Evaluation of
Palliative Care Education Programs
In Northern Ontario

FINAL REPORT

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Northern Health Human Resources Research Unit
Lakehead and Laurentian Universities

EVALUATION OF PALLIATIVE CARE EDUCATION PROGRAMS IN NORTHERN ONTARIO

FINAL REPORT

Submitted to:
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EXECUTIVE SUMMARY

In 1992, the Ministry of Health for Ontario announced funding for initiatives in community palliative care education for family physicians, other health care providers and volunteers. These initiatives followed the general trend toward devolution in the provision of human services in the province. By shifting the responsibility for planning, delivering and, to a certain extent, funding decisions to the district level, the Ministry encouraged the development of programs tailored to local circumstances. As a result, the palliative care education initiatives fostered a wide variety of educational programs and delivery strategies across the province.

In September, 1994, the Northern Health Human Resources Research Unit (NHHRRU) at Lakehead and Laurentian Universities was commissioned to conduct an in-depth evaluation of palliative care education programs that were to be delivered in Northern Ontario during 1994-95. The evaluation focussed on the "Train the Trainer" educational model employed in the initiatives, by profiling the educational programs, documenting the educational experience of the participants, and examining the effects of the programs on the participants' knowledge and attitudes toward palliative care.

In consultation with the three Long-Term Care Area Managers, NHHRRU selected six of the thirteen palliative care education programs which were conducted in the region. These served populations in the Districts of Cochrane-Temiskaming *(Extendicare Palliative Care Education Program)*, Parry Sound (*Parry Sound District Home Care Program*), Nipissing (*Nipissing District Palliative Care Education Program*), and Manitoulin-Sudbury (*Sudbury Regional Palliative Care Association Interdisciplinary Initiative*), as well as two regional programs, one for physician providers in the Northeastern region (*Palliative Care Education Program for Family Physicians*) and another for physicians and other providers in the Northwestern region (*Palliative Care Institute '94*). The programs selected were chosen as being representative of different local and regional responses to the Province's palliative care initiatives, including variations in the number of disciplines covered and broad differences in delivery approaches.

Methodology and Limitations

To assess the effectiveness of the educational model and document the educational experience of participants, a variety of evaluation methodologies and sources of data were used, generating qualitative and quantitative data concerning program planning, delivery and implementation. These included document reviews, surveys and interviews. The data collected was limited by the ten-month time-frame of the project, which precluded pretesting of participants and analysis of program developments, or long-term impact assessment. While the overall survey response rate was satisfactory, low response rates from a few sectors mean that some programs and occupational groups may be under-represented and that certain statistical procedures were not feasible.

Summary of Findings and Recommendations

1.   **Program Approaches:**

The six programs evaluated adopted diverse approaches to the educational model, each constituting a grassroots-driven response to the needs of providers, partner agencies, facilities and communities. All programs appeared to be effective, producing short-term attitudinal, behavioral and educational effects. Since each program's strength was derived from its ability to meet the needs of participating providers, agencies and communities, it is recommended that the Ministry:

> *1.1   Encourage agencies and facilities to form partnerships to develop community-driven palliative care education programs that are responsive to the needs of providers in specific communities or regions;*
>
> *1.2   Encourage agencies and facilities to develop coordinated interdisciplinary education programs for providers in home-care, long-term care and acute care settings;*
>
> *1.3   Consider combining Physician and Interdisciplinary Education Initiatives to facilitate development of multidisciplinary approaches to palliative care.*

2. *Program Content:*

Although all programs presented 30 hours of formal training addressing the core skills content requirements outlined in Ministry directives, analysis of program materials and survey responses indicates variation in the interpretation of the Core Skills Guidelines and the "Train the Trainer" model. Many participants, coordinators and administrators felt that program content could be improved: by providing more detailed goals and objectives; increasing the number of formal training hours and providing training and resource manuals in advance. In light of these findings, it is recommended that the Ministry:

> *2.1   Retain Core Skills Guidelines as a central component of Palliative Care Education programs;*
>
> *2.2   Review the current Core Skills Guidelines to provide more detailed goals and objectives concerning the core skills required for palliative care education programs;*
>
> *2.3   Emphasize training in six major Core Skills areas: Principles of Palliative Care, Physiological Issues, Pain and Symptom Management, Communication, Spiritual Implications and Support to Dying Persons and Family Caregivers;*
>
> *2.4   Re-examine the number of formal training hours for Palliative Care Education Training Programs to ensure that they are sufficient to meet Core Skills Guidelines;*
>
> *2.5   Encourage program coordinators to provide program guidelines, training manuals and teaching materials to participants at least one month prior to formal training sessions, in order to make the best use of formal training hours.*

3. Program Delivery - The Educational Model:

Although the majority of those surveyed were in favour of continuing palliative care education funding based on the "Train the Trainer" model, many had reservations about the model's ability to provide flexible, responsive training for all provider groups. To enhance the flexibility of the model, it was suggested that consideration be given to identifying basic and advanced educational needs of different provider groups and evaluating the effectiveness of "Train the Trainer" programs. Given these findings concerning the educational model, it is recommended that the Ministry:

3.1   *Continue to fund Palliative Care Education Initiatives based on the "Train the Trainer" model;*

3.2   *Permit flexibility in adopting the "Train the Trainer" model to meet identified educational needs of providers, partner agencies, facilities and communities;*

3.3   *Encourage program coordinators to identify basic and advanced educational needs of different provider groups;*

3.4   *Encourage program coordinators to include evaluability criteria in program design to facilitate short-term evaluation of palliative care education training outcomes;*

3.5   *Encourage program coordinators to undertake objective evaluations to assess the short-term effectiveness of palliative care education programs in meeting the identified training needs of provider groups.*

4. Program Delivery - Implementing the Educational Model:

While a majority of participants had taken informal actions towards implementing the "Train the Trainer" model, many participants, coordinators and administrators reported difficulties in formally implementing the model. Insufficient knowledge about the "Train the Trainer" model, lack of instruction in learning principles and teaching strategies and weak commitment to teaching were especially problematic. To support informal and formal implementation of the model, it is recommended that the Ministry:

4.1   *Revise the current Core Skills Guidelines to add a component on how to implement the "Train the Trainer" model, including intensive training in adult learning principles, as well as informal and formal teaching strategies;*

4.2   *Examine the possibility of developing an extensive resource manual providing more detailed instruction about the palliative care education Core Skills Guidelines and implementation of the "Train the Trainer" model;*

4.3   *Encourage agency administrators to support informal implementation of the model by facilitating staff coaching and discussions of palliative care issues;*

> *4.4   Encourage adoption of more stringent Participant Selection Criteria for participants to ensure that training is directed towards those who are interested in and committed to formally teaching others about palliative care;*

> *4.5   Adjust Participant Selection Criteria to permit agencies and facilities to send key staff members to consecutive training sessions, in order to upgrade trainers' palliative care education, knowledge, and skills.*

5. Program Development - Palliative Care Education Programs:

While participants, program coordinators and administrators greatly appreciated the opportunity to provide palliative care education under the present initiatives, evaluation findings indicate that most were concerned about the further development of palliative care education programs. Since funding is not provided for inservice education programs or long-term assessments, it is recommended that the Ministry:

> *5.1   Examine the possibility of using existing available resources to fund staff release time for provider agencies and facilities to develop palliative care education inservice programs for provider agencies;*

> *5.2   Examine the possibility of using existing available resources to fund community and regional computer resource databases for palliative care education in order to expedite information and skill exchanges among partner agencies, facilities and providers;*

> *5.3   Consider funding a one-day workshop for training program coordinators of all Northern Ontario initiatives to share their experiences and learn from each other on how to develop and deliver future palliative care education initiatives;*

> *5.4   Consider funding a follow-up study of the 1994-95 training programs, surveying coordinator, participant and agency administrator cohorts to assess the long-term effectiveness of these Palliative Care Education Initiatives.*

CONCLUSION

Although the present evaluation reveals that programs were successful in producing short-term attitudinal, behavioral and educational effects, findings suggest that

improvements can be made in many areas of palliative care education. Such improvements could enhance the quality of palliative care education and palliative care services provided throughout the region.

SOMMAIRE

En 1992, le ministère de la Santé de l' Ontario a annoncé le financement d'initiatives de formation en soins palliatifs dans la collectivité, initiatives destinées aux médecins de famille, aux autres professionnels de la santé et aux bénévoles[1]. Ces initiatives suivaient la tendance générale à décentraliser la prestation des services sociaux dans la province. En transférant au niveau du district la responsabilité en matière de planification, de prestation et dans une certaine mesure de financement, le Ministère encourageait l'établissement de programmes adaptés aux conditions locales. Par conséquent, les initiatives de formation en soins palliatifs ont donné naissance à une gamme de programmes de formation et de stratégies de prestation d'un bout à l'autre de la province.

En septembre 1994, l'Unité de recherche du Nord en ressources humaines dans le domaine de la santé (URNRHS) à Lakehead University et l'Université Laurentienne a été mandatée pour effectuer une évaluation en profondeur des programmes de formation en soins palliatifs qui devaient avoir lieu dans le Nord de l'Ontario en 1994-95. Cette évaluation, ayant pour centre le modèle didactique de "formation de la formatrice" employé dans ces initiatives, a adopté comme critères les programmes de formation, l'expérience éducative des participantes, et les résultats des programmes sur les connaissances et l'attitude des participantes envers les soins palliatifs. Sur un total de treize programmes de formation en cours de réalisation dans la région du Nord, et avec l'accord des trois directrices régionales des soins de longue durée, l'URNRHS a sélectionné six programmes de formation en soins palliatifs: ceux-ci desservent la population des districts de Cochrane-Témiscaming, (Programme de formation en soins palliatifs d'Extendicare), de Parry Sound (Programme de soins à domicile de Parry Sound), et de Manitoulin-Sudbury (Initiative interdisciplinaire de l'Association régionale des soins palliatifs de Sudbury), ainsi que deux programmes régionaux, l'un pour les médecins de la région du Nord-Est (Programme de formation en soins palliatifs pour médecins de famille), et un autre pour médecins et autres professionnelles de la santé dans la région du Nord-Ouest (Institut 1994 en soins palliatifs). Les programmes ainsi sélectionnés représentaient une variété de réactions locales et

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[1] *N.B. : l'utilisation du féminin dans le présent document a pour seul but d'alléger le texte et s'applique sans discrimination aux personnes des deux sexes.*

régionales aux initiatives en soins palliatifs de la part de la province, notamment dans le nombre de disciplines couvertes et de méthodes de prestation.

Méthodologie et limites du sujet.

En vue de mesurer l'efficacité du modèle didactique et d'examiner l'expérience éducative des participantes, on a utilisé des méthodologies variées d'évaluation, et des sources diverses de données, ce qui a fourni des données qualitatives et quantitatives sur la planification de programme, son exécution et sa mise en pratique. Il s'agissait d'examen de documents, d'enquêtes et d'entrevues. Le rassemblement des données a été limité par le délai d'exécution du projet (10 mois), excluant de ce fait l'administration préalable de tests aux participantes et l'analyse des programmes en cours, ou l'évaluation des effets à long terme. Si le taux global de réponses a été satisfaisant, par contre dans quelques secteurs le taux de réponses peu élevé signifie que certains programmes et certains groupes professionnels sont peut-être insuffisamment représentés et que certaines opérations statistiques ne sont pas réalisables.

Sommaire des résultats et recommandations

1. Méthodes des programmes :

Les six programmes considérés ont adopté des méthodes diverses vis à vis du modèle didactique, car chacun constituait une réaction locale particulière devant les besoins des personnes donnant les soins, des agences partenaires, des établissements et des collectivités diverses. Tous les programmes ont semblé efficaces et ont eu des conséquences à court terme sur l'attitude, le comportement et les connaissances. Du fait que la force de chaque programme provient de sa capacité à répondre aux besoins du personnel, des agences et des collectivités participant au programme, il est recommandé que le Ministère:

> *1.1 encourage les agences et établissements à former des partenariats en vue d'élaborer des programmes de formation en soins palliatifs ayant leur raison d'être dans la collectivité, et qui correspondent aux besoins des personnes donnant les soins dans des collectivités ou des régions précises;*

> *1.2 encourage les agences et établissements à mettre en place des programmes interdisciplinaires de formation pour les personnes donnant*

les soins à domicile, dans les établissements de soins de longue durée et de soins intensifs;

1.3   *envisage de combiner les initiatives de formation des médecins aux initiatives interdisciplinaires afin de faciliter l'introduction de méthodes pluridisciplinaires de soins palliatifs.*

2. Contenu des programmes:

Tous les programmes fournissaient 30 heures d'enseignement centré sur les compétences de base exigées dans les directives du Ministère, mais une analyse du contenu du programme et les réponses à l'enquête indiquent une certaine variation dans l'interprétation des directives sur les compétences de base et le modèle de "formation de la formatrice." De nombreuses participantes, coordonnatrices et administratrices sont d'avis que le contenu du programme pourrait être amélioré de la façon suivante: buts et objectifs plus détaillés; augmentation du nombre d'heures d'enseignement; envoi à l'avance des manuels de formation et des ressources pédagogiques. A la lumière de ces résultats, il est recommandé que le Ministère:

2.1   *garde comme élément central des programmes de formation en soins palliatifs les directives sur les compétences de base;*

2.2   *révise les directives actuelles sur les compétences de base en vue de fournir des buts et objectifs plus détaillés se rapportant aux compétences nécessaires dans les programmes de formation en soins palliatifs;*

2.3   *insiste qu'il y ait une formation dans les six domaines principaux de compétences de base: principes des soins palliatifs, questions de physiologie, gestion de la douleur et des symptômes, communication, questions de spiritualité, soutien aux mourants et aux membres de la famille donnant des soins;*

2.4   *examine à nouveau le nombre d'heures de cours des programmes de formation en soins palliatifs pour s'assurer que ce nombre d'heures suffit à remplir les conditions des directives sur les compétences de base;*

2.5   *encourage les coordinatrices de programme à faire parvenir aux participantes au moins un mois avant le commencement des cours les directives, manuels de formation, documents pédagogiques, afin de leur permettre de profiter au maximum des heures d'enseignement.*

3. Mise en oeuvre du programme - le modèle didactique:

En majorité, les personnes ayant répondu à l'enquête étaient en faveur de la continuation du financement de la formation en soins palliatifs, selon le modèle de "formation de la formatrice", mais beaucoup d'entre elles exprimaient des réserves sur la capacité du modèle quand il s'agit de fournir une formation souple et adaptée à tous les groupes de personnes donnant des soins. Afin d'augmenter la souplesse du modèle, il a été proposé que l'on identifie les besoins éducatifs (essentiels, plus avancés) des divers groupes de prestation, et que l'on évalue l'efficacité des programmes de "formation de la formatrice." Étant donné les résultats portant sur le modèle didactique, il est recommandé que le Ministère :

> *3.1   continue de financer les initiatives de formation en soins palliatifs basées sur le modèle de "formation de la formatrice";*
>
> *3.2   permette une certaine souplesse d'adaptation au modèle de "formation de la formatrice" en vue de répondre aux besoins éducatifs précis des personnes donnant les soins, des agences en partenariat, des établissements et des collectivités;*
>
> *3.3   encourage les coordonnatrices de programmes à indiquer le niveau élémentaire ou avancé des besoins éducatifs des divers groupes de prestation;*
>
> *3.4   encourage les coordonnatrices de programmes à incorporer au programme des critères d'évaluation en vue de faciliter l'évaluation à court terme des résultats de la formation en soins palliatifs;*
>
> *3.5   encourage les coordonnatrices de programmes à entreprendre des évaluations objectives dans le but d'évaluer l'efficacité à court terme des programmes de formation en soins palliatifs quand il s'agit de répondre aux besoins des groupes participants.*

4. Mise en oeuvre du programme - application du modèle didactique:

Si en majorité les participantes ont appliqué à leur façon le modèle de "formation de la formatrice", de nombreuses participantes, coordonnatrices et administratrices ont eu des difficultés à implanter le modèle de façon systématique. La connaissance insuffisante du modèle de "formation de la formatrice", le manque de formation en matière de principes d'apprentissage et de pratique d'enseignement, et le peu d'importance accordée à

l'enseignement constituent les principaux problèmes. Afin d'encourager l'application plus ou moins systématique du modèle, il est recommandé que le Ministère:

> *4.1* *révise les directives sur les compétences essentielles et ajoute une partie supplémentaire sur la mise en oeuvre du modèle de "formation de la formatrice", avec un cours intensif sur les principes d'apprentissage par les adultes, ainsi que des leçons sur les méthodes (structurées ou non) d'enseignement;*

> *4.2* *examine la possibilité de créer un manuel complet de ressources de formation en soins palliatifs, contenant des instructions plus détaillées sous la rubrique des directives sur les compétences de base, et dans le domaine de la mise en oeuvre du modèle de "formation de la formatrice";*

> *4.3* *encourage les administratrices d'agence à favoriser l'application moins systématique du modèle en facilitant l'instruction pratique du personnel des soins palliatifs, et grace à des discussions sur les questions de soins palliatifs;*

> *4.4* *encourage l'adoption de critères plus exigeants dans la sélection des participantes à la formation en soins palliatifs afin que cette formation soit destinée à des personnes qui s'y intéressent et qui s'engagent à enseigner aux autres les soins palliatifs;*

> *4.5* *adapte les critères de sélection des participantes pour permettre aux agences et établissements d'envoyer des membres essentiels du personnel à des sessions consécutives de formation, afin d'augmenter les connaissances et compétences des formatrices en soins palliatifs.*

5. Mise en oeuvre du programme - programmes de formation en soins palliatifs:

Les participantes, coordonnatrices de programmes et administratrices ont beaucoup apprécié l'occasion de fournir des cours et de la formation en soins palliatifs selon les initiatives actuelles; néanmoins, les résultats de l'évaluation indiquent que la plupart d'entre elles s'inquiétaient au sujet de l'avenir des programmes de formation en soins palliatifs. Du fait que le financement de programmes de formation n'est prévu ni sur le lieu de travail, ni pour les évaluations à long terme, il est recommandé que le Ministère:

> *5.1* *examine la possibilité d'utiliser les ressources disponibles actuelles pour financer le temps nécessaire au personnel des agences et établissements*

en vue de mettre sur pied des programmes de formation en soins palliatifs sur le lieu de travail pour les agences de prestation;

5.2 examine la possibilité d'utiliser les ressources disponibles actuelles en vue de financer des banques de données locales et régionales de ressources pour la formation en soins palliatifs, afin de faire parvenir rapidement les renseignements et d'effectuer des échanges d'expertise entre agences partenaires, établissements et personnes donnant les soins;

5.3 envisage de financer un atelier d'une journée pour former les coordonnatrices de programmes de toutes les initiatives du Nord de l'Ontario, afin de leur permettre de partager leur expérience et leurs connaissances sur la façon de créer et mettre en oeuvre à l'avenir des initiatives de formation en soins palliatifs;

5.4 envisage de financer une étude de suivi des programmes de formation de 1994-95, en faisant des enquêtes auprès de cohortes de coordonnatrices, participantes et administratrices d'agences, afin de mesurer l'efficacité à long terme de ces initiatives d'enseignement de soins palliatifs.

RÉSUMÉ

La présente évaluation indique que les programmes ont réussi à produire des effets à court terme en matière d'attitude, de comportement et de connaissances, mais l'analyse des résultats montre que des améliorations peuvent se faire dans de nombreux domaines de l'enseignement des soins palliatifs. Ces améliorations pourraient rehausser la qualité de la formation en soins palliatifs et des services de soins palliatifs d'un bout à l'autre de la région.

