7), F-Family (8.4), O-Openings (8.3), R-Relating (8.2), T-Team (8.5). The training manual was used by 88% of nurses, with an overall usefulness rating of 8.1.

Finally, Table 1 details the number of disciplines trained by nurse teams who attended one of the four courses. Overall, 355 nurses trained 9,720 additional healthcare professionals: 797 physicians, 7,267 nurses, 306 social workers, 121 chaplains, and 1,232 other providers. On average, each team trained 59 other healthcare providers.

Discussion

Given that most oncology providers do not know how to engage in palliative care communication about care priorities and options (Hui et al., 2018; Meier et al., 2017), the train-the-trainer model for communication training appears to be a viable and promising strategy for teaching palliative care communication across disciplines and across cancer settings. Nurses from a variety of cancer settings were able to return to their institutions and

train others, with most nurses using the training manual to disseminate training content. Moreover, a large majority of goals focused on needs assessment and training nurse colleagues, supporting the ongoing need for oncology nurses to have a supportive work environment to help minimize stress and burnout related to palliative care implementation (Feldenzer et al., 2019).

Unique to train-the-trainer programs, nurses in this study completed institution-wide communication skill building and system changes that targeted improvements to team communication and collaboration with others. In line with findings that palliative care in oncology improves communication between patients and providers (Hallman & Newton, 2019), nurses recognized the need for open communication between oncology and palliative care. Oncology nurses need to have solid interprofessional skills for successful collaboration and processes in place to ensure regular communication with palliative care teams (Hui & Bruera, 2016). Moreover, institution-wide training goals completed support the need to establish open communication about palliative care topics across the entire institution (Tartaglione et al., 2018).

Common barriers associated with the inability to complete outcome goals were primarily system-level. Consistent with long-time research findings, nurses reported that they did not have enough time to complete goals (West, Barron, & Reeves, 2005). High caseloads and organizational re-structuring left them with little support to accomplish goals. Similar to recent nurse reports of an “unsupportive organizational culture”, nurses in this study described a lack of leadership, team support, and inability to coordinate and schedule needed personnel (Valizadeh, Zamanzadeh, Dewar, Rahmani, & Ghafourifard, 2018).

Several aspects of the train-the-trainer model are worth noting. First, program evaluation is needed to assess that communication training was implemented with fidelity. While nurses were provided with a training manual and faculty support for goals, more trainee feedback is needed to determine to what extent training content was followed. While all training modules were used by nurses and reported to be useful, no information was collected about the length, frequency, and duration of use. Second, refresher trainings should be scheduled regularly as training content changes and is updated. In this study, courses were offered over a four-year period and while training content was updated each year, this content was not provided to past attendees. Finally, further research is needed to develop an evidence for whether a train-the-trainer model has utility in reducing communication training costs and that such training can yield desirable outcomes.

The study is limited by a lack of diversity in the participant sample, despite significant recruitment efforts to diversify attendees. The largely female, Caucasian sample implicates systems and resources across the country and enforces disparities in palliative services also reflected in Center to Advance Palliative Care statistics. The homogenous nature of this sample is representative of the palliative care nursing demographic.

Implications for Nursing Practice

Considering the scarcity of palliative care resources across organizations (Hui et al., 2018), this study demonstrates that a train-the-trainer communication course is a potential solution

to meeting the palliative care training needs of oncology providers. Goals completed demonstrate that nurses can: 1) impact the communication training of colleagues in their own settings and 2) improve palliative care communication practices with COMFORTTM SM content. There are direct implications for hospital/institutional policy as barriers reflected that organizational support is vital, with changes needed in scheduling, staffing, and clinical load to provide leadership support for trainers who return to their institution ready to train others. Future training structures should maintain the nurse-supported model implemented in this national training program, which includes funding participant training and organizing across a two-day period of satiation. The current study demonstrates that nurses can be trained to serve as "communication champions" and support palliative care communication training needs within their institution.

Conclusion

More than two third of adults in the US have never heard of palliative care (Trivedi et al., 2019) and many have misperceptions about what this type of care entails (Dailey, 2016). Nurse communication is imperative to the goals of palliative care (Hallman & Newton, 2019), as a lack of knowledge among cancer patients and families prevents the successful implementation of palliative care (Harden et al., 2017). While there are no set standards for integrating palliative care into oncology, the COMFORTTM SM train-the-trainer course shows success for one approach aimed at providing palliative care communication training.

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Implications for Practice

- COMFORTTM SM Communication for Oncology Nurses is an example of a successful train-the-trainer communication course for developing nurse leaders who can provide palliative care communication training to interdisciplinary oncology providers.
- Oncology providers who are not members of the palliative care team can provide patient and family education on palliative care and streamline the referral process for patients in need of consultation and care.
- System-level support for palliative care communication training must mitigate the challenges of unsupportive leadership, team dynamics, and coordination of schedules and personnel.

Table 1.

Number of Disciplines Trained by Oncology Nurses Who Attended Course

Disciplines Trained	Total N=164 nurse teams	NCI-Designated N=59	Community Cancer Centers N=57	Ambulatory Cancer Clinics N=32	Academic/ University Medical Centers N=6	Veteran's Health System N=10
Physicians	797	126	547	102	12	10
Nurses	7,264	3,028	2,377	1,136	67	656
Social Workers	306	64	184	37	5	16
Chaplains	121	37	56	18	2	8
Other	1,232	244	510	245	14	219
Total Trained	**9,720**	**3,499**	**3,674**	**1,538**	**100**	**909**