I.   INTRODUCTION

In 1992, the Ministry of Health for Ontario announced funding for initiatives in community palliative care education for family physicians, other health care providers and volunteers. These initiatives followed the general trend toward devolution in the provision of human services in the province. By shifting the responsibility for planning, delivering and, to a certain extent, funding decisions to the district level, the Ministry encouraged the development of programs tailored to local circumstances. As a result, the current palliative care education initiatives fostered a wide variety of educational programs and delivery strategies across the province.

In September, 1994, the Northern Health Human Resources Research Unit (NHHRRU) at Lakehead and Laurentian Universities, was commissioned to conduct an in-depth evaluation of provincial palliative care education initiatives, examining six programs delivered in Northern Ontario during 1994-95. The research team for this project included three principal investigators, Prof. Suzanne Caty, Director, School of Nursing, Laurentian University; Dr. Bruce Minore, Co-Director, NHHRRU - Lakehead Site; and Dr. Raymond Pong, Co-Director, NHHRRU - Laurentian Site. Mary Ellen Hill was employed as a full-time researcher to implement the evaluation plan. Evaluation activities occurred over ten months, with the project officially commencing September 1, 1994 and ending June 30, 1995.

This report presents the findings of the evaluation and discusses the rationale behind the adoption of the "Train the Trainer" model, implementation strategies and delivery approaches employed by the six selected programs in Northern Ontario. As noted in the following sections, Ministry policy directives, program materials, internal evaluation documents, interviews with program coordinators and administrators and data from surveys of participants were used to assess the model and approaches.

Palliative Care Education Policy Initiatives

The Province of Ontario's palliative care implementation strategies were designed to improve community and institutional care for the terminally ill and their family members, through funding for four palliative care initiatives: (i) initiating palliative care education for interdisciplinary providers in community and institutional settings;   (ii) offering

additional palliative care education programs to complement existing programs for family physicians; (iii) supporting and maintaining hospice volunteer visiting programs and (iv) establishing pain and symptom management teams.

Of the $4.82 million in annual funding provided for the palliative care initiatives, $2.58 million was allocated specifically to provide patient-centred palliative care education for multidisciplinary service providers. Development of implementation guidelines and operational criteria for palliative care education initiatives involved extensive consultations between the Ministry and the Palliative Care Initiatives Steering Committee and four working groups established to develop guidelines for program implementation. To ensure that the steering committee and working groups were representative of all agencies, organizations and communities with an interest in palliative care education, members were selected from diverse groups representing all facets of palliative care education and delivery in the province.

While physicians, nurses, other health professionals and support staff constituted the majority of members of the steering committee and working groups, particular attention was given to obtaining representation from consumer groups, including advocacy groups for individuals with chronic illness, long-term care residents, cancer patients, HIV positive individuals, aboriginal peoples and members of the multicultural and francophone communities. These groups were instrumental in the development of the initiative itself and their continuing participation was perceived to be of utmost importance.

The Educational Model

The "Train the Trainer" educational model employed in the palliative care initiatives was derived from adult education principles. The model assumes that the most effective way to educate the staff of agencies, facilities or organizations was to deliver formal education courses which provide intensive training for one person in each facility or agency. In turn, those educated as trainers under the "Train the Trainer" model are expected to return to their agency or facility to share information and educate their colleagues, coworkers and communities.

In keeping with this model, Ministry directives for the present palliative care education initiatives for physicians and other health care providers specified that all participants selected must attend at least 30 hours of formal palliative care education sessions, agree to provide educational inservice and act as resource persons upon completion of the program. Within eight weeks of completion of formal courses, physicians were also expected to complete an individualized one-week palliative care practicum or internship. As outlined in subsequent sections of this evaluation, Ministry directives also stipulated

course requirements, core skill sets and funding formulas for the two initiatives, using guidelines established by the Ministry, the steering committee and working groups. (Ministry of Health, 1993b).

Funding

The physician and interdisciplinary provider palliative care education initiatives allocated funding on a per agency/facility/provider per year formula, with funds flowing through the 14 local Long Term Care Area Offices of the Ministry of Health. Except for homemaking agencies and commercial nursing services, allocation for interdisciplinary providers was $1,800 per facility per year, based on staff replacement cost for 30-40 hours and the cost of course tuition and materials. For homemaking and commercial nursing agencies, funds were allocated in the sum of $13,646 for each Home Care Program area. For physician providers, the funding allocation was $6,380 per physician, covering the cost of their course, plus costs of a locum and enhancement for the course and practicum (Ministry of Health, 1993a).

Although funded separately, both initiatives encouraged agencies, facilities and providers to pool palliative care education resources to meet the specific needs of communities and groups of providers. Pooling was viewed as being especially beneficial to small facilities and isolated communities, and as a means to increase cost-effectiveness, consistency of palliative care education programs and level of expertise offered (Ministry of Health, 1993b).

IIA. SCOPE OF THE EVALUATION

Although the Ministry directives for the present palliative care initiatives suggested a number of things about palliative care education programs that could be evaluated, the Ministry commissioned the Northern Health Human Resources Research Unit to evaluate only selected aspects of the initiative, focussing on the "Train the Trainer" educational model employed in the initiatives, profiling the educational programs, documenting the educational experience of the participants and the effects of the programs on the participants' knowledge and attitudes toward palliative care.

The decision on what aspects to evaluate was determined by a number of factors including time frame, resources, data availability and recommendations of the Palliative Care Implementation Strategies Steering Committee and the three Area Managers who initiated the project. Based on these factors, the evaluation project focused on four evaluative dimensions, each of which deals with a different aspect of the palliative care education programs.

1. Profile and evaluation of the education programs:

The first dimension, a process evaluation, describes the six education programs in detail and examines how the participants view the different aspects of the programs. It includes the following elements: description of each of the six programs (e.g., number and background of the participants, participant selection criteria, instructors/facilitators, educational models and teaching methods used, curricula and practicums); and assessment of the programs and participants by the program participants, coordinators and agency administrators.

2. Changes in participants' knowledge, skills and attitudes:

This dimension, a form of outcome evaluation, examines what the participants have learned or acquired as a result of taking part in the education programs. As the timeframe for the evaluation made it impossible to collect pre-program data on participants' knowledge, skills or attitudes, changes could only be evaluated using respondents' self-assessments. Some of the evaluation questions asked were: Have participants' palliative care knowledge

and skills improved as a result of the education programs? Have their attitudes toward terminal patients and care for the dying changed as a result of the education programs? What aspects of the programs contributed to such changes?

3. Effects of education programs on service delivery:

The task undertaken during this part of the evaluation was to ascertain if the education programs had resulted in changes in the way palliative care was provided. Again, as reliable and consistent data on existing palliative care services were not available in all agencies or communities, interview and survey data were used to gauge the perceived effects of the education programs, examining possible effects on the ways palliative care is being provided by the participants and possible changes in the way participants relate to dying patients and their family members.

4. Effectiveness of educational model and delivery approaches:

In this dimension of the evaluation, two major aspects of the educational model and delivery approaches were examined. In keeping with the focus on the "Train the Trainer" model in the Ministry initiatives, it was important to determine the extent to which participants passed on palliative care information and know-how to their co-workers, to find out which factors promoted or inhibited the sharing of knowledge among fellow professionals or within an agency. Secondly, as the programs differed in sponsorship, structure and approach, it was important to consider how delivery approaches affected participation and outcomes. While several programs were interdisciplinary in nature, one program was designed primarily for physicians and another for both physicians and other providers.

The evaluation attempted to determine the pros and cons of these different approaches, to learn how variations in sponsorship and structure affected the delivery of education programs and the outcomes of palliative care education. Such information was considered to be critically important in assessing both the educational model and the outcomes described in the preceding objectives.

Program Selection Criteria

Although 13 palliative care education programs were conducted throughout Northern Ontario during 1994 and 1995, NHHRRU, in consultation with the three Long-Term Care Area Managers, chose to evaluate six palliative care education programs. (See Appendix "A" - Palliative Care Education Programs In Northern Ontario - for a comprehensive list of the programs.) These served populations in the districts of Cochrane-Temiskiming (Extendicare Palliative Care Education Program), Parry Sound (Parry Sound District Home Care Program), Nipissing-East Parry Sound (Nipissing District Palliative Care Education Program), Manitoulin-Sudbury (Sudbury Regional Palliative Care Association Interdisciplinary Initiative), as well as two regional programs, one for physician providers in the Northeastern region (Palliative Care Education Program for Family Physicians) and another for physicians and other providers in the Northwestern region (Palliative Care Institute '94).

The programs selected were representative of the three different approaches to palliative care education delivery adopted in the Ministry of Health Northern Planning Region. While the Northwest (Thunder Bay Area Office) adopted one single integrated program for the entire region and the Northeast (North Bay Area Office) developed nine separate programs, the North Central (Sudbury Area Office) took a middle-of-the-road approach, offering two integrated programs, one for physicians and one for other providers.

Within each region, NHHRRU also selected programs which were felt to be representative of the wide variety of local and regional responses to palliative care initiatives, ranging from programs serving a single community to those covering almost half of the entire Northern region of the province. As shown on the accompanying map (Figure 1), the six programs chosen also reflected the geographic dispersion found among palliative care education programs in the North.

In addition, programs were also chosen to represent variations in the number of disciplines covered. Some programs were designed primarily to meet the needs of specific provider groups, such as home support workers or physicians, while others were planned to meet the palliative care education needs of all types of providers in a chosen community or region. Given these considerations, programs selected also reflect broad differences in palliative care education delivery approaches, representing everything from workshops through palliative care courses, to comprehensive multi-day workshops or institutes.

Figure 1 - Map of Ontario
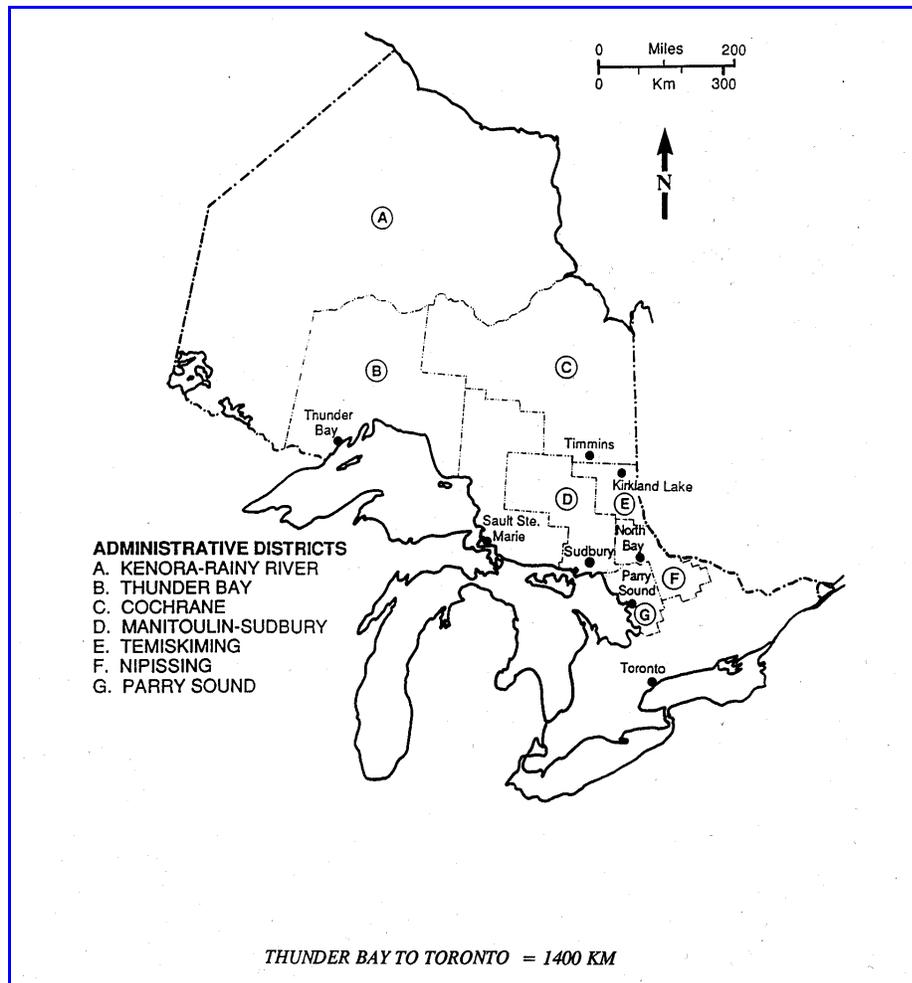
IIB. PROFILE OF THE PROGRAMS

To document the educational programs and their effects, the evaluation first concentrated on profiling each program in detail, analyzing differences in the number and background of participants, selection criteria, teaching methods used, curricula and practicums. As noted earlier, information was derived from a wide variety of program documents, including proposals, agendas, instruction materials, attendance reports and internal evaluation reports. Whenever appropriate, documentary evidence has been supplemented by additional insights gained during interviews with program coordinators and associates.

Cochrane-Temiskiming District - Extendicare Palliative Care Education Program

Of the programs being evaluated, this one presents the most formal version of the model, using an inservice education program developed by Extendicare Health Services, a private corporation which operates nursing home facilities throughout the Province. One of two programs offered in the District, this program delivered four days of intensive "Train the Trainer" sessions in Kirkland Lake during January 1995. Sixteen palliative care inservice educators participated, representing ten long-term care facilities located in eight communities with populations ranging from 5,000 to 45,000. All costs of the program were covered by the initiative, including reimbursement to agencies for participants' salaries.

Developed by the Extendicare organization's educational consultant and delivered by palliative care trainers, the education program assisted participants in reviewing nine inservice sections, covering the topics of palliative care, dying, responsibilities to residents, coping mechanisms and interventions, support of family and friends, staff and self, principles of physical care, pain and symptom control and helping families after death. An additional session familiarized participants with the Extendicare organization's palliative care program, outlining current policies and proposed changes. After each session, exercises and group discussions were employed to familiarize participants with appropriate teaching techniques. In addition, one half-day session was devoted entirely to principles of adult learning and facilitation.

After completion of the program, agency-selected participants were given a copy of the program binder and related teaching materials to use in presenting the inservice sessions in their facilities during the three months following the training session. In-house evaluation of this program was extensive, involving completion of participant workshop evaluations during the training, pre- and post-test evaluations of participants' knowledge and skills, followed by a performance evaluation of the trainer on the job and a formal program evaluation by the clinical coordinator. Additional insights into the program's effectiveness would be provided through ongoing discussions with family members involved in palliative care.

Nipissing and Northeast Parry Sound Districts - Palliative Care Education Program

To provide palliative care education for interdisciplinary service providers in the Nipissing and Northeast Parry Sound Districts, three home care agencies, one home nursing agency, eight long-term care facilities and one voluntary organization pooled funds and resources to develop a four-component palliative care education program. Program activities occurred over an 11-month period, commencing May 1994 and ending March 1995. Although some components were delivered on-site, in participating agencies and facilities, most activities were centred in North Bay, a community of approximately 45,000 residents. Resource persons and instructors for this initiative were found within the local community and region, with the exception of a pain and symptom workshop team from Mt. Sinai Hospital in Toronto. Because of the extensive nature of this program and the large number of participants, only the costs of program materials, staff replacement for facilitators, tuition and books were covered by Ministry of Health funding.

In this initiative, the "Train the Trainer" model was employed only for the first component of the program, which involved training one facilitator from each of 12 participating agencies to present a two-hour introductory inservice module in their facility, to faciliate subsequent program development and to encourage interest in ongoing palliative care education. Although exact attendance figures were not available, program documentation indicates that in excess of 200 agency employees attended this initial component of the program. For the second and most extensive component of the program, Canadore College was contracted to deliver six sections of a comprehensive, 30-hour "Orientation to Palliative Care" course, in the communities of North Bay, Corbeil, Powassan, Mattawa and Sturgeon Falls. The 138 agency personnel who participated in this component were reimbursed for tuition and books.

The third component supplemented the above general training by delivering additional specific palliative care education services. During July and August 1994, the project conducted a needs assessment survey to identify global training needs of 300 providers and a two-day weekend pain and symptom control workshop for 200 providers. To obtain additional information about palliative care education resources and training techniques, a number of individuals were sent to conferences in the fall of 1994. Five individuals were sent to the Canadian Palliative Care Conference in Toronto and one individual to a regional "Train the Trainer" seminar, with the expectation that all would produce a training video for participating agencies during the following year.

The fourth component consisted of sending one individual from each agency to a one-day workshop on palliative care for cancer patients in the fall of 1994. For all components, each agency was allocated "seats" in proportion to the agency's total number of staff, with each agency choosing its own participants. With the exception of those individuals chosen to act as agency facilitators for the introductory module and those sent to conferences for informational purposes, participants were agency-selected.

After attending the introductory module or any of the workshop sessions, all participants were asked to complete detailed session evaluation forms, assessing the course content, instruction, facilities and usefulness of each session. Evaluative information on the 30-hour palliative care education course was provided by Canadore College, which gave summaries of information collected through student ratings questionnaires, assessing the content, delivery and perceived effectiveness of the course.

Northeastern Ontario - Palliative Care Education Program for Family Physicians

Under the provincial initiative of palliative care education for physicians, this three-component program for family physicians in Northeastern Ontario was developed under the sponsorship of the Northeastern Ontario Regional Cancer Centre in Sudbury. Acting in partnership with four organizations representing provincial and regional medical education programs and local and district medical societies, one home nursing agency, two acute care facilities, one voluntary agency and one community palliative care association, the program trained physicians from nineteen communities throughout the region. All costs were covered by the initiative, including course instruction and practicums, as well as associated transportation, accommodation and meals. Although costs of locums were also included in the funding, none was used by physicians attending the course.

To enhance the development of physician-facilitated palliative care education in regional communities, program organizers established strict criteria for selecting the 20 physicians participating in the program. All physicians chosen were involved in primary care, and were practising within the Northeastern Ontario region. Priority was given to applicants from remote, rural and other underserved areas, who had demonstrated an interest in palliative care services, were willing and able to develop palliative care in their community, and agreed to act as resource persons on an ongoing basis.

In keeping with the curriculum guidelines established by the Ministry for physician provider initiatives, the course for family physicians consisted of 30 hours of formal instruction during September and October 1994: 20 hours of academic instruction at a three-day workshop in Sudbury, followed by 10 hours of teleconferencing. With the exception of one keynote speaker from Toronto, all resource persons for this initiative were found within the region, with medical sessions delivered by specialists from the Regional Cancer Centre and sessions on psychosocial issues facilitated by staff from the Sudbury Regional Palliative Care Association. Following completion of these components, participating physicians were expected to arrange individual practicums of approximately 25 to 30 hours in length, tailored in content and location to the physician's interests and practice area.

Workshops began with an intensive one-day session devoted to clinical problems in palliative care, including pain and symptom management issues, roles in community-based care and clinical providers, and group discussions of palliative care issues. The second day of the program addressed psychosocial issues, involving communication, death and dying, grief, bereavement, spirituality and stress management for providers. The final half-day session dealt with a variety of special palliative care topics, including roles of physiotherapists, dieticians and radiation oncologists, neurological-neuropsychiatric problems and AIDS.

During the month immediately following the academic workshop sessions, participants were given the opportunity to take part in four teleconferences at which specialists from the region discussed related issues, including multidisciplinary team approaches, multicultural issues, home care programs and medico-legal issues.

The program was evaluated extensively, with all participants completing assessments of the content, delivery and learning associated with each workshop and teleconference session. In addition, overall evaluations were given for the academic palliative care education course, the teleconference sessions and individual practicums, documenting the strengths and weaknesses of each format. Emphasis was also given to participants' plans for sharing palliative care information gained in the course and possible impacts upon palliative care practice.

Manitoulin-Sudbury District - Interdisciplinary Palliative Care Education Program

To provide palliative care education for providers other than physicians throughout the Manitoulin-Sudbury District under the interdisciplinary provider initiative, the Sudbury Regional Palliative Care Association, in partnership with one home care agency, one home nursing agency, six long-term care facilities and three regional acute care facilities, developed a comprehensive five-day "Train the Trainer" program. Centred in Sudbury, the program educated 20 palliative care providers representing seven communities. Except for accommodations and meals, all costs of the program were covered by the initiative, including reimbursement to agencies for participants' salaries.

Using resource persons from the Sudbury Regional Palliative Care Association and 15 guest speakers from the community and region, the Sudbury-centered program provided 30-hours of formal instruction to providers in June 1994. Presenting a five-day, intensive workshop format, the program emphasized psychosocial topics, including information on the history and principles of palliative care, group dynamics and experiential learning, followed by sessions on the dying process, grief and bereavement, spiritual issues and family dynamics. Additional sessions covered self-awareness, communication, stress management and palliative care education goals and objectives.

Through a unique partnership agreement with the Northeastern Ontario Family Physician Education Initiative described above, participants in this program were given an opportunity to gain an additional 12 hours of medically-oriented palliative care education through attending days one and three of the physician workshop described above. In addition, participants were given the option of attending any or all of the four two-hour teleconference sessions offered in conjunction with the physicians' initiative. Eighteen of the 20 interdisciplinary participants took advantage of this option, attending one or more of the physician workshops or teleconference sessions.

Participants in the program were agency-selected and expected to act as inservice resource persons after training. Evaluation of all components of the initiative was extensive, using evaluation instruments similar to those employed in the Northeastern Ontario physician initiative. For workshops and teleconference sessions, all participants were asked to complete formal, written assessments, outlining strengths and weaknesses of the program, expectations and learning. In addition, each participant also provided additional information on plans for sharing information and impacts upon palliative care practice.

Northwestern Ontario - Palliative Care Institute '94

Unlike the other two regions in Northern Ontario, which offered a variety of separate programs for physician and other providers, the Northwestern region combined both initiatives, pooling funds and resources to offer a single, integrated five-day institute for multidisciplinary service providers in October 1994. The program was developed to serve regional primary care physicians providing palliative care and delegates from 53 partnership agencies, including 11 home care agencies, one home nursing agency, 13 long-term care facilities, 12 acute care facilities, one hospice unit, one psychiatric facility, six volunteer groups and seven other organizations with specialized service mandates for aboriginals, francophones and persons with medical conditions, such as AIDS.

With the consent of the stakeholders and ongoing consultations with partner agencies and providers, the Northern Educational Centre for Aging and Health (NECAH) at Lakehead University was contracted to plan and deliver the program. The program educated 22 criteria-selected primary care physicians and 65 agency-selected health care providers, serving a population of approximately 200,000 residents located in Thunder Bay and 15 other communities. With the exception of meals and accommodation for participants residing in Thunder Bay, all costs of the program were covered by funding provided under the two initiatives. As with the Northeastern Family Physician program, all physicians attending the Northwestern program were expected to arrange 25-30 hour practicums at a later date.

Local and regional expertise was supplemented by three nationally-recognized keynote speakers. Each day of the Institute program was oriented towards a major palliative care issue or theme, beginning with palliative care approaches, "Train the Trainer", ethics and cross-cultural issues, followed by days devoted to initial, ongoing and final phases of palliative care, bereavement and palliative care training issues. Daily agendas began with lectures by keynote speakers, followed by simulated patient interviews and multidisciplinary discussions in the morning, a choice of two of ten concurrently-offered workshops and specialized site visits during the afternoon. To encourage multidisciplinary approaches, participants were also given daily opportunities to work together with facilitators in multidisciplinary teams, concluding with community-based exercises and plans for peer training following the Institute.

To assist in subsequent training, each delegate was given an extensive educational manual containing information on the principles of adult learning, suggestions for presentations, samples of educational material and interlibrary loan access to print and video resource material assembled for the Institute. Participant evaluation booklets provided

extensive written assessments of daily plenary sessions, lectures, workshops, site visits and overall evaluations of the Institute and the "Train the Trainer" model.

IIC.   METHODOLOGY

To assess the effectiveness of the educational model, document the educational experience of participants and provide further insights into palliative care education itself, a variety of evaluation methodologies and sources of data were used. Reviews of internal documents produced by the programs included proposals, program binders and resource manuals, attendance lists and internal evaluation materials and reports. To provide another dimension to the evaluation, information on program delivery was supplemented by data derived from interviews with coordinators, their associates and agency administrators, who offered additional insights into some of the more technical problems associated with program development and delivery.

Instrumentation, Sampling Strategies and Response Rates

Separate survey and interview instruments were developed for palliative care education program coordinators, participants and agency administrators. Each instrument was designed to evaluate specific aspects of the educational programs, providing comprehensive documentation on factors facilitating or impeding program planning, delivery and implementation. (See Appendix "B" - Instrumentation.) To ensure that the evaluation met ethical standards, all survey instrumentations received approval from the Senate Ethics Review Committee of Lakehead University. Covering letters and consent forms were used to inform coordinators, participants and agency administrators about the purposes of the research, its potential benefits and the procedures taken to minimize risks of harm to the individuals or their agencies. As participation was voluntary, respondents were free to withdraw from the evaluation process at any time.

(a) Coordinators and Associates

At the beginning of the study, program coordinators were contacted by telephone to collect background information on the development of each palliative care program, including sponsorship, steering committee composition and interpretation of the palliative care education model. Coordinators were also asked to supply any available program documentation, including attendance and mailing lists and to assist the research team in

developing sampling frames for participant surveys and agency administrator interviews. In addition, the research team sent letters providing further information about the evaluation framework, goals and objectives. (Copies included in Appendix "B" - Instrumentation.)

At least one month after completion of each educational program, in-depth interviews were conducted on-site with program coordinators and their nominated associates (N=13). Interview questions were used to solicit detailed information on program development and delivery and the educational model. Additional questions collected more detailed information on difficulties encountered during delivery of the program, focussing on those factors that facilitated or hindered implementation.

(b) Participants

As the timeframe of the evaluation made it impossible to collect pre-program data on participants' knowledge, skills or attitudes, information on attitudinal changes and the educational experiences of participants could only be obtained using two post-program surveys. Initial and follow-up surveys were delivered to participants in stages, the initial survey being sent at least one month after completion of the program and the second survey, at least three months after completion of the program.

While both surveys were designed to tap participants' views on the educational programs attended, the initial survey instrument emphasized participants' evaluation of the program components. Items assessed learning about topics and issues identified in the core skills directives, including knowledge about palliative care, death and dying and support of the terminally ill. In addition, the survey collected information on behavioral and cognitive changes resulting from participants' educational experiences and their plans for ongoing palliative care education, including practicums for physicians. This survey also gathered initial information on participants' plans for implementing the "Train the Trainer" model in their agencies, including potential problems in sharing palliative care information. To assist in analyzing findings, the survey also gathered participants' attitudes, palliative care experience and professional and personal background information.

In comparison, the second survey instrument provided a more focussed evaluation of the educational program attended, by gathering additional evaluative information concerning actions taken to implement the "Train the Trainer" model. To identify possible factors facilitating or impeding implementation of the model, the survey also contained items assessing agency support for palliative care education programs and palliative care policies. Other items obtained information on participants' views of the "Train the Trainer" model itself, including items evaluating participants' learning about the model and their opinions concerning the model's suitability as a basis for palliative care education programs.

Largely due to the timeframe of the project itself, unforeseen delays in the delivery of some of the programs and the need to deliver the surveys sequentially, variation occurred in the number of participants included in the first and second surveys. While the first survey was delivered to all 480 identified participants between December 1994 and April 1995, the second survey was mailed to only 356 participants in March and April 1995. Follow-up survey mailings and telephone calls were used to remind and encourage participants to complete the evaluation surveys.

After exclusions for mailing list errors and adjustments for incomplete returns, analysis of survey log data indicated that the first survey showed an effective response rate of 50% (N= 233) and the second, 45% (N=148). When the survey log data for both surveys were merged, data indicated that there was a combined overall response rate of 54% from the 480 participants responding to one or both of the two surveys (N=257). Breakdown of response rates according to mailing list information for each program, however, indicates that significant variation in response rates occurred among programs, with the highest response rates found in the Sudbury, Cochrane-Temiskaming and Northwestern programs and lowest response rates among the Parry Sound, North Bay and Northeastern physician programs. Further analysis of response rates by agency type and occupations, however, indicates that much of this apparent variation in response rates among programs may in fact reflect occupational differences, with those programs exhibiting the lowest response rates also being those which were directed either towards physicians or support workers in long-term care facilities and homecare agencies.

While any number of factors could explain this variation in response rates, participants' written comments and informal discussions with program coordinators and agency administrator suggests that low response rates probably reflect a complex interplay of factors, including the voluntary nature of the survey, respondents' perspectives on the evaluation process and difficulties inherent in the design of the survey instruments themselves. In some instances, respondents indicated that they chose not to participate because they felt that the in-house evaluations completed at the time of the program were sufficient. Other participants commented that they did not have time to complete such a lengthy survey. Finally, some noted that having one survey instrument for all participants and all programs created difficulties, including survey questions that were too complex and demanding.

(c) Administrators

To provide further information on the model and its implementation, the evaluation project also conducted telephone interviews with a purposive (non-random) sample of

agency administrators, at least three months after completion of the palliative care education programs. The administrator interview contained five questions to assess satisfaction with the education programs and the "Train the Trainer" model, administrators' views on the advantages and disadvantages of the model, its implementation and its linkages to funding for palliative care education. For additional information on the effectiveness of the educational initiatives, the interviews also sought administrators' opinions about effects on agency palliative care organization and policies. (See Appendix "B" - Instrumentation.)

Using mailing lists and other documentation provided by program coordinators, the research team constructed a purposive sample of 26 agency administrators, representing approximately 30% of the agencies participating in the programs being evaluated. Consideration was also given to including community homemaking and home nursing programs, long-term care facilities, volunteer organizations and acute care facilities in the sample. Attempts were also made to ensure that selected agencies were geographically representative of urban centres, smaller towns and rural or isolated communities. The response rate for the administrator survey was excellent (85%), with 24 of the selected 26 agency administrators or delegated administrative staff participating in the interviews, 22 by telephone and two providing written answers. Two individuals declined to participate because they had been recently appointed to their positions and lacked familiarity with the palliative care education initiatives.

Data Analysis and Limitations

Data analysis examined both qualitative and quantitative materials concerning program delivery and implementation, using SPSSx software for the analysis of quantitative data and Qualitative Solutions and Research Non-numerical Unstructured Data Indexing Searching and Theory-building (NUD.IST 3.0) software for the analysis of qualitative data. The ability to conduct a comprehensive and in-depth evaluation of data collected during this project, however, has been constrained by several factors, including the time-frame of the project itself and variation in participant response rates.

As noted earlier, the timeframe of the project, beginning September 1, 1994 and ending June 30, 1995, constituted the most important constraint on both the collection and analysis of data. As several of the programs had been underway well before the evaluation began, surveying participants prior to the programs and intensive analysis of program development were not possible. Similarly, the fact that some programs did not complete delivery of their programs until the latter part of March 1995 made it impossible to conduct any long-term assessment of program impacts. In addition, low response rates from certain

sectors mean that some programs and occupational groups may be under-represented in the analysis and that the use of certain statistical procedures is restricted.

Given these limitations, profiles of program participants are presented in the next section, followed by comparisons of program sponsorship, content and delivery. Subsequent sections provide analyses of participant educational experiences and outcomes. After discussing support for palliative care education and practice, the report concludes with a summary of the evaluation findings and recommendations, including suggestions and recommendations for improving future palliative care education programs.

IIIA.   PROFILE OF PROGRAM PARTICIPANTS

To assist in understanding participants' opinions, the first survey questionnaire contained three sections soliciting information on participants' professional and personal backgrounds. Additional items assessed their knowledge about palliative care, their experience with palliative care situations and their attitudes towards palliative care.

Professional Backgrounds

As shown in Table 1, the occupational characteristics of the participants reflected the interdisciplinary nature of the educational programs and the diverse disciplinary backgrounds of the participants.

TABLE 1 - OCCUPATIONAL CHARACTERISTICS OF PARTICIPANTS

Usual Occupation:	%*		(N=231)
Nurses		49	(112)
Support workers		21	(49)
Physicians	7		(17)
Social workers		7	(14)
Other professionals	7		(16)
Volunteers	6		(13)
Others	4		(10)
Years Worked In Occupation:		%*	(N=229)
Less than 5	27		(61)
More than 5, less than 10		30	(69)
More than 10, less than 15	14		(32)
More than 15, less than 20	9		(20)
More than 20, less than 25	7		(16)
More than 25, less than 30	6		(14)
More than 30, less than 35	5		(12)
More than 35	2		(5)

*% of participants responding to survey item.

Almost half reported that they worked in nursing, a fifth in home support occupations, including personal support, homemaker, health care aide and respite worker positions, and one-tenth each from family medicine and social work backgrounds. A great variety of other occupations was also represented, including individuals with backgrounds in occupational therapy, physical therapy and pharmacy, as well as those with backgrounds in administration. In addition, three of the programs included volunteers. Survey participants had worked in their occupations for varying periods of time, ranging from 4 months to 55 years, the majority being experienced practitioners, with two-thirds of the sample reporting having worked more than five years in their occupation.

Considering their diverse occupational backgrounds, respondents reported comparatively high levels of education. As indicated in Table 2, over one-half had graduated from community college or equivalent post-secondary programs and almost a third had graduated from university baccalaureate programs. In addition, one in ten participants had degrees in medicine or post-graduate degrees in nursing or other human services fields.

TABLE 2 - EDUCATIONAL BACKGROUND

Highest Level of Education Completed:		%*	(N=244)
Less than High School Diploma	3		(6)
High School Diploma1		6	(37)
Community College Diploma		55	(128)
University Bachelor Degree	15		(33)
University Master's Degree	2		(4)
Doctor of Medicine	7		(16)

*% of Participants responding to survey item.

Other survey items provide further information about participant's work backgrounds, including experience working in specific types of care settings. As shown on Tables 3, half of those responding to an item asking whether they had worked in any of six different practice settings reported that they had worked either in home care or in long-term care facilities. In addition, one of every three indicated that they had worked in chronic care units and one of every four in acute care units. Less than one in every eight respondents had worked in private clinics, hospice or palliative care settings.

TABLE 3 - CARE SETTINGS WORKED IN

Have Worked In :	%*	(N=233)
Client's home	57	(133)
Long-term care facility	51	(118)
Acute care unit	30	(69)
Chronic care unit	27	(62)
Hospice or palliative care unit	13	(30)
Private office or clinic	13	(30)
Other care settings	4	(9)

*% participants responding to this question - multiple-response item,
so category percentages do not add up to 100%.

Given the emphasis on community-based care in the initiatives, it was not surprising that the majority of those participating in the educational programs were working at present in home care. As outlined in Table 4, survey responses to an item asking "where did you work most of the time during the past 12 months" indicate that almost one-half had worked in home care settings, a third in long-term care and the remainder in private clinics, acute care, chronic care, palliative care or hospice settings.

TABLE 4 - CARE SETTINGS WORKED IN MOST DURING PREVIOUS 12 MONTHS

Worked In Most:	%*	(N=201)
In client's home	43	(86)
Long-term care facility	33	(67)
Acute care unit	10	(21)
In private office or clinic	7	(13)
Chronic care unit	4	(7)
Hospice	4	(7)
Other care settings	3	(7)

*% participants responding to this question - multiple-response item,
so category percentages do not add up to 100%.

It appears that program participants responding to the survey were generally representative of the types of professionals, paraprofessionals and volunteers currently providing palliative care services in Northern Ontario. As noted in the earlier discussion of survey response rates, however, low response rates mean that results may under-represent some provider groups, particularly physicians and home support workers.

Personal Backgrounds

The participants ranged in age from 22 through 73, averaging 44 years of age. Given that the majority of the participants were from nursing and support worker occupations, it is to be expected that approximately eight of every ten survey respondents were female, were married and had children. Six of every ten respondents reported having religious or spiritual affiliations, divided about equally between Catholic and Protestant denominations. Almost half of the participants responding to this question reported the that their commitment to religious or spiritual beliefs was "average" and about a third "strong."

As might be expected, participants represented a variety of different ethnic and cultural backgrounds. Analysis of an open-ended question on ethnic and cultural backgrounds revealed that the majority of survey participants considered themselves to be "Canadian", representing British, French, European or First Nation cultural backgrounds. In addition to speaking English, approximately one-third of the sample spoke French and one-tenth other languages, including aboriginal dialects.

Experience Working With the Terminally Ill

Considering the varying educational and occupational backgrounds of the participants, it was necessary to obtain some added information on their experience working with the terminally ill and their attitudes towards palliative care. Table 5 shows that they had worked with the terminally ill from less than one to 36 years. When asked about the terminally ill patients they had cared for during the past twelve months, participants indicated that they had worked with varying numbers of individuals, from none to over 200. Caseloads for most survey respondents were moderate, however, with two-thirds reporting ten or fewer terminally ill patients cared for during the previous year.

To provide further information on experience with palliative care, the survey also asked survey respondents for details concerning the terminally ill clients with whom they had worked during the past 12 months, including information on age groups, illnesses and patients' cultural or linguistic backgrounds. Although some participants had worked with

terminally ill children, teens or young adults, the majority indicated that they had mostly worked with elderly or middle-aged patients during the past year. Eight of every ten reported caring for elderly patients, with a further one in five having experience providing care for middle-aged patients.

TABLE 5 - YEARS WORKED WITH THE TERMINALLY ILL

How long worked with terminally ill:		%*	(N=205)
Less than 5 years	25		(52)
More than 5 years less than 10 years	23		(47)
More than 10 years less than15 years		17	(35)
More than 15 years less than 20 years		10	(20)
More than 20 years less than 25 years		15	(30)
More than 25 years less than 30 years		2	(5)
More than 30 years	8		(16)

*% of participants responding to survey item.

As indicated in Table 6, participants' terminally ill patients had suffered from a variety of chronic conditions. Four of every ten indicated that they had worked mostly with cancer patients, while a further one in five had patients with cardiovascular disease, both leading causes of morbidity and mortality in Northern Ontario. Fewer than one in ten reported having cared for patients suffering from respiratory illnesses. Small numbers of patients had neurological conditions, AIDS or other illnesses.

TABLE 6 - ILLNESSES OF PATIENTS WORKED WITH DURING PAST 12 MONTHS

Illness of patients:	%*		(N=153)
Cancer		60	(91)
Cardiovascular		18	(27)
Respiratory	7		(11)
Other illnesses		16	(24)

*% of participants responding to survey item.

To give further insights into palliative care experiences, the survey also contained an open-ended question asking respondents to indicate with which cultural and linguistic groups they worked most of the time during the previous twelve months. Although information from this question is difficult to interpret, responses suggest that participants worked with clients from diverse cultural and linguistic backgrounds. While approximately one in three stated that they worked with "Canadian" patients, significant numbers also indicated that they worked with individuals from British, French, European, Asian and First Nations backgrounds. Eight of every ten reported that their clients were English-speaking, while one in four also indicated working with French-speaking patients and one in 20, Ojibway or Cree-speaking. Small numbers reported working with other linguistic groups, including Finnish, Italian, Polish and Ukrainian.

Experience with Palliative Care Situations

In addition, the survey also asked participants to indicate whether they had experienced a variety of specific palliative care situations, including delivering "bad news" and being present when individuals died. As indicated on Table 7, most respondents reported having dealt with a variety of sensitive situations involving terminally ill clients and their families. While comparatively few individuals, with the exception of physicians, reported having delivered "bad news" to individuals with terminal conditions or their families, significant numbers had informed family when a relative was near death or when a relative had died. Seven of every ten were present when an individual died and eight of every ten reported having attended a funeral or memorial service for a former patient.

TABLE 7 - EXPERIENCE WITH PALLIATIVE CARE SITUATIONS

In connection with work in palliative care, have ever:	%*	(N=233)
Delivered "bad news" to individual with terminal condition	28	(64)
Delivered "bad news" to family members of terminally ill	46	(106)
Been present when individual died	64	(148)
Informed family when relative was near death	58	(135)
Informed family when relative had died	49	(115)
Attended a memorial service for a former patient	81	(172)

*% participants responding to this question - multiple-response item,

so category percentages do not add up to 100%.

Attitudes Towards Palliative Care

In order to evaluate respondents' opinions about palliative care issues, the survey asked participants to complete the 32-itemWinget scale (Winget et. al, 1977). Widely employed to assess attitudes about death and dying among health care professionals, the Winget scale assesses the degree of flexibility that individuals display in caring for the terminally ill, with low scores indicating a greater openness to palliative care and more insights into the psychological factors affecting dying patients and their families.

With possible total scores ranging from 32 to 160, the scores of survey respondents ranged from 84 to 120, with a mean of 105. As indicated in Table 8, however, significant variations in mean scores were found among different occupational groups ($p \leq .01$) and groups from different care settings ($p \leq .05$). Among occupational groups, the lowest scores were displayed by support workers and health care aides, the highest by physicians and social workers, intermediate scores by nurses, other professionals and volunteers. In terms of care settings, moreover, lowest scores were found among those respondents working in client's homes, higher in long-term care settings and the highest in other care settings, including a variety of settings associated with the acute care system.

TABLE 8 - WINGET SCALE SCORES BY OCCUPATION AND CARE SETTINGS

Occupational Groups:	Mean	S.D.	N
Physicians	109.67	6.89	(12)
Social workers	109.38	6.55	(13)
Other professionals, including chaplains	106.71	6.17	(14)
Volunteers	105.92	4.03	(12)
Nurses	105.15	6.28	(99)
Support workers, health care aides	101.15	6.62	(33)

Care Settings Worked In:	Mean	S.D.	N

Other care settings	107.63	5.65	(43)
Long-term care	105.22	6.60	(54)
Client's home	104.32	6.76	(69)

While the lack of pre-test scores and small sample sizes for some occupational groups restrict detailed interpretations of these findings, results would suggest that openness to palliative care may be a complex product of several factors, including occupational backgrounds, work environments and palliative care training itself.

IIIB.   COMPARISON OF PROGRAMS

To provide a framework for comparing the six selected palliative care education programs, the evaluation first focuses on evaluating the programs against the Ministry directives for palliative care education programs, including directives concerning sponsorship, program content and delivery.

Ministry Guidelines for Palliative Care Education Programs

In keeping with the "Train the Trainer" educational model, Ministry directives for the present palliative care education initiatives encouraged agencies to form partnerships with other provider agencies as an effective strategy for increasing access to palliative care education for providers, having economies of scale that allow agencies to educate more than one provider per year. In addition, Ministry guidelines specified that all participants selected must attend at least 30 hours of formal palliative care education sessions, agree to provide educational inservice and act as resource persons in their place of work upon completion of the program. Within eight weeks of completion of formal courses, physicians were also expected to complete an individualized one-week palliative care practicum or internship.

Under the initiatives for physician and other providers, course content was expected to be consistent with core skill sets identified by the initiative working groups. For interdisciplinary providers, palliative care core skills content included sessions on the history and principles of palliative care; psychological, emotional, social and spiritual issues; knowledge of physiological changes; pain and symptom management; signs and symptoms of approaching death; information on ethical, legal and religious concerns involving sensitivity to cultural and spiritual issues; strategies for dealing with family grief and bereavement; communication issues and stress management techniques for caregivers.

Core skill sets for the physician initiatives were parallel to the nine identified for other providers, including awareness of fundamental philosophical, ethical and legal issues; pain and symptom management; concepts of adult education and awareness of palliative care delivery models. Special attention was also given to psychological, social, emotional, cultural and spiritual issues, including communication with patient and family, social impacts of illness, alternative therapies, attitudes towards death and grief and bereavement. In addition, physicians were expected to acquire information about palliative care delivery

models, liaison and facilitation of comm unity support networks. Both physician and interdisciplinary provider directives stipulated that providers be given specific training about the "Train the Trainer" model, including information on principles of adult learning and appropriate teaching strategies for use in conveying palliative care information. Palliative care education programs were expected to provide teaching resources for participants, including sample teaching materials and exercises, and provide an internal evaluation of each program (Ministry of Health, 1993b).

Evaluating Program Approaches

In view of the importance attached in the initiatives to local decision-making, the evaluation of program approaches first examined possible effects of variations in sponsorship and structure upon the delivery and content of the selected palliative care education programs. Some of the basic questions addressed in this part of the evaluation were: How have differences in program sponsorship and structure influenced accessibility to palliative care education for different provider groups? How have variations in program approaches affected program content, particularly in relation to core skills and palliative care issues and topics? Considering the importance attached to the model, how have variations in program delivery and structure influenced participants' understanding of adult education and the "Train the Trainer" model itself? In addition, how have differences in sponsorship and structure affected participants' educational experiences?

(a) Sponsorship and Structure

As shown in the accompanying summary of program sponsorship (see Chart 1), the programs evaluated employed different sponsorship arrangements and different partnership strategies to enhance access to palliative care education for agencies, facilities, and providers. While the Ministry directives note that simply increasing the number of partnership agencies may be an effective strategy for increasing access to palliative care education for providers, information on partnerships, communities and number of participants suggests that this strategy is most effective in communities with relatively concentrated population and a variety of agencies, facilities or health care organizations. If communities are geographically isolated, with extremely dispersed populations, and limited numbers of agencies or facilities, however, regional care approaches or alternative delivery formats may be the only way to increase access to palliative care education.

CHART 1 - Northern Ontario Palliative Care Education Programs Variation in Sponsorship, Partnerships, Sites, and Target Groups						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Northwestern Institute
Principal Sponsor or Coordinating Agency	Extendicare (Canada) Incorporated	Parry Sound District Home Care Program	Canadian Red Cross Homemaker Service	Northeastern Ontario Regional Cancer Centre	Sudbury Regional Palliative Care Association	Northern Educational Centre for Aging and Health
Initative	Nonphysician	Nonphysician	Nonphysician	Physician	Nonphysician	Nonphysician and physician
Partnerships with Agencies, Long-term Care Facilities or Health Care Organizations (# Partners)	Long-term (10)	Long-term (2) Home-care (1)	Long-term (7) Home-care (3) Home-nursing (1) Volunteer (1)	Home-nursing (1) Acute-care (2) Hospice (1) Volunteers (1) Physicians (4)	Long-term (6) Home-care (1) Home-nursing (1) Acute-care (3) Volunteers (1)	Long-term (13) Home-care (11) Home-nursing (1) Acute-care (12) Volunteers (6) Hospice (1) Psychiatric (1) Physicians (1) Other (7)

CHART 1 - Northern Ontario Palliative Care Education Programs Variation in Sponsorship, Partnerships, Sites, and Target Groups						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Northwestern Institute
Total # Partners	10	3	12	9	12	53
Total # Communities	6	1	6	13	7	16
Primary Sites	Kirkland Lake	Parry Sound	North Bay Corbeil Powassan Mattawa Sturgeon Falls	Sudbury	Sudbury	Thunder Bay

CHART 1 - Northern Ontario Palliative Care Education Programs Variation in Sponsorship, Partnerships, Sites, and Target Groups						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Northwestern Institute
Target Groups for Palliative Care Education Program	Professional and para-professional inservice educators in long-term care facilities	Home support workers, health care aides, respite workers, nurses, therapists in long-term care facilities and home-care agencies	Home makers, home support workers, health care aides, nurses, therapists and volunteers in long-term care facilities, home-care, and home-nursing and agencies.	Family physicians providing palliative care services.	Professional and para-professional inservice providers in long-term care facilities, home-care agencies, and home-nursing agencies, acute-care settings and volunteer services.	Professional and para-professional inservice providers in long-term care, home-care, home-nursing and volunteer agencies, acute-care, hospice and psychiatric facilities. Family and primary-care physicians providing palliative care

CHART 1 - Northern Ontario Palliative Care Education Programs Variation in Sponsorship, Partnerships, Sites, and Target Groups					
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Northwestern Institute
Total # Participants	16	98 (includes 1 physician)	12-138-200 (varies by component)	19	20	87 (includes 2 2 physicians)

Analysis of program sponsorships suggests that the strengths of the programs were largely derived from each program's grassroots and community-driven origins. As shown in Chart 1, each program employed slightly different program sponsorship arrangements, developing community, district, or regional approaches to meet the palliative care needs of agencies, facilities and practitioners. While Parry Sound and Nipissing developed partnerships specifically designed to meet the needs of large numbers of home care agencies and long-term care facilities located in a relatively small geographic area, Cochrane-Temiskaming and Manitoulin-Sudbury developed programs providing more intensive training for similar types of agencies located in a larger, less densely-populated area, each program serving two districts. In the Northeastern physician and Northwestern programs, partnerships were formed on a regional basis as an efficient strategy for providing education to agencies, facilities and physicians located in widely dispersed geographic locations, including remote and isolated communities.

In comparison, analysis of variations in program structure suggests that program strengths were also associated with the interdisciplinary nature of the evaluated programs, with five of the six providing education for specific target groups of interdisciplinary providers employed in partnership agencies, facilities or communities. While Cochrane-Temiskaming offered the most intensive training, concentrating on paraprofessional and professional providers in long-term care facilities, somewhat broader disciplinary focus emerged in Parry Sound and Nipissing, both programs offering educational programs for

palliative care providers from long-term care facilities and home-care agencies. The Manitoulin-Sudbury and the Northwestern programs adopted the most wide-ranging disciplinary approaches, both providing interdisciplinary education for professional, paraprofessional and volunteer trainers from a variety of palliative care settings, including long-term care facilities, home care agencies, home-nursing agencies, acute-care settings and volunteer palliative care programs. In addition, two programs also educated physician palliative care providers, the Northwestern program including primary care physicians in all sessions and the Manitoulin-Sudbury program providing an optional component for interdisciplinary providers in conjunction with the Northeastern family physician palliative care education program.

(b) Delivery

Further examination of variations in sponsorship and program characteristics also suggests that the different approaches or delivery strategies chosen by each program shaped their type and content. Chart 2, which shows program selection criteria, program type and instructors, indicates that the programs adopted distinctly different strategies for delivering palliative care education to participating agencies.

While the majority of the programs were only offered to representatives of partnership agencies, the Parry Sound and Nipissing initiatives chose to open their programs to the community, believing that they would be beneficial to other provider groups. Although most programs relied on a combination of local and regional expertise, four imported "outside" help, with Cochrane-Temiskaming relying on a trainer from the Extendicare national headquarters in Toronto, Nipissing employing a pain and symptom management team from Toronto, the Northeastern family medicine program presenting a featured speaker from Toronto and the Northwestern multidisciplinary program using three nationally-known keynote speakers.

Programs also displayed a great diversity in delivery, developing some very innovative ways of offering the types of palliative care education training mandated under the initiatives. Four programs chose to use an intensive four- or five-day workshop format as the basis for their program delivery, actual structure of the programs varied considerably, depending upon the numbers of participants and program resources. Among the four programs using this format, Cochrane-Temiskaming presented an inservice-based program for 16 trainers representing ten long-term care facilities; Thunder Bay, a comprehensive educational institute, combined lectures, workshops, and teamwork to site visits, for 22 physicians and 65 other providers representing 53 home care programs, long-term care facilities, and acute care agencies; and the Manitoulin-Sudbury interdisciplinary program

and the Northeastern physician program, an intermediate approach, offered integrated workshops and teleconferences for 19 physicians and 20 other providers, representing 12 partnership agencies. In comparison, the two programs delivered in Parry Sound and Nipissing chose alternative program structures to educate large numbers of providers by using multiple sections of workshops, lectures, and courses that presented participants with palliative care information tailored to provider needs.

Program structures also differed as a result of variations in the total hours of instruction received by individual participants. Although all programs met the Ministry's requirement of providing a minimum of 30 hours of formal training, total hours of instruction received by individual participants varied from program to program. While all participants in the Cochrane-Temiskaming, Manitoulin-Sudbury, Northeastern physician and Northwestern programs were given 30 hours of mandatory training, participants in Parry Sound programs received from 6 to 12 hours of training and participants in Nipissing received from 2 to 54 hours, depending on program components attended.

CHART 2 - Northern Ontario Palliative Care Education Programs Variation in Program Selection Criteria, Type, Instructors, Program Materials, and Evaluation						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Palliative Care Institute
Selection Criteria	Agency-selected	Agency-selected and self-selected	Agency-selected and self-selected	Criteria-selected	Agency-selected	Non-physicians agency-selected Physicians criteria-selected

CHART 2 - Northern Ontario Palliative Care Education Programs Variation in Program Selection Criteria, Type, Instructors, Program Materials, and Evaluation						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Palliative Care Institute
Program Type (Length of Program Components)	Inservice Training Sessions (30 hrs)	Home Support Workers Workshop (6 hrs, repeated twice) Nurses Workshop (6 hrs, repeated twice) Lectures (6 hrs)	Facilitators Training Session (6 hrs) Introductory Module (2 hrs) Orientation to Palliative Care Course (30 hrs) Workshop Pain (12 hrs) Workshop Cancer (6 hrs)	Workshop (20 hrs) Teleconferences (10 hrs) Physician Practicums (25-30 hrs, arranged by individual physicians)	Workshop (30 hrs) Optional attendance at physician workshops (12 hrs) and teleconfer-ences (10 hrs)	Lectures, Workshops, Teamwork, Site Visits (30 hrs) Physician Practicums (25-30 hrs, arranged by individual physicians)
Total Hrs Instruction Received by Participants	30 hrs	6 hrs	2 - 54 hrs, according to components attended	30 hrs, plus practicums for physicians	30 - 52 hrs, according to sessions attended	30 hrs, plus practicums for physicians

CHART 2 - Northern Ontario Palliative Care Education Programs Variation in Program Selection Criteria, Type, Instructors, Program Materials, and Evaluation						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Palliative Care Institute
Instructors	Corporate Trainer	Local	Local Regional National (Pain and Symptom Workshop only)	Local Regional National (Keynote Speakers)	Local Regional National (Keynote Speakers)	Local Regional National (Keynote Speakers)
Program Materials Provided For Participants	Program teaching resource binder for inservice sessions	Handouts	Program binder for agency facilitators presenting introductory module only	Program binder containing articles and references	Preprogram binder containing material on experiential learning	Educational manual on principles of adult learning; print and video library resources
Program evaluation	Workshop	Workshop	Workshop and overall	Workshop and overall	Workshop and overall	Workshop and overall

(c) Content

While all programs attempted to meet the core skills content guidelines specified in Ministry directives for palliative care education, variation was displayed in the types of information provided to participants and time devoted to specific palliative care education topics. In addition, some programs provided a greater variety of choices for participants, allowing them to tailor the content of the program to meet their individual needs and interests. From an evaluation perspective, however, the most significant differences in content were associated with the "Train the Trainer" model itself. As outlined below, variations in each of these content areas strongly affected the structure and format of the evaluated programs, shaping the learning environments and experiences offered to participants.

CHART 3 - Northern Ontario Palliative Care Education Programs Variation in Program Content, By Hours of Instruction Offered*						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Northwestern Institute
Core Skills #1 - #9 - (Required under Ministry Directives for Physician and Nonphysician Providers)						
#1 Principles of palliative care	Workshops (5)	Home Support Workshop (1) Nurses Workshop (1.5) Lectures (1)	Introduction (2) Orientation to Palliative Care Course (12)	Workshop (1)	Workshop (3)	Lectures (2)

CHART 3 - Northern Ontario Palliative Care Education Programs Variation in Program Content, By Hours of Instruction Offered*						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Northwestern Institute
#2 Psychological, emotional, spiritual	Workshop (1)		Workshops Cancer (6)	Workshops (3) Teleconference (4)	Workshops (9)	Lecture (2) Workshops (10) Site Visit (14)
#3 Physical care issues	Workshop (3)	Home Support Workshop (2) Lectures (1)		Workshop (3)		Lecture (2) Teamwork (1)
#4 Pain and symptom management.	Workshop (4)	Nurses Workshop (4)	Workshop Pain (12)	Workshop (2) Teleconference (2)		Workshops (8)
#5 Communication	Workshop (3)	Home Support Workshop (2) Lectures (1)		Workshop (1)	Workshops (6)	

CHART 3 - Northern Ontario Palliative Care Education Programs Variation in Program Content, By Hours of Instruction Offered*						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Northwestern Institute
#6 Ethical, legal, and religious issues				Teleconference (2)		Lecture (1) Teamwork (1) Workshop (2)
#7 Stress management	Workshop (3)	Home Support Workshop (2) Nurses Workshop (1.5) Lectures (1)	Orientation to Palliative Care Course (6)	Workshop (2)	Workshop (3)	Workshops (4)
#8 Grief and bereavement	Workshop (2)	Home Support Workshop (1)	Orientation to Palliative Care Course (6)	Workshop (1)	Workshop (2)	Lecture (2) Workshops (4)
#9 Death and dying	Workshop (5)	Nurses Workshop (1)	Orientation to Palliative Care Course (6)	Workshop (1)	Workshop (1)	Lecture (2) Teamwork (1) Workshops (4)

CHART 3 - Northern Ontario Palliative Care Education Programs **Variation in Program Content, By Hours of Instruction Offered***						
Region	Northeastern			Northcentral		Northwest ern
Program	Cochrane-Temiskami ng	Parry Sound	Nipissing	Northeaste rn Physicians	Manitouli n-Sudbury	Northwest ern Institute
Core Skills #10 - 11 - Content - Palliative Care Delivery System (Required under Ministry directives for Physician Providers only)						
#10 Palliative care delivery models				Workshop (2) Teleconfer ence (2) Practicum for Physicians (25-30)		Lectures (2) Teamwork (2) Site Visits (4) Practicum for Physicians (25-30)
#11 Liaison and facilitation of communit y networks				Workshop (2)		Workshop s (8)
Core Skills #12-13 - Train the Trainer (Required under Ministry directives for both Nonphysician and Physician Providers						

CHART 3 - Northern Ontario Palliative Care Education Programs Variation in Program Content, By Hours of Instruction Offered*						
Region	Northeastern			Northcentral		Northwestern
Program	Cochrane-Temiskaming	Parry Sound	Nipissing	Northeastern Physicians	Manitoulin-Sudbury	Northwestern Institute
#12 Principles of adult learning and "Train the Trainer" model	Workshop (2)		Facilitator Training Session (3)	Workshop (1)	Workshop (2)	Lectures (1) Teamwork (2)
#13 Teaching strategies	Workshop (2)		Facilitator Training Session (3)		Workshop (2)	Workshop (2) Teamwork (2)
* Total hours of instruction offered represents the number of hours provided by the program in each core skills area. Because not all participants attended all program components, lectures, workshops or courses, however, the hours for each individual participant varied considerably, with some individuals receiving as little as two hours of instruction, others in excess of 30 hours.						

Although all programs provided basic information about principles of palliative care, psychological, emotional, and spiritual issues, stress management, grief and bereavement and death and dying, some programs opted to provide more intensive information on selected topics than on others (see Chart 3). Nipissing concentrated on introducing palliative care as a major component of its program, offering a condensed two-hour introductory session as an inservice in all participating agencies and paying tuition for agency-selected participants to attend a ten-week 30-hour orientation to palliative care course provided at Canadore College. While this course also discussed other core skills areas, including multidisciplinary

approaches, stress, death and dying, a major proportion of lecture hours was devoted to introducing palliative care philosophy and concepts, including terminology, current approaches and trends.

Similar variations occurred in the emphasis placed upon pain and symptom management and other specialized topics. As might be expected, programs which contained components directed specifically towards physicians and other health care professionals provided more extensive coverage of such issues, while those directed to home care workers and other support staff emphasized less technical subjects. Time allocated for discussion of pain and symptom management, for example, was minimal in the Parry Sound program which was directed towards home support staff, optional in the Sudbury program for other than physician providers and extensive in the Northeastern physician, Nipissing interdisciplinary and Northwestern multidisciplinary programs.

Iinformation on ethical, legal and religious concerns was included in the Northeastern physician and Northwestern programs, made optional in Manitoulin-Sudbury and omitted entirely from the Cochrane-Temiskaming, Parry Sound and Nipissing programs. Treatment of communication issues also differed, varying from a full-day workshop in Manitoulin-Sudbury, a half-day session in Cochrane-Temiskaming and Parry Sound, a one-hour workshop in the Northeastern physician program and omitted from the Nipissing and Thunder Bay programs.

With the exception of the Cochrane-Temiskaming program, all of the evaluated programs provided some content choices for participants. In Parry Sound, participants were offered a choice of attending two different workshops, one designed primarily for home support workers, the other for nurses. In Nipissing, participants could take one or more of the three major program components, involving the introductory module, the orientation to palliative care course or more specialized workshops on pain and cancer. Most extensive workshop options were provided by the Northwestern Institute program, which gave participants the choice of six workshops from the thirty offered. While these programs offered choice within core program components, Manitoulin-Sudbury presented participants with choices outside the core program components, by negotiating access to twelve hours of workshops and four teleconference sessions on specialized clinical issues delivered by the Northeastern physician program. For physician participants in both programs, additional opportunities for customizing the program were provided through follow-up practicums, arranged by the physicians themselves.

From an evaluation perspective, however, the most noticeable variation in program content was related to the presentation of information concerning the "Train the Trainer" model itself. Although all programs met the Ministry's requirement for providing palliative

care information which could be shared informally with providers, three programs adopted more formal versions of the model. In Cochrane-Temiskaming and Manitoulin-Sudbury, discussions of adult learning and facilitation were included in approximately six hours of workshops and group discussions, while the Northwest provided an alternative delivery model, using 10 hours of lectures, workshops and teamwork exercises to encourage participants to train their colleagues and coworkers.

IVA.   EVALUATION OF PARTICIPANTS' EDUCATIONAL EXPERIENCES

To assess the overall educational experiences of participants in the six programs, the NHHRRU research team relied on a variety of assessment tools, combining quantitative and qualitative approaches. To provide a quantitative tool for assessing program effectiveness, the research team developed 20 Likert-scale items, each related to one of the core skills areas or key components in the Ministry's directives concerning palliative care education initiatives. (See Appendix "B" - Instrumentation.) For further details on participants' learning experiences, the quantitative items were supplemented by a series of open-ended questions, gathering qualitative data regarding participants' views on the palliative care education programs attended.

Assessment of Educational Experiences

In the survey, participants were asked to evaluate the education program, indicating the extent of agreement with each, by choosing one of the following responses: "strongly agree", "agree" "uncertain", "disagree", "strongly disagree" and "not applicable." After excluding answers in the "not applicable" category, responses to each were scored on a scale of 1 = strongly disagree to 5 = strongly agree.

Three items evaluated learning about palliative care approaches in general (#5, #13, #20), four examined information acquired about death and dying (#1, #3, #9, #19), and five addressed specific knowledge and skills used in caring for the terminally ill, their families and caregivers (#7, #8, #14, #15, #17). Five items each were used to assess participants' perceptions of behavioral and attitudinal changes resulting from the program (#4,# 6, #10, #12) and four items were used to assess the effectiveness of program delivery techniques (#2, #11, #16, #18).

As a means of evaluating the overall effectiveness of the programs, all twenty evaluative items were summarized into an additive scale. Each of these dimensions of the evaluation will be described in detail in the following sections which present results for the entire sample and variations between programs.

(a) Learning about palliative care approaches, death and dying

As shown in Tables 9 and 10, participants from all six programs generally agreed that the programs had helped them learn about the approaches, philosophy and concepts behind palliative care and the importance of patient-centred palliative care. Agreement was strongest that "effective palliative care should focus on needs and priorities of terminally ill individuals" (#20), and learning that "palliative care requires a holistic, interdisciplinary approach" (#5).

TABLE 9 - LEARNING ABOUT PALLIATIVE CARE APPROACHES (Scoring - 1-5)

	Entire Population			ANOVA
	Mean	S.D.	N	F-ratio
The program taught me that palliative care requires a holistic, interdisciplinary approach. (#5)	4.3	1.73	220	1.25
The program taught me that "palliative care is a belief rather than a job."(#13)	4.1	3.88	223	3.00*
The program taught me that effective palliative care should focus on needs and priorities of terminally ill individuals.(#20)	4.3	5.62	225	0.97

*$p \leq .05$

Significantly more differences of opinion were found among participants in relation to the statement that "palliative care is a belief rather than a job", suggesting that programs might have differed in their presentation of palliative care concepts and philosophy (#13 - $p \leq .05$). Again, participants agreed strongly that their respective programs were generally successful in teaching them about some of the complex psychological, physiological, legal and spiritual implications of death and dying. Significant variations between program respondents emerged with respect to the knowledge gained about physiological changes (#3) and the spiritual implications of death and dying (#19).

TABLE 10 - LEARNING ABOUT DEATH AND DYING
(Scoring - 1-5 , Strongly Disagree to Strongly Agree)

	Entire Population			ANOVA
	Mean	S.D.	N	F-ratio
The program made me more aware of the complex psychological issues associated with the dying process. (#1)	4.27	.71	226	1.88
Because of this program, I know more about the physiological changes associated with death and dying. (#3)	3.97	.91	222	3.89**
The program made me more aware of the legal implications of death and dying. (#9)	3.5	3.9	221	20.52
In the program, I became more aware of the spiritual implications of death and dying. (#19)	3.8	4.9	322	54.53***

$**p \leq .01$, $***p \leq .001$

(b) Learning about supporting the terminally ill, their families, and caregivers

As outlined in Table 11, participants in all of the programs generally agreed that they had acquired knowledge or skills used to support the terminally ill and their families. Agreement was very strong among participants that they had gained understanding about stress and burnout among staff caring for the terminally ill (#14) and had learned more about different ways for family members to cope with grief and bereavement (#15).

There also was consensus that the programs had taught participants more about different methods of managing pain and controlling symptoms (#7) and more about communicating effectively with members of the interdisciplinary care team (#8). On the other hand, participants generally disagreed that they had learned more about offering support to the dying person during the last few hours of life (#17). When variations between programs were considered, however, the only significant differences emerged for

"learning more about different ways that family members cope with grief and bereavement" (#15 - p≤.05).

TABLE 11 - SUPPORTING THE TERMINALLY ILL, FAMILIES, AND CAREGIVERS
(Scoring 1-5)

	Entire Population			ANOVA
	Mean	S.D.	N	F-ratio
The program taught me more about different methods of pain management and symptom control. (#7)	4.16	.80	218	0.56
In the program, I learned how to communicate more effectively with members of the interdisciplinary care team. (#8)	3.83	.86	217	1.66
The program helped me to understand factors that lead to stress and burnout among staff caring for the terminally ill. (#14)	4.18	.72	227	1.97
In the program, I learned more about different ways that family members cope with grief and bereavement. (#15)	4.15	.71	226	3.08*
As part of the program, I learned more about offering support to the dying person during the last few hours of life. (#17)	2.19	1.07	230	2.13

*p ≤ .05

(c) Behavioral and attitudinal changes

As shown in Table 12, survey respondents also agreed that the programs attended had produced behavioral or attitudinal changes. Using self-assessment, participants reported that attending the programs had changed their interactions with colleagues, coworkers and clients. Strongest agreement was shown for trying "to create positive, supportive relationships with my palliative care coworkers and colleagues" (#10), suggesting in fact that the programs helped to strengthen relationships among palliative care colleagues and coworkers. Responses also indicate that participants felt that the programs produced other behavioral changes in the work setting, with participants agreeing that they had taken more time at work to talk about death and dying with terminally ill individuals (#6).

In addition, participants felt that their attendance at palliative care education programs had fostered attitudinal changes. They generally agreed that they found their work with dying individuals to be more rewarding since attending the program (#12), and that they had taken more time to keep in touch with their own feelings about death and dying (#4). Participants from all programs reported similar levels of agreement on these behavioral and attitudinal changes, except for keeping in touch with feelings about death and dying (#4)

TABLE 12 - ATTITUDINAL AND BEHAVIORAL CHANGES
(Scoring - 1-5)

	Entire Population			A N O V A
	Mean	S.D.	N	F - ratio
Since I attended the program, I have taken	3.84	.93	225	3.76**
more time to keep in touch with my own feelings about death and dying. (#4)				
As a result of the program, I spend more time at work talking about death and dying with terminally ill individuals. (#6)	3.34	1.01	1841.76	
Since attending the program, I have tried to create positive, supportive relationships with my palliative care coworkers and colleagues. (#10)	3.98	.79	186	0.56
Since attending the program, I feel that my work	3.86	.92	181	1.18

with dying individuals is more rewarding. (#12)

**p $\leq$ .01

(d) Effectiveness of Program Delivery

Table 13 suggests that the greatest variation in participants' evaluations occurred for those items assessing program delivery. For these items, variation was displayed both in the level of agreement among the entire sample of survey respondents and between groups of participants from different programs. Agreement was strongest that facilitators and instructors were willing to spend time discussing concerns raised by participants (#2) and that the program resource package contained helpful reference material (#11). In comparison, participants displayed more uncertainty about whether their program "would have been more effective if it had included a structured 'teaching kit'" (#16) and "contained too much information to digest in so short a time" (#18). Significant variation between programs occurred only for items #11 and #18 (p$\leq$.001), suggesting that programs differed most strongly in their ability to present helpful reference material and to present that information in the brief time allowed for the programs.

TABLE 13 - PROGRAM DELIVERY
(Scoring - 1-5)

	Entire Population			ANOVA
	Mean	S.D.	N	F-ratio
Facilitators and instructors were willing to spend time discussing concerns raised by participants.	4.43	.59	230	1.63
The program resource package contained helpful reference material.	4.23	.72	221	4.47***
The program would have been more effective if it had included a structured "teaching kit" for participants to take back to their facilities.	3.52	1.03	216	0.52
The program contained too much information to digest in so short a time.	3.07	1.29	229	9.94***

***p ≤ .001

Overall Evaluation Score

As discussed above, results suggest that programs varied significantly, displaying differences in program content, in such areas as teaching participants about palliative care, death and dying; in teaching support of the terminally ill, their families and caregivers and in producing behavioral and attitudinal changes in the caregivers themselves. In addition, findings indicate that programs differed in delivery, in ability to present information in the brief time allowed and in producing a resource package containing helpful reference material. To provide an approximate indicator assessing participant perceptions of overall program effectiveness, the research team combined the 20 Likert-scaled items into a simple additive scale (with items 16 and 18 reversed). The resulting scale has possible scores ranging from 20 to 100. Low scores indicate participant "disagreement" and high scores indicate "agreement" that the program met core skills requirements and other objectives. While it is not clear how much each dimension of the evaluation contributed to this scale, further analyses showed that the scale itself appeared to be reliable, accurately reflecting individual items comprising the scale (alpha = .8783). As shown in Table 14, distribution of scale scores ranged from a low of 43 to high of 97 (mean = 77), indicating that the majority of participants (N=135) agreed that the program attended was generally effective.

TABLE 14 - OVERALL EVALUATION SCALE SCORE
(Scale Score Possible Range - 20 - 100, Low effectiveness to high effectiveness)

Programs	Mean	S.D.	N
Entire Population	77.65	9.62	135
Program 1	83.60	6.35	5
Program 2	81.13	6.45	24
Program 3	77.46	11.15	48
Program 4	67.60	8.39	5
Program 5	81.13	6.45	15
Program 6	76.53	8.21	38

F- ratio = 3.89   p. = .07 (NS)

Occupational Groups	Mean	S.D.	N

	Mean	S.D.		N
Entire Population	77.65	9.62		135
Nurses	78.26	9.83		76
Support workers, health care aides, respite workers	79.68	8.10		25
Physicians	69.00	7.39		11
Social Workers	79.80	7.66		5
Other Professionals (including Chaplains)	81.50	8.80		8
Volunteers	71.67	12.63		6
Others	75.50	6.56		4

F- ratio = 2.56   p. = .02 (Sig.)

Work Settings	Mean	S.D.		N
Entire Population	78.02	9.70		121
Acute care unit	77.00	9.10		17
Chronic care unit	80.67	10.05		6
Long-term care setting	78.93	7.89		42
Hospice or palliative care unit	83.00	5.66		5
In client's home	78.58	10.62		45
In private office or community clinic	63.50	8.04		6

F- ratio = 2.56   p. = .005 (Sig.)

Although the difference between programs approaches significance (p = .07), linking such results to observed variations in program content and delivery would be very difficult, due to the small sample sizes in some programs, low response rates in others and the complex nature of the educational programs themselves. Given the differences in the educational and occupational backgrounds of the participants, however, it is possible that apparent differences in participants' evaluation of programs also could reflect participants' educational or employment experiences, including exposure to specific work settings. While small sample sizes of some educational, occupational groups and work settings precluded any exhaustive testing of possible relationships between these factors, analysis of variance suggested that educational levels had no significant effect on participant evaluation scores. However, occupational factors (p ≤ .05) and work settings (p ≤ .01) were significantly related to the participants' assessment of the programs.

Comparison of mean evaluation scores by occupational groups indicates that overall evaluation scores were lowest for physicians and volunteers, highest for other professionals, including social workers and support workers, and intermediate for nurses. With respect to

work settings, overall scores were highest among those who worked in hospices and chronic care units, lowest among those working in private offices or clinics and intermediate among those working in long-term care settings, in client's homes or in acute care units.

Because the highest evaluation scores were found among those occupational groups which had most direct contacts with the terminally ill and in those work settings mainly dedicated to the care of terminal patients, the results suggest that the programs developed from the present initiatives were in fact most effective for those who worked with the terminally ill on an ongoing basis. While such conclusions must be interpreted with a great deal of caution, they suggest that the most effective palliative care education programs are occupation specific, tailored to the needs of different provider groups, and shaped to fit the demands of particular work settings. As noted in the following section, such conclusions are supported by participants' perspectives on their educational experiences.

Participants' Perspectives on Educational Experiences

As a supplement to the scale items assessing participant's educational experiences, additional survey items asked participants to provide further evaluative information on their educational experiences, indicating what they liked most, what they liked least and what they had learned. Of those respondents providing information on what they liked most (N=214), many noted that they especially valued speakers (N=31), instructors and facilitators (N= 22), especially those relating personal experiences about palliative care (N=24). Others liked having workshops on specialized topics, such as pain and symptom control, communication techniques or stress management (N=39). In programs with an interdisciplinary focus, participants also appreciated opportunities to work together as a team (N=16), to network and share palliative care experiences with a wide cross-section of providers (N=31). In addition, some respondents also made special mention of resource materials provided, including audio and video tapes, handouts, manuals, lists of references, teaching strategies or suggestions for presentations (N=19).

Offering opinions similar to those stated in internal program evaluations, the majority of survey respondents who indicated what they disliked about the programs expressed frustration with specific aspects of program delivery and content (N=190). Chief among their concerns was the "time" allocated for the programs, with many commenting that sessions were "rushed" and sometimes scheduled at inconvenient times, with not enough time allowed for participation, discussion, review of resource manuals and breaks (N=67). Others noted that the time difficulties encountered during programs were often compounded by technical problems, including crowded, noisy or uncomfortable settings and

malfunctioning audiovisual equipment. As many respondents suggested, program delivery could be improved immensely by paying attention to such details, allowing more time for presentations, discussions and breaks, scheduling sessions to accommodate shift workers, providing comfortable seating and ensuring adequate audiovisual facilities.

Given program time constraints, respondents often commented that they felt overwhelmed intellectually and emotionally by the amount of material in the programs, manuals and handouts, indicating that it was simply "too much information" to absorb during the limited time allowed (N=54). Considering these difficulties, many providers suggested that it was important to have closer links between program content and provider learning needs, with professionals preferring more specialized, technical training and paraprofessional support workers wanting more practical "hands on" information to help them care for the terminally ill. As one individual stated, it also might have been helpful to have closer ties between the programs presented and the resource manuals, because there simply was "not enough time to absorb it all" during the program.

In spite of these difficulties, many of the survey respondents indicated that several types of important learning had occurred during the educational programs (N=112). While some considered that the most important learning was about the philosophy and concepts of palliative care (N=32), others indicated that their most important learning involved attitudinal and behaviourial changes, learning to "listen to patients" and their families (N=41). As one participant noted, she learned that "the best living is often done when dying." Other respondents were equally appreciative of learning new techniques for managing pain and symptoms, communications or stress (N=66). Some respondents also valued information about team approaches to palliative care, including providers and services available in their community or region (N=23). Finally, at a personal level, all of those responding to this question indicated that they had experienced important learning about themselves, to be less judgmental, more compassionate and take time "to care for the caregiver" (N=112).

Program Coordinators' and Agency Administrators' Perspectives

Although all coordinators and most administrators interviewed felt very positive about the programs provided, they indicated that there were many areas for improvement. Echoing the comments provided by survey respondents, coordinators and administrators

provided detailed insights into some of the technical difficulties of developing and delivering palliative care education programs to diverse groups of providers[2].

Like participants, coordinators and administrators noted that in interdisciplinary programs there were recurrent difficulties in choosing topics and presenting information which met the needs of both paraprofessionals and professionals. In programs which concentrated on more philosophical or theoretical issues, for example, paraprofessionals often wanted more emphasis on practical topics in palliative care, including techniques for "hands on" care of the terminally ill. For programs oriented towards general approaches and practical palliative care, however, coordinators found that professionals requested more information on specialized technical topics such as pain and symptom management or care of cancer and geriatric patients.

Given the inherent dilemmas associated with the interdisciplinary approach and the limited number of hours allocated for formal training, coordinators felt that it might be important to adjust program guidelines to permit special sessions or training programs to address the needs of particular provider or client groups. In areas without existing provider networks, for example, coordinators suggested that providers would benefit by having special programs to assist them in organizing local palliative care networks and setting up palliative care teams. Alternatively, in areas with large francophone populations, coordinators noted that it would have been beneficial to have French-language presentations and materials. Those from areas with large First Nations populations felt that more information on native spirituality and cultural sensitivity would have been beneficial.

Like coordinators, some administrators commented that the programs did not provide specialized training needed by their agency or facility employees. Some administrators noted, for example, that the programs did not provide their employees and volunteers with enough "practical" training. Administrators suggested that paraprofessionals would also have benefited by practical training in "comfort measures" and by learning additional techniques for supporting terminally ill individuals and their families. Additionally, others felt that some of the programs lacked technical training in pain and symptom control needed by professionals and paraprofessionals working in long-term care institutions and home-care. Finally, some programs were seen to be deficient in not providing enough information about "caring for the caregiver", including stress management and related psychosocial issues.

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[2] *Numerical analysis of coordinator and administrator interview data was not feasible, considering the small number of program coordinators/associates (N=13) and agency administrators (N=24) interviewed.*

n addition, some administrators expressed concerns that the material provided by the programs was not necessarily appropriate to their work setting, their staff or their patient care needs. For example, when program resource manuals contained articles, case studies, handouts and teaching suggestions developed for professionals, administrators of home-care programs and long-term care programs noted that their staff had to spend many hours adapting the materials to meet the needs of paraprofessional providers. Given these difficulties, some administrators suggested that programs would have been more useful had they presented more structured teaching materials designed specifically for long-term care inservice education.

IVB.   EVALUATING THE EDUCATIONAL MODEL

Although the evaluation time frame precluded any long-term assessment of the educational model, follow-up surveys attempted to determine whether in fact the model increased participants' palliative care knowledge, enhanced their ability to share that knowledge with colleagues and provided better care for the terminally ill. In keeping with this objective, both surveys also contained qualitative items asking participants to indicate how they had attempted to put the model into practice by sharing palliative care information. Participants were also asked to assess agency support for palliative care education and practice policies. As an overall evaluation of the educational model, respondents also were asked to evaluate specific features of the "Train the Trainer" model, including learning about the model and its effectiveness.

Sharing Palliative Care Information

Participants were asked how often they had shared palliative care information with colleagues and coworkers since attending the program. As shown in Table 15, the majority of survey respondents indicated that they had made some attempts to do so; however, the type of actions taken and the frequency varied considerably. Almost all participants reported sharing palliative care information with colleagues through informal contacts during work. Two of every three participants responding to this question also indicated that they had shared information through discussing palliative care issues at staff meetings and had told others about palliative care resources. Less than half reported conducting inservice sessions and less than a third indicated that they had met with their administrators to develop a plan for palliative care education within their agency.   The action taken least often was participating in a support group to help caregivers cope with the stresses of providing palliative care.

Comparisons by program indicates significant differences occurred between programs in taking all types of actions ($p \le .05$), except for the action of discussing palliative care issues at staff meetings. Because frequency of taking specific types of actions is also related to occupation ($p \le .01$) and work setting ($p \le .05$), however, it is unclear how often

actions were related to the program attended and how much they reflected the opportunities and constraints associated with the participant's work roles and work setting.

TABLE 15 - SHARING PALLIATIVE CARE INFORMATION

% Respondents Taking Actions:	Never Once	Only or Twice/ Month	Once or Week	Once a Twice/ More	Once Day or	N/A (N)
Met with my administrator to develop a plan for palliative care education in my agency.	54%	19%	14%	0%	0%	13%(139)
Shared information on palliative care with my coworkers through inservice lessons.	47%	24%	21%	1%	0%	7%(141)
Shared information about palliative care with my colleagues through informal contacts at work.	6%	49%	29%	4%	6%	8%(143)
Participated in a support group which helped caregivers deal with the stress of palliative care.	65%	10%	11%	4%	0%	10%(137)
Discussed palliative care issues at staff meetings.	21%	29%	38%	3%	0%	9%(141)
Shared information about palliative care education resources, ie. teachers, speakers, videos, handouts, etc.	20%	26%	36%	11%	1%	5%(141)

Responses to the open-ended questions about initial efforts at sharing palliative care information indicate that occupational variables and work settings created a variety of barriers to implementation, associated with finding both the opportunities and the time to share information. While those who worked in home care often noted that they lacked

opportunity because of minimal contacts with colleagues and coworkers, participants from long-term care and acute-care settings had contacts with coworkers but were equally frustrated because of the lack of time to present information sessions. As one long-term care facility employee stated, she was "overwhelmed" by the difficulties encountered in trying to prepare and present an education session for her coworkers and simply didn't realize "how much of her own time she would have to contribute."

Support for Palliative Care Education and Practice Policies

To provide a better understanding of factors facilitating or impeding sharing of palliative care information, the survey asked participants to rank their agency's support for palliative care education and palliative care practice. As indicated in Tables 16 and 17, the majority of the respondents felt that their agencies were supportive of such policies, although it is not clear from the data whether support for such policies in fact preceded or followed the present palliative care education initiatives.

Table 16 - AGENCY SUPPORT FOR PALLIATIVE CARE EDUCATION
(VS- very supportive, S - supportive, NL - neutral, U - Unsupportive, VU - very unsupportive)

% Respondents:	VS	S	NL	U	VU	(N)
Including palliative care issues and topics in regular inservice lessons.	30%	41%	24%	5%	1%	(134)
Coordinating palliative care education programs offered to staff.	27%	47%	22%	3%	1%	(135)
Discussing palliative care issues at regular staff meetings.	16%	52%	26%	5%	2%	(129)
Establishing a palliative care education resource centre, ie. with books, manuals, pamphlets, videos.	26%	44%	24%	5%	2%	(133)
Offering interdisciplinary	20%	39%	29%	11%	2%	(133)

palliative care education sessions.

Giving staff paid lead to attend   20%   40%   20%   12%   7%   (129)
palliative care education work-
shops, training sessions or courses.

With respect to palliative care education, results shown in Table 16 indicate that two of every three respondents felt that their agency was supportive or very supportive in coordinating palliative care education programs for staff. Equally high levels of support were reported for including palliative care issues and topics in regular inservice lessons, establishing a palliative care resource centre and discussing palliative care issues at regular staff meetings. Although approximately one in four respondents indicated that their agency was neutral towards such policies, lack of support was noticeable only for offering interdisciplinary palliative care education sessions and giving staff paid leave to attend palliative care education workshops, training sessions, or courses. As shown in Table 17, respondents reported even higher levels of agency support for palliative care policies. Eight of every ten respondents reported that their agency was supportive or very supportive in permitting family members extended visiting hours with terminally ill relatives, in advocating for medication policies that allow effective pain control and in establishing patient-centred care policies.

Table 17 - AGENCY SUPPORT FOR PALLIATIVE CARE POLICIES
(VS- very supportive, S - supportive, NL - neutral, U - Unsupportive, VU - very unsupportive)

% respondents:	VS (N)	S	NL	U	V U
Establishing support groups or debriefing sessions to help staff cope with stresses of palliative care.	22%	35%	35%	5%	3% (130)
Allowing staff to spend more time with terminally ill individuals and their families.	28%	42%	21%	7%	2% (134)
Permitting family members extended visiting hours with terminally ill relatives.	61%	24%	13%	1%	1% (112)
Advocating for medication policies that	53%	27%	16%	3%	1% (124)

allow effective pain control for dying patients.

Using trained volunteers to assist in palliative care.	38%	27%	26%	8%	2% (124)
Establishing patient-centred rather than task-oriented care policies for the terminally ill.	45%	32%	19%	2%	2% (126)

Slightly less support and more variation in support were reported for those policies directly associated with staffing, with lower levels of support for policies allowing staff to spend more time with terminally ill individuals and their families. Lowest levels of support were reported for using trained volunteers to assist in palliative care and for establishing support groups or debriefing sessions to help staff cope with stresses of palliative care. Taken together, the above data suggests that agencies are generally supportive of palliative care education and palliative care policies.

As might be expected, however, support for specific policies varies considerably, with support being most consistent for palliative care education and practice policies which can easily be incorporated into existing programs using existing resources. In responses to open-ended questions about agency support, participants frequently suggested that lack of agency support for palliative care education and palliative care policies was directly related to financial problems associated with long-term care funding restraints. Many shared the feeling that agencies were, in the words of one participant, "supportive in principle but not financially."

Evaluating the "Train the Trainer" Model

For the final component of the evaluation, the second survey contained four Likert-scale items assessing the educational model and two open-ended questions asking participants to share their experiences and opinions concerning the "Train the Trainer" concept. As shown in Table 18, nearly all of those responding to these survey items appeared to have acquired a basic understanding of the model and its implications.

As nine of every ten respondents agreed or strongly agreed that "Train the Trainer" meant sharing palliative care information with colleagues and coworkers, the results suggest that programs were effective in teaching participants about the basic educational principles associated with "Train the Trainer." Further indicating participants' appreciation of the model, only slightly lower levels of agreement emerged concerning whether the model was

the most effective way of providing palliative care education. Least agreement was found concerning items assessing the educational programs' presentation of the model. Perhaps reflecting the educational programs' interpretations of the model, less than half of those responding agreed or strongly agreed that the education program gave them very helpful information on "how to teach" coworkers about palliative care issues and there was least agreement on whether the educational program spent adequate time teaching participants about "Train the Trainer."

TABLE 18 - EVALUATION OF "TRAIN THE TRAINER"
(Scores - SA - strongly agree, A = agree, U = uncertain, D = disagree, SD = strongly disagree,
NA = not applicable)

% Respondents	SA	A	U	D	SD	NA (N)
"Train the Trainer" means that I should share palliative care information learned at the program with my colleagues and coworkers.	53%	38%	3%	1%	0%	6 % (140)
"Train the Trainer" is the most effective way of providing palliative care education.	17%	40%	32%	4%	1%	6 % (139)
The education program spent adequate time teaching us about "Train the Trainer."	10%	26%	31%	20%	5%	9 % (133)
The education program I attended gave me very helpful information on "how to teach" my coworkers about palliative care issues.	14%	34%	18%	22%	4%	9 % (137)

While six of every ten respondents agreed or strongly agreed that "Train the Trainer" was the most effective way of providing palliative care education, respondents' noticeably high levels of uncertainty and lack of agreement concerning the model surfaced in response

to an open-ended question: "Did the program give you enough information about teaching and learning principles to teach others about palliative care?" As shown in Table 19, respondents' opinions were divided almost equally between affirmative and negative answers, varying with the program attended by the participant ($p \leq .05$), but not with respondents' occupational background or work setting.

Table 19 - ENOUGH INFORMATION ABOUT TEACHING AND LEARNING

Did the program give you enough information about teaching and learning principles to teach others about palliative care? (Open-ended question, researcher coded)

	%	(N=127)
Yes	45%	(57)
No	48%	(61)
Uncertain	3%	(4)
Not applicable	4%	(5)

Although it is difficult to interpret such findings, due to small number of respondents from some programs and occupational groups, participants' written comments suggest that they were most likely to respond positively when programs had provided formal instruction on teaching and learning principles. Even when programs offered instructions in teaching and learning, however, participants' responses suggest that they were not completely satisfied with the information provided because they had experienced difficulties in trying to implement the model. Many participants commented that additional instruction on teaching and learning principles could have been helpful, some suggesting that they would have been better prepared to learn had they been provided with information about the model ahead of time.

Other respondents also found that the information provided about teaching and learning was too general and required too much modification to meet their "specific situation and needs." Several participants noted that even good resource materials required considerable adaptation and preparation before they could be presented to coworkers and colleagues. Finally, other respondents noted that they had experienced difficulties because the programs had given them considerable information on learning principles but little information about practical teaching techniques. Several commented that, due to time constraints and heavy workloads, they would have preferred teaching materials that could be delivered with little preparation time. As one participant remarked, they needed "simple,

straightforward, foolproof instructions." As shown in Table 20, participants' opinions were similarly mixed when asked whether further funding should be allocated to palliative care education programs based on the "Train the Trainer" model. While three-quarters of survey respondents agreed that funding should be allocated based on the model, the remainder expressed reservations, uncertainty or opposition to the model and its linkage to palliative care education funding.

TABLE 20 - FURTHER FUNDING AND THE TRAIN THE TRAINER MODEL

Should further funding be allocated for palliative care education programs
based on the "Train the Trainer" model? (Open-ended question, researcher coded.)

	%	(N=127)
Yes	75%	(95)
Yes, with reservations	5%	(12)
No	6%	(7)
Uncertain	10%	(13)
Not applicable	4%	(5)

While participants' opinions about funding were not related to program attended or work setting, there was some association between opinions about funding and the occupational background of the participant ($p \leq .05$). Although such findings are difficult to interpret due to the low response rate for the question from some occupational groups, participants' written comments suggest that opposition to the model came primarily from professionals who thought that the model was not appropriate for all provider groups. Some physicians and nurses, for example, indicated that they opposed the linkage between the model and palliative care funding because they wanted to be educated but "do not have any interest in teaching." Other professionals stated that they could not adopt the model because there were no resources available for palliative care education in their long-term care facilities, agencies or communities. As one physician said: "In a small rural town without any such services to begin with...Where to start?"

Given these difficulties, survey respondents suggested that some of the existing funding for palliative care education programs could be directed towards alternative models of education offering enhanced experiential or "first hand" educational opportunities for palliative care providers. While some favoured diverting all or some of the funding to educate providers using existing community college and university courses, others argued that it was equally important to use funding to establish or expand inservice programs in

home care agencies, long-term care facilities and acute care facilities. Others suggested that financial incentives for training would help support palliative care education in encouraging staff to attend training sessions offered outside normal working hours. As noted in the following section, these concerns were also shared by program coordinators and administrators.

Other Viewpoints - Coordinators and Administrators

To provide another perspective on the "Train the Trainer" educational model, coordinator and administrator interviews also contained questions asking respondents to assess the educational model and provide additional insights into its suitability for palliative care education. Although, with a few exceptions, the coordinators and administrators interviewed expressed satisfaction with the outcomes of the palliative care education programs presented, many of the coordinators and administrators, like the participants, appreciated the complexities of palliative care training and saw both advantages and disadvantages in employing the "Train the Trainer" model for palliative care education.

(a) Coordinators:

With few exceptions, the coordinators expressed satisfaction with the present educational initiatives based on the "Train the Trainer" educational model. While nearly all coordinators said that one of the major advantages of the model was its efficiency as a means of training individuals to provide general orientations to palliative care philosophy and concepts, most indicated that the model had limitations and was not necessarily the most effective way of producing individuals who are qualified and effective palliative care education trainers. As one coordinator remarked, "I think it works and works well in the area of updating and in the area of providing introductory sessions and inservices ... but it's not the whole picture."

Others noted that even with training, there were problems with expecting individuals from the field to assume a training role: "People who work effectively in the field are not necessarily the same types of people who are educators." In addition, several noted that physicians, home care nurses, support workers or volunteers may, because of their independent work roles, simply not be able to assume the role of educators. Given these limitations, some coordinators viewed the "Train the Trainer" model as representing an unnecessary duplication of programs and favoured shifting funding to programs providing

more "first hand experience" and using existing palliative care education resources available in the community college and university system.

Several coordinators, however, suggested that the model could work effectively, when and if coordinators and program participants were given both the time and resources to deliver and implement palliative care education programs. Like participants, coordinators stressed that considerable "unpaid" time and volunteer labour was required to deliver and implement education programs, and that without administrative support, nothing was feasible. As one coordinator remarked: "unless administration gives them the time to do it now, unless administration buys into this...it won't work." Others felt that community support for palliative care education was equally important, especially in smaller or more isolated communities, where limited educational resources made implementation difficult. As one coordinator noted, no one provided palliative care "all on their own" and each trainer required support from administrators, fellow trainers and community at various times during implementation.

(b) Agency Administrators:

Like coordinators, the majority of agency administrators were satisfied with the model. However, unlike coordinators, who were primarily concerned with the content and delivery of the educational programs, many administrators interviewed had actually begun implementing the model or were in the process of planning to do so. As a result, administrators were more focussed on the possible long-term effectiveness of the model and its implication for palliative care education and palliative care practice.

In terms of advantages associated with the model, administrators were equally appreciative of the fact that "Train the Trainer" programs had provided otherwise unavailable training, enabling facilities to develop their own "on site" training and resources to provide ongoing training for current staff and new employees. The model was seen as providing an opportunity for administrators to "formalize" or "add legitimacy" to existing palliative care training and reassure staff that they were providing effective palliative care. Others saw an advantage in the model's ability to promote interdisciplinary networking, to enhance the resources available to their facilities and create an interdisciplinary basis for palliative care practice in their communities.

While most saw advantages in using the "Train the Trainer" model, several administrators noted that there were potential problems associated with implementing the model, including difficulties selecting the individuals who were going to be trained as

"trainers" and associated costs. As there was no mechanism at present for ensuring that training was actually provided, some reported that they had experienced unforseen problems in selecting individuals who initially appeared to be suitable but later were found to lack the necessary background, teaching abilities or interest in being a trainer. Staff turnover created similar problems, making it difficult for administrators to ensure consistency in training. Under such circumstances,"informal sharing" of information might take place, but it would be highly unlikely that "formal training" would occur.

Other administrators pointed out that there were additional costs associated with training that exceeded the funding currently provided. In terms of time and money, for example, sending staff members to a workshop sessions for several days or a week was felt to be too disruptive. As an additional issue, staff replacements were not available or funding was not sufficient to cover the additional costs of finding a suitably qualified replacement worker. Some administrators felt that the funding provided was not enough to cover the extra transportation, accommodation and living expenses incurred in sending someone to a workshop in a distant centre. This was a particular problem in more remote areas of the North, where costs of sending someone to a workshop or training session located in a distant community could be prohibitively expensive.

Administrators also indicated that there were "hidden" costs associated with the model and the initiative itself. Almost all administrators noted that program educational materials and resources required considerable modification to meet the specific needs of agency employees, thus adding to the time and financial costs associated with implementing palliative care education. Administrators from smaller agencies and those without existing inservice programs felt especially frustrated by the lack of support during implementation, stating that they did not have enough resources to give a staff member time during working hours to prepare and present an inservice program. The alternative, asking staff to prepare inservice on their own time, was seen as equally unacceptable.

As well, administrators identified significant problems associated with palliative care education provider networks and resource sharing. In communities which lacked existing palliative care resources and palliative care provider networks, the financial costs of getting "the system set up" was seen as a major obstacle to establishing ongoing palliative care education. Even in communities with existing provider networks, however, the costs of networking and sharing resources could be prohibitive. As one administrator remarked, palliative care education is "resource intensive", requiring a high degree of information and skill exchange. Where none existed, establishing even rudimentary collections of reference materials or computer data bases for palliative care education could be prohibitively expensive, far beyond the resources of most organizations.

Although most administrators suggested that the above problems could be alleviated by devoting more time and resources to supporting palliative care education programs, a few administrators expressed dissatisfaction with the current emphasis on funding only the "Train the Trainer" model of palliative care education. They suggested that it was important to assess the long-term effectiveness of the model in comparison to programs providing more experiential, "first-hand" learning. For comparative purposes, some administrators proposed diverting a portion of palliative care education funding to train providers using existing palliative care courses in community college and universities. Others argued that it would be equally effective to fund more specialized training programs, including internships and residencies for health professionals providing palliative care. Such programs were viewed to be especially beneficial for palliative care providers dealing with disease-specific problems or special-needs patient groups.

V. FINDINGS AND RECOMMENDATIONS:

While the findings reported in the previous sections generally indicate that the evaluated educational programs were successful in meeting their goal of providing palliative care education to a diverse group of palliative care providers in Northern Ontario, results also suggest a number of areas for improvement in program approaches, content, delivery and development. Accordingly, each of the following sections presents an overview of the evaluation results, followed by a summary of the findings and relevant recommendations.

1.   Program Approaches - Sponsorship and Structure:

The six programs evaluated represent diverse approaches to the educational model, each program representing interdisciplinary, grassroots-driven responses to the needs of specific partnership agencies, facilities and communities. The strength of each program was derived from its ability to meet the needs of participating providers, agencies and communities: Cochrane-Temiskaming presenting an inservice-based four-day formal version of "Train the Trainer" for long-term care facilities; Parry Sound offering locally-developed one-day workshop sessions for professional and paraprofessional home care workers; Nipissing providing a complex four-component educational program for interdisciplinary providers and volunteers using introductory modules, workshops and ten-week community college courses; Northeastern program for family physicians delivering a three-day workshop accompanied by ten hours of teleconferencing; Manitoulin-Sudbury offering an intensive five-day workshop emphasizing psychosocial palliative care topics for health care providers other than physicians and volunteers and Northwestern presenting an integrated five-day institute for interdisciplinary service providers, family physicians and volunteers. *(References: Description of programs, pp. 8-14; analysis of variations in sponsorship and structure, pp. 27-29; comparison of delivery approaches, pp. 30-32.)*

Program participants who took part in the NHHRRU evaluation were generally representative of the multidisciplinary nature of the education programs attended, with half from nursing, a fifth from home support, health care aide and respite worker positions and one tenth from social work, physician and other professional backgrounds. Half had worked primarily in home care settings during the previous 12 months, a third in long-term care facilities and the remainder in a variety of acute care settings, including clinics, hospice and

palliative care units. In addition, program participants had extensive experience in providing palliative care, having worked on the average 11 years in the field. During the past year, the majority of respondents had worked with elderly or middle-aged patients who suffered from cancer or cardiovascular conditions, from a variety of cultural backgrounds, including anglophones, francophones and First Nations. Given their wide-ranging experience, participants surveyed had experienced a wide range of specific palliative care situations, including being present at a client's death. Attitudes towards care of the terminally ill differed significantly, reflecting both the occupational backgrounds and care settings of participants. *(References: Analysis of respondents' professional backgrounds, pp. 19-25.)*

The survey data indicate that participants generally considered the educational programs attended to be effective in teaching them about palliative care approaches, death and dying and specific skills needed in supporting clients, family and caregivers. Survey respondents also reported that the education programs produced behavioral and attitudinal changes, including more positive, supportive interactions with coworkers, more time taken to talk with terminally ill clients, feeling their work was more rewarding and keeping in touch more with their own feelings. For some, the most important learning was about the philosophy and concepts of palliative care and the need to "listen to the patient." Others were equally appreciative of learning about new techniques, resources, and services available in their community or region. Finally, at a personal level, many indicated that their most important learning involved learning about themselves and about the need to be less judgmental, more compassionate and to take time "to care for the caregiver." *(References: Program learning, behavioral, and attitudinal effects, pp. 36-40.)*

In addition, the different approaches to palliative care education had all produced short-term educational effects. Almost all participants reported sharing palliative care information during informal contacts at work, at staff meetings and through sharing resources. Formal inservice training or planning for palliative care education within agencies occurred less frequently. While many of the evaluative assessments showed variations between programs, findings were also affected by participants' occupational backgrounds and work settings, suggesting that there may be a complex relationship between these three factors. (References: Sharing palliative care information, pp. 47-51.)

Summary and Recommendations:

The six programs evaluated adopted diverse approaches to the educational model, each constituting a grassroots-driven response to the needs of providers, partner agencies, facilities and communities. All programs appeared to be effective, producing short-term attitudinal, behavioral and educational effects. Since each program's strength was derived from its ability to meet the needs of participating providers, agencies and communities, it is recommended that the Ministry:

    1.1   Encourage agencies and facilities to form partnerships to develop community-driven palliative care education programs that are responsive to the needs of providers in specific communities or regions;

    1.2   Encourage agencies and facilities to develop coordinated interdisciplinary education programs for providers in home-care, long-term care and acute care settings;

    1.3   Consider combining Physician and Interdisciplinary Education Initiatives to facilitate development of multidisciplinary approaches to palliative care.

2. *Program Content - Core Skills Guidelines:*

Analysis of program content indicates that the six programs adopted various approaches to enhance access to palliative care education, delivering 30 hours of formal training and addressing the Core Skills guidelines outlined in Ministry directives on palliative care interdisciplinary initiatives. While all programs provided basic information about principles of palliative care, psychosocial issues, stress management, grief and death and dying, each program tended to interpret the Core Skills guidelines differently, placing more emphasis on some topics than on others. In addition, wide variations occurred in the way programs presented information on pain and symptom management, spirituality, communications and ethical-legal issues, with some programs choosing to omit discussion of some topics entirely. The most significant variation, however, was found in presentation of information concerning the "Train the Trainer" model itself. Although all programs provided information which could be shared informally with colleagues and coworkers, three programs adopted more formal approaches to the model, offering participants discussions in adult learning, facilitation and teaching skills. *(References: Analysis of variations in program content, pp. 30-35.)*

While evaluative data indicate that program participants, program coordinators and agency administrators were generally appreciative of the information provided about palliative care, results suggest that participants felt the programs were "rushed" and needed

more information about a variety of "practical" or "hands on" issues: physiological changes; pain and symptom management; communications; stress management; spiritual and cultural implications and support to dying persons and family caregivers. To facilitate provision of such information, some participants, coordinators and administrators suggested that it might be helpful to provide more detailed goals and objectives for the Core Skills guidelines, increasing the number of formal training hours and providing training and resource manuals in advance. *(References: Participant viewpoints on program content, pp. 40-46.)*

Summary and Recommendations:

Although all programs presented 30 hours of formal training addressing the core skills content requirements outlined in Ministry directives, analysis of program materials and survey responses indicates variation in the interpretation of the Core Skills Guidelines and the "Train the Trainer" model. Many participants, coordinators and administrators felt that program content could be improved: by providing more detailed goals and objectives; increasing the number of formal training hours and providing training and resource manuals in advance. In light of these findings, it is recommended that the Ministry:

> 2.1   *Retain Core Skills Guidelines as a central component of Palliative Care Education programs;*
>
> 2.2   *Review the current Core Skills Guidelines to provide more detailed goals and objectives concerning the core skills required for palliative care education programs;*
>
> 2.3   *Emphasize training in six major Core Skills areas: Principles of Palliative Care, Physiological Issues, Pain and Symptom Management, Communication, Spiritual Implications and Support to Dying Persons and Family Caregivers;*
>
> 2.4   *Re-examine the number of formal training hours for Palliative Care Education Training Programs to ensure that they are sufficient to meet Core Skills Guidelines;*
>
> 2.5   *Encourage program coordinators to provide program guidelines, training manuals and teaching materials to participants at least one month prior to formal training sessions, in order to make the best use of formal training hours.*

3. *Program Delivery - The Educational Model:*

While the majority of participants, coordinators and administrators surveyed were in favour of continuing palliative care education funding based on the "Train the Trainer" model, many had reservations about the model's ability to provide flexible, responsive training for all provider groups. Some participants, for example, opposed the linkage between the model and palliative care funding because they wanted to be educated but "do not have any interest in teaching." Others indicated that they could not adopt the model because there were no resources available for education in their long-term care facilities, agencies or communities. *(References: Respondents' perspectives on implementation, pp. 51-52.)*

Coordinators and administrators noted additional problems with expecting individuals from the field to assume a training role, as most physicians, home care professionals and volunteers worked quite independently. Some coordinators suggested that the model could work effectively only if participants were given the time, resources and administrative support required to deliver and implement palliative care education programs. Administrators also suggested a need for continuing evaluation of programs based on this model in comparison to more traditional programs based on experiential, "first hand" learning. *(References: Coordinator and administrator concerns about implementation, pp. 54-56.)*

Given these concerns, many participants, coordinators and administrators suggested introducing more flexibility into the educational model to meet the identified educational needs of provider groups, including upgrading palliative care skills among professional or paraprofessional groups; assisting providers in organizing local palliative care networks in communities without such supports; developing linguistically and culturally sensitive training materials for providers in areas with large francophone or First Nations populations; offering training for providers working with special client groups, such as cancer patients or geriatric populations and providing specialized training materials for providers working in long-term care facilities or home-care agencies. *(References: Participant, coordinator and administrator viewpoints, pp. 49-56.)*

Summary and Recommendations:

Although the majority of those surveyed were in favour of continuing palliative care education funding based on the "Train the Trainer" model, many had reservations about the model's ability to provide flexible, responsive training for all provider groups. To enhance the flexibility of the model, it was suggested that consideration be given to identifying basic

and advanced educational needs of different provider groups and evaluating the effectiveness of "Train the Trainer" programs. Given these findings concerning the educational model, it is recommended that the Ministry:

> 3.1 *Continue to fund Palliative Care Education Initiatives based on the "Train the Trainer" model;*

> 3.2 *Permit flexibility in adopting the "Train the Trainer" model to meet identified educational needs of providers, partner agencies, facilities and communities;*

> 3.3 *Encourage program coordinators to identify basic and advanced educational needs of different provider groups;*

> 3.4 *Encourage program coordinators to include evaluability criteria in program design to facilitate short-term evaluation of palliative care education training outcomes;*

> 3.5 *Encourage program coordinators to undertake objective evaluations to assess the short-term effectiveness of palliative care education programs in meeting the identified training needs of provider groups.*

4. Program Delivery - Implementation of the Model:

Evaluation of the educational outcomes of the programs suggested that the different approaches to palliative care education had all produced some short-term educational effects. Almost all respondents indicated that they had taken some action to implement the model, mostly by sharing through informal contacts during work, discussing palliative care issues at staff meetings and telling others about palliative care resources. Formal actions, such as conducting inservice sessions, meeting with administrators to develop a plan for palliative care education or participating in a support group, occurred less frequently. *(References: Analysis of participant sharing of palliative care information, pp. 47-48.)*

Although participants indicated that their agencies and facilities were highly supportive of palliative care education, many participants, coordinators and administrators reported that participants had experienced barriers to implementation, created by program variables, occupational factors and work settings. Because of variations in educational programs, some participants reported that they were hampered by insufficient knowledge about the "Train the Trainer" model and lack of specific instruction in learning principles and teaching strategies. In some instances, participants also reported that educational

materials required considerable modification to meet the specific needs of provider groups or work settings, which added to the time and financial costs of implementation. *(Reference: Agency support for palliative care education, pp. 49-50.)*

Coordinators and administrators also noted that implementation problems with "Train the Trainer" also occurred as a result of difficulties in selecting the individuals who were going to be trained as "trainers." Absence of an appropriate educational background, lack of teaching abilities or weak commitment to teaching caused problems for administrators in ensuring that training was carried out. *(Reference: Coordinator and administrator perspectives on implementation, pp. 54-56.)*

Summary and Recommendations:

While a majority of participants had taken informal actions towards implementing the "Train the Trainer" model, many participants, coordinators and administrators reported difficulties in formally implementing the model. Insufficient knowledge about the "Train the Trainer" model, lack of instruction in learning principles and teaching strategies and weak commitment to teaching were especially problematic. To support informal and formal implementation of the model, it is recommended that the Ministry:

> *4.1*   *Revise the current Core Skills Guidelines to add a component on how to implement the "Train the Trainer" model, including intensive training in adult learning principles, as well as informal and formal teaching strategies;*

> *4.2*   *Examine the possibility of developing an extensive resource manual providing more detailed instruction about the palliative care education Core Skills Guidelines and implementation of the "Train the Trainer" model;*

> *4.3*   *Encourage agency administrators to support informal implementation of the model by facilitating staff coaching and discussions of palliative care issues;*

> *4.4*   *Encourage adoption of more stringent Participant Selection Criteria to ensure that training is directed towards those who are interested in and committed to formally teaching others about palliative care;*

> *4.5*   *Adjust Participant Selection Criteria to permit agencies and facilities to send key staff members to consecutive training sessions, in order to upgrade trainers' palliative care education knowledge and skills.*

5. *Program Development - Palliative Care Education Programs:*

Notwithstanding the fact that a majority of those surveyed felt that the current palliative care education programs had met their educational objectives, many program participants, coordinators and administrators identified significant problems associated with developing palliative care education programs in partner agencies, facilities and communities. In agencies, facilities or communities which lacked existing palliative care resources and palliative care provider networks, the financial costs of getting "the system set up" was seen as a major obstacle to establishing ongoing palliative care education.

Even in communities with existing provider networks, the costs of networking and sharing resources could be prohibitively expensive. As one administrator remarked, palliative care is "resource intensive", requiring a high degree of information and skill exchange. Where none existed, establishing even rudimentary collections of reference materials for palliative care trainers and facilitators could be very expensive, far beyond the resources of most agencies and health care organizations. Given these difficulties, some participants, coordinators and administrators suggested devoting more time and resources to supporting inservice education programs, including funding staff release time and community or regional resource bases. In addition, coordinators and administrators stressed that it was especially important to conduct both short-term and long-term assessments of palliative care education programs. *(Reference: Participant, coordinator and administrator views on program development, pp. 49-53).*

Summary and Recommendations:

While participants, program coordinators and administrators greatly appreciated the opportunity to provide palliative care education under the present initiatives, evaluation findings indicate that most were concerned about the further development of palliative care education programs. Since funding is not provided for inservice education programs or long-term assessments, it is recommended that the Ministry:

5.1 *Examine the possibility of using existing available resources to fund staff release time for provider agencies and facilities to develop palliative care education inservice programs for provider agencies;*

5.2 *Examine the possibility of using existing available resources to fund community and regional computer resource databases for palliative care*

education in order to expedite information and skill exchanges among partner agencies, facilities and providers;

5.3 *Consider funding a one-day workshop for training program coordinators of all Northern Ontario initiatives to share their experiences and learn from each other on how to develop and deliver future palliative care education initiatives;*

5.4 *Consider funding a follow-up study of the 1994-95 training programs, surveying coordinator, participant and agency administrator cohorts to assess the long-term effectiveness of these Palliative Care Education Initiatives.*

CONCLUSION

Although the present evaluation reveals that programs were successful in producing short-term attitudinal, behavioral and educational effects, findings suggest that improvements can be made in many areas of palliative care education. Such improvements could enhance the quality of palliative care education and palliative care services provided throughout the region.

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APPENDICES

APPENDIX A - Palliative Care Education Programs

Northern Ontario   July 1994

Region	Program and Location
Northeastern Region	*Victorian Order of Nurses - Porcupine Branch*
	Extendicare - Kapuskasing, Hearst, Timmins, Cochrane
	Temiskaming Home Care Program
	Temiskaming Long-Term Care Facilities - Temiskaming Lodge, Extendicare Kirkland Lake, Extendicare Tri-Town, Northview Lodge, Teck Pioneer Residence
	Muskoka-East Parry Sound Home Care
	Muskoka Nursing Home
	Parry Sound Home Care
	Nipissing District Palliative Care Education Initative
Northcentral Region	*Northeastern Family Physicians Program*
	Algoma-Sault Ste Marie Interdisciplinary Program
	Manitoulin-Sudbury Interdisciplinary Program
Northwestern Region	*Northwestern Ontario Palliative Care Institute '94*

APPENDIX B - INSTRUMENTATION

PARTICIPANT SURVEY - COVERING LETTER FOR INITIAL SURVEY

Dear Colleague:

The Northern Health Human Resources Research Unit (NHHRRU), based at Lakehead and Laurentian Universities, has been funded by the Ministry of Health to conduct an evaluation of palliative care education programs in Northern Ontario, examining programs which represent different regions, alternative models and approaches.

As you have been identified as a participant in one of the educational programs chosen for this project, we invite you to participate in the evaluation process through completing this post-program survey, designed to assess program participants' views on the palliative care programs attended, plans for implementing palliative care education, opinions about palliative care and experience with palliative care. All survey materials and procedures have been approved by the Lakehead University Ethics Advisory Committee. In addition, all evaluative data will be presented in the form of grouped descriptive statistics, making it impossible to identify you as an individual or as an employee of a particular institution.

If you are willing to participate in the evaluation, please sign the enclosed consent form and return it with your completed questionnaire. As we may need to contact you at a later date during our follow-up evaluation, we also ask you to provide current address and telephone numbers. Participation is voluntary and will have no impact on your employment or enrollment in future palliative care courses. Should you desire further information on the evaluation or wish to discuss your participation in the project, please call our Project Researcher, Ms. Mary Ellen Hill at (807) 343-2103.

Sincerely,

J. Bruce Minore, PhD   *Raymond W. Pong, PhD   Suzanne Caty, BScN, MSc*
Co-Director, NHHRRU   Co-Director, NHHRRU   Director, School of Nursing
Lakehead University   Laurentian University   Laurentian University

Principal Investigators

PARTICIPANT SURVEY - COVERING LETTER FOR FOLLOW-UP SURVEY

Dear Colleague:

Thank you for participating in our post-program survey of participants who attended one of the educational programs chosen for the Northern Human Health Resources Research Unit evaluation of palliative care education in Northern Ontario.

At this time, we hope that you will assist us in our follow-up evaluation through completing a survey designed to assess your actual implementation of the "Train the Trainer" model of palliative care education and gather further information on your opinions about palliative care. As with previous surveys, all evaluative data from this survey will be presented in the form of grouped descriptive statistics, making it impossible to identify you as an individual or as an employee of a particular institution.

Again, thank you for your assistance in our evaluation. If you would like further information on this survey or would like a summary of survey results, when available, please call our Project Researcher, Ms. Mary Ellen Hill at (807) 343-2103.

Sincerely,

J. Bruce Minore, PhD   *Raymond W. Pong, Ph.D Suzanne Caty, BScN, MSc*
Co-Director, NHHRRU   *Co-Director, NHHRRU   Director, School of Nursing*
Lakehead University   *Laurentian University   Laurentian University*

Principal Investigators

PARTICIPANT SURVEY - CONSENT FORM LETTER

Dear Colleague:

Thank you for participating in our post-program survey of participants who attended one of the educational programs chosen for the Northern Human Health Resources Research Unit evaluation of palliative care education in Northern Ontario.

At this time, we hope that you will assist us in our follow-up evaluation through completing a survey designed to assess your actual implementation of the "Train the Trainer" model of palliative care education and gather further information on your opinions about palliative care. As with previous surveys, all evaluative data from this survey will be presented in the form of grouped descriptive statistics, making it impossible to identify you as an individual or as an employee of a particular institution.

Again, thank you for your assistance in our evaluation. If you would like further information on this survey or would like a summary of survey results, when available, please call our Project Researcher, Ms. Mary Ellen Hill at (807) 343-2103.

Sincerely,

J. Bruce Minore, PhD   *Raymond W. Pong, PhD*   *Suzanne Caty, BScN, MSc*

Co-Director, NHHRRU   *Co-Director, NHHRRU*   *Director, School of Nursing*

Lakehead University   *Laurentian University*   *Laurentian University*

Principal Investigators

PARTICIPANT SURVEY - CONSENT FORM

Northern Health Human Resources Research Unit
"Evaluation of Palliative Care Education Programs"

Consent to Participate

Please read, sign and date the following consent form, enclose in the small envelope provided, seal and enclose with your completed questionnaire:

The purpose of this study is to evaluate palliative care education programs in Northern Ontario, to determine how differences in sponsorship and structure affect the delivery of education programs and the outcomes of palliative care education. We believe that the findings will assist agencies to design more effective palliative care education programs and, further, will help foster more effective palliative care services for dying persons and their families.

The research teams asks you to assist in the study by participating in post-program and follow-up surveys. Your participation is voluntary and you may decide to withdraw from the survey series at any time.

Although questionnaires have been prenumbered, all coding numbers are solely designed for bookkeeping procedures, to provide a record of returns and facilitate the mailing of follow-up questionnaires. Your answers will be confidential and you will not be identified in any written reports or subsequent presentations of survey results.

I, _____, agree to be surveyed as part of the Northern Health Human Resources Research Unit study entitled "Evaluation of Palliative Care Education Programs in Northern Ontario." In addition, I give permission to the researchers to have access to the information from all surveys and other evaluative materials completed during the course of the education program I attended.

_____
Signature

_____
Date

PARTICIPANT SURVEY - ADDRESS FORM

Northern Health Human Resources Research Unit

"Evaluation of Palliative Care Education Programs in Northern Ontario"

As we may need to contact you at a later date during our follow-up evaluation, we also ask you to provide current address and telephone numbers, as indicated below:

Name: _____

Position/Title:_____

Work Address:_____

_____

_____ Postal Code

Work Phone No.:_____

If you wish to have follow-up materials sent to your home, please provide current home address and telephone numbers:

Home Address:_____

_____

_____

_____ Postal Code

Home Phone No.:_____

COORDINATOR INTERVIEWS - CONSENT FORM

"Evaluation of Palliative Care Education Programs"

Consent For Interview With Coordinators

The purpose of this study is to evaluate palliative care education programs in Northern Ontario, to determine how differences in sponsorship and structure affect the delivery of education programs and the outcomes of palliative care education. We believe that the findings will assist agencies to design more effective palliative care education programs and, further, will help foster more effective palliative care services for dying persons and their families.

The research teams asks you to assist in the study by participating in a post-program interview of coordinators. Your participation is voluntary and you may decide to withdraw from the interview at any time.

We ask that you also give consent for audiotaping of the interview, to facilitate our subsequent data analysis. Audiotapes will be destroyed after data analysis, to ensure the confidentiality of your answers. In addition, you or your agency will not be identified in any written reports or subsequent presentations of survey results.

I, _____, agree to be interviewed as part of the Northern Health Human Resources Research Unit study entitled "Evaluation of Palliative Care Education Programs in Northern Ontario."

In addition, as Coordinator for the _____
Palliative Care Education Program, I also give permission to the researchers to access information from all surveys and other evaluative materials completed during the course of the education program, including relevant records, lists of participants and internal evaluation reports.

_____
Signature

_____
Date

COORDINATOR INTERVIEWS - ASSOCIATES' CONSENT FORM

"Evaluation of Palliative Care Education Programs"

Consent For Interview With Associate Coordinators

The purpose of this study is to evaluate palliative care education programs in Northern Ontario, to determine how differences in sponsorship and structure affect the delivery of education programs and the outcomes of palliative care education. We believe that the findings will assist agencies to design more effective palliative care education programs and, further, will help foster more effective palliative care services for dying persons and their families.

The research teams asks you to assist in the study by participating in a post-program interview of coordinators. Your participation is voluntary and you may decide to withdraw from the interview at any time. We also ask that you give consent for audiotaping of the interview, to facilitate our subsequent data analysis. Audiotapes will be destroyed after data analysis, to ensure the confidentiality of your answers. In addition, you or your agency will not be identified in any written reports or subsequent presentations of survey results.

I, _____, agree to be interviewed as part of the Northern Health Human Resources Research Unit study entitled "Evaluation of Palliative Care Education Programs in Northern Ontario."

_____
Signature

_____
Date

ADMINISTRATOR SURVEY - COVERING LETTER

Dear Colleague:

The Northern Health Human Resources Research Unit (NHHRRU), based at Lakehead and Laurentian Universities, has been funded by the Ministry of Health to conduct an evaluation of palliative care education programs in Northern Ontario. We believe that the findings will assist agencies to design more effective palliative care education programs and, further, will help foster more effective palliative care services for dying persons and their families.

The research team asks you to assist in the study by participating in our interviews with agency administrators. Interviews will be conducted by telephone during the month of May and are expected to take about 30 minutes to complete. Your participation is voluntary and you may decide to withdraw from the interview at any time. All survey materials and procedures have been approved by the Lakehead University Ethics Advisory Committee. In addition, all evaluative data will be presented in the form of grouped descriptive statistics, making it impossible to identify you as an individual or as an administrator of a particular institution.

We will be contacting you in the near future to discuss your participation in the survey and arrange a time for the interview. In the meantime, we are enclosing a copy of the five interview questions, to allow you to take time to think about the questions and make some notes prior to the interview. We are also enclosing a consent form for the interview, to be returned by mail should you decide to participate in the interview. If you would like further information on the evaluation or wish to discuss your participation in the interview, please call our Project Researcher, Mary Ellen Hill, collect at (807) 343-2103.

Sincerely,

J. Bruce Minore, PhD   *Raymond W. Pong, PhD   Suzanne Caty, BScN, MSc*
Co-Director, NHHRRU   *Co-Director, NHHRRU   Director, School of Nursing*
Lakehead University   *Laurentian University   Laurentian University*

Principal Investigators

ADMINISTRATOR SURVEY - CONSENT FORM

Northern Health Human Resources Research Unit
"Evaluation of Palliative Care Education Programs"

Agency Administrator Telephone Surveys - Consent to Participate

If you agree to participate in our interview, please read, sign and date the following consent form and return in the postage-prepaid envelope provided:

The purpose of this study is to evaluate palliative care education programs in Northern Ontario, to determine how differences in sponsorship and structure affect the delivery of education programs and the outcomes of palliative care education. We believe that the findings will assist agencies to design more effective palliative care education programs and, further, will help foster more effective palliative care services for dying persons and their families.

The research teams asks you to assist in the study by participating in our telephone survey of agency administrators. Your participation is voluntary and you may decide to withdraw from the interview at any time. In addition, to assist us in documenting your answers, we also ask that you give consent for audiotaping of the interview, on the understanding that all tapes will be destroyed after analysis. Your answers will be confidential and you will not be identified in any written reports or subsequent presentation of survey results.

I, _____, agree to be surveyed as part of the Northern Health Human Resources Research Unit study entitled "Evaluation of Palliative Care Education Programs in Northern Ontario."

In addition, please check one of the following:
(a) I give permission to the researchers to audiotape the interview.   ____
(b) I do not give permission to the researchers to audiotape the interview.   ____

_____
Signature

_____
Date

PARTICIPANT SURVEY #1 - PROGRAM EVALUATION

Northern Health Human Resources Research Unit
Evaluation of Palliative Care Education Programs in Northern Ontario

POST-PROGRAM SURVEY OF PARTICIPANTS - MAILED QUESTIONNAIRE -
Code #: _____

I - EVALUATION OF PALLIATIVE CARE EDUCATION PROGRAMS - PART A -
Instructions: Please read each of the following statements carefully and check ✓ the box below the response that best matches your current evaluation of the program you attended:

	Strongly Agree	Agree	Uncer-tain	Disagree	Strongly Disagree	N/A
1. The program made me more aware of the complex psychological issues associated with the dying process.						
2. Facilitators and instructors were willing to spend time discussing concerns raised by participants.						
3. Because of this program, I know more about the physiological changes associated with death and dying.						
4. Since I attended the program, I have taken more time to keep in touch with my own feelings about death and dying.						
5. The program taught me that palliative care requires a holistic, interdisciplinary approach.						
6. As a result of the program, I spend more time at work talking about death and dying with terminally ill individuals.						

	Strongly Agree	Agree	Uncer-tain	Disagree	Strongly Disagree	N/A
7. The program taught me more about different methods of pain management and symptom control.						
8. In the program, I learned how to communicate more effectively with members of the interdisciplinary care team.						
9. The program made me more aware of the legal implications of death and dying.						
10. Since attending the program, I have tried to create positive, supportive relationships with my palliative care coworkers and colleagues.						
11. The program resource package contained helpful reference material.						
12. Since attending the program, I feel that my work with dying individuals is more rewarding.						
13. The program taught me that "palliative care is a belief rather than a job."						
14. The program helped me to understand factors that lead to stress and burnout among staff caring for the terminally ill.						
15. In the program, I learned more about different ways that family members cope with grief and bereavement.						

	Strongly Agree	Agree	Uncer-tain	Disagree	Strongly Disagree	N/A
16. The program would have been more effective if it had included a structured "teaching kit" for participants to take back to their facilities.						
17. As part of the program, I learned more about offering support to the dying person during the last few hours of life.						
18. The program contained too much information to digest in so short a time.						
19. In the program, I became more aware of the spiritual implications of death and dying.						
20. The program taught me that effective palliative care should focus on needs and priorities of terminally ill individuals.						

PART B - Instructions: We would also like to know your actual current views on the palliative care education program you attended. Unless otherwise indicated, please write your answers in the spaces provided below each question. If more space is required, please write on page backs.

1.   Which palliative care education programs did you attend? Please check ✓ program attended :

Cochrane - Extendicare		Sudbury - Interdisciplinary	
North Bay - Red Cross Society		Sudbury - Physicians	
Parry Sound - Hospital Homecare		Thunder Bay - Palliative Care Institute '94	

2. What three things did you like most about the program?

(i)	
(ii)	
(iii)	

3. What three things did you like least about the program?

(i)	
(ii)	
(iii)	

4. In your opinion, what were the three most important things you learned during the program?

(i)	
(ii)	
(iii)	

5. Since you attended the program, how have you shared palliative care information with your colleagues and coworkers?

6. What difficulties, if any, have you experienced in trying to share palliative care information with colleagues and coworkers?

> (blank box)

7. What future plans have you made for sharing palliative care information with your colleagues and coworkers?

> (blank box)

8. Since you attended the program, how have you changed your interactions with terminally ill individuals?

> (blank box)

9. Similarly, how have you changed your interactions with the families of the terminally ill?

> (blank box)

10. Also, how have you changed your interactions with palliative care colleagues or coworkers?

> (blank box)

11. Prior to the present palliative care education course, what types of palliative care training have you taken (i.e., courses in death and dying or seminars on care of the terminally ill and their families)?

> (blank box)

12. If offered in future, would you consider taking another palliative care education program?

Yes	
No	
Don't Know	
Comments:	

13. What suggestions or recommendations would you make to improve future palliative care education programs?

II - OPINIONS ABOUT PALLIATIVE CARE

Instructions: To help us understand your evaluation of palliative care education, we would like to know your opinions about some important palliative care issues. Please check ✓ the box below the response that best matches your current opinion about each of the following statements:

	Strongly Agree	Agree	Uncert-ain	Disagree	Strongly Disagree
1. Regardless of age, disabilities and personal preferences, a person should be kept alive as long as possible.					
2. Dying individuals should be told they are dying.					
3. The dying person is best served by a matter-of-fact focus on medical issues.					

	Strong ly Agree	Agree	Uncer t-ain	Disag ree	Stron gly Disag ree
4. It is important in the treatment of dying patients to discuss their feelings with them.					
5. Fear of death is natural in all of us.					
6. Feelings of depression in the dying person are unusual.					
7. People are better off not knowing their diagnosis even when it carries an implication of imminent death.					
8. If terminally ill persons talk about their fear of death, health providers should reassure them that they have little to worry about.					
9. Those who support the principle of "death with dignity" endorse active as well as passive euthanasia.					
10. No matter what my personal beliefs, in my role as a caregiver, I would fight to keep a terminally ill person alive.					
11. Dying persons who talk about their future plans for work, family, trips, etc., do not realize the seriousness of their condition.					
12. Individual freedom of choice ultimately should mean freedom of choice to live or die within a context of responsibility for self.					
13. Even if they don't ask, relatives should be told when death is imminent for a terminally ill family member.					

	Strong ly Agree	Agree	Uncer t-ain	Disag ree	Stron gly Disag ree
14. Dealing with dying patients makes us aware of our own feelings regarding death.					
15. Family members who stay close to the bedside of a dying person often interfere with health provider's job of caring for the person's needs.					
16. Dying in Canada is handled more humanely than it is in most other parts of the world.					
17. I rarely think of dying.					
18. Health care providers tend to cut down on their visits to dying individuals if there is little that can be done for them medically.					
19. When thinking of dying, I fear the idea of disability and pain more than death itself.					
20. Nurses should be the primary health providers trained to deal with the reactions of dying patients.					
21. Relatives who know the prognosis of terminally ill family members make patient management more difficult.					
22. Terminally ill individuals frequently turn to their health providers to discuss feelings about dying.					
23. The more intelligent persons are, the less they fear death.					

	Strong ly Agree	Agree	Uncer t-ain	Disag ree	Stron gly Disag ree
24. Dying persons mourn their own approaching death.					
25. Dying is a physically painful process.					
26. The dying person should be separated from other patients during the final days of life.					
27. Many people prefer to be told their death is near..					
28. The term "pass away" is preferable to the term "die."					
29. It is all right for people to whisper to one another in the presence of a dying person.					
30. Health providers should be emotionally detached if they are to work in the best interests of dying patients.					
31. Suicide may be justified when a person is terminally ill.					

III - BACKGROUND

PART A - Professional Background - Instructions: To help us understand your views on palliative care education, we would like some information about your professional

background and experience with palliative care. Unless otherwise indicated, please check ✓ all applicable responses for each question.

1. What is your usual occupation?   Please briefly describe your primary profession, job title or volunteer role:

2. How long have you worked at this occupation?

____
____
___
Year
s

3. How long have you been working with terminally ill patients or clients?

____
____
___
Year
s

4. During the past 12 months, where did you work with terminally ill patients or clients?

a) Have you worked in any of the following practice settings?	Yes	No	b) Where did you work <u>most</u> of the time during the past 12 months?
Acute care unit			
Chronic care unit			
Long-term care setting			
Hospice or palliative care setting			
In client's home			
In private office or clinic setting			
Other care settings (please specify):			

5. During the past 12 months, approximately how many terminally ill individuals have you cared for? _____

6. Considering only those terminally ill patients or clients you have worked with during the past 12 months:

a) Did you work with the following age groups?	Yes	No	b) Please check ✓ only one.
Children			
Teens			
Young adults			
Middle-aged adults			
Elderly adults			

c) Which illnesses were they suffering from?	Yes	No	d) Please indicate which illness most of your patients or clients suffered from, by checking ✓ only one group.
Cancer			
Cardiovascular			
Respiratory			
Neurological			
AIDS			
Other illnesses (please specify):			

e) Which cultural and linguistic groups did you work with most of the time?

7. In connection with your work in palliative care, have you ever:

	Yes	No
Delivered "bad news" to individual with terminal condition?		
Delivered "bad news" to family members of terminally ill individual?		
Been present when individual died?		
Informed family when relative was near death?		
Informed family when relative had died?		
Attended a funeral or memorial service for a former patient or client?		

PART B - Personal Background - Instructions: Although the following questions are optional, your answers would help us understand your responses to other survey questions.   Unless instructed otherwise, please check ✓ only one response for each question.

1. What was your age on your last birthday?

Age:

2. In which community do you live?

Name of community:

3. What is the highest level of education you have completed?

High school diploma	
Community college diploma	
University bachelors' degree	
University masters' degree	
University doctoral degree	
Other education (Please specify):	

4. Gender:

Female	
Male	

5. Marital status:

Never married	

6. Parental status:

Children	
No children	

7. Religion or spiritual affiliation:

8. Intensity of religious or spiritual beliefs:

Strong	
Average	
Weak	
Not applicable	

9. What is your ethnic or cultural background?

10. What languages do you speak?

Married	
Divorced or separated	
Widowed	

THANK YOU FOR COMPLETING OUR QUESTIONNAIRE. PLEASE USE THE BACK OF THIS PAGE FOR ANY ADDITIONAL COMMENTS.

PARTICIPANT SURVEY #2 - ASSESSMENT OF TRAIN THE TRAINER

Northern Health Human Resources Research Unit

Evaluation of Palliative Care Education Programs in Northern Ontario

ASSESSMENT OF TRAIN THE TRAINER COMPONENT - Code #: _____

I - SHARING PALLIATIVE CARE INFORMATION: Instructions: In this survey, we are interested in knowing how the program you attended helped you share palliative care information and provide better palliative care.

a) Since attending the program, how often have you taken the following actions to share palliative care information with your colleagues or coworkers? (Please mark an "X" below the response that best matches your answer.)

	Never	Only once	Once or twice a month	Once or twice a week	Once a day or more	N/A
1. Met with my administrator to develop a plan for palliative care education in my agency.						
2. Shared information on palliative care with my coworkers through inservice lessons.						
3. Shared information about palliative care with my colleagues through informal contacts during work.						
4. Participated in a support group which helps caregivers deal with the stress of palliative care.						

5. Discussed palliative care issues at staff meetings.						
6. Shared information about palliative care education resources, ie. teachers, speakers, videos, handouts, etc.						

b) Did you take <u>any other actions</u> to share palliative care information with your colleagues or coworkers? Please describe:

II - AGENCY SUPPORT FOR PALLIATIVE CARE EDUCATION:

We would also like to know something about your agency's support for palliative care education.

a)   In your opinion, <u>how supportive</u> is your agency concerning the following palliative care education policies?   (Please mark an "X" below the response that best matches your answer.)

Policies:	Very Supportive	Supportive	Neutral	Unsupportive	Very Unsupportive
1. Including palliative care issues and topics in regular inservice sessions.					
2. Coordinating palliative care education programs offered to staff.					
3. Discussing palliative care issues at regular staff meetings.					
4. Establishing a palliative care education resource centre, ie., with books, manuals, pamphlets, videos, etc.					
5. Offering interdisciplinary palliative care education sessions.					
6. Giving staff paid leave to attend palliative care education workshops, training sessions or courses.					

b) Overall, how much support has your agency given for employee participation in palliative care education?

```
[blank box]
```

c)   Please give an <u>example</u> of the way your agency has supported staff participation in palliative care education workshops, programs or courses:

```
[blank box]
```

II - AGENCY SUPPORT FOR PALLIATIVE CARE POLICIES:

We would also like to know something about your agency's support for palliative care policies.

a)   <u>How supportive</u> is your agency concerning the following palliative care policies?
(Please mark an "X" below the response that best matches your answer.)

Policies:	Very Supportive	Supportive	Neutral	Unsupportive	Very Unsupportive
1. Establishing support groups or debriefing sessions to help staff cope with stresses of palliative care.					

2. Allowing staff to spend more time with terminally ill individuals and their families.					
3. Permitting family members extended visiting hours with terminally ill relatives.					
4. Advocating for medication policies that allow effective pain control for dying patients.					
5. Using trained volunteers to assist in palliative care.					
6. Establishing patient-centred rather than task-oriented care policies for the terminally ill.					

b) How much support has your agency provided for establishing <u>interdisciplinary</u> palliative care teams?

c) Please provide an <u>example</u> of the support your agency has given staff who are interested in establishing interdisciplinary palliative care teams:

```
┌─────────────────────────────────────────────────────────┐
│                                                           │
│ ......................................................... │
│                                                           │
│ ......................................................... │
│                                                           │
└─────────────────────────────────────────────────────────┘
```

IV - EVALUATION OF THE "TRAIN THE TRAINER" MODEL:

To help us evaluate the "Train the Trainer " component of the palliative care education workshops, courses or institute you attended, we would like to know what you learned about the model and how you implemented it.

a) What are your <u>current views</u> on "Train the Trainer" component of the palliative care education program you attended? Please mark an "X" below the response that best matches whether or not you agree with each of the following statements:

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applic-able
1. "Train the Trainer" means that I should share palliative care information learned at the program with my colleagues and coworkers.						
2. "Train the Trainer" is the most effective way of providing palliative care education.						

3. The education program spent adequate time teaching us about "Train the Trainer."						
4. The education program I attended gave me very helpful information on "how to teach" my coworkers about palliative care issues.						

b) Did the program give you <u>enough information</u> about teaching and learning principles to teach others about palliative care?

c) Should <u>further funding</u> be allocated for palliative care education programs based on the " Train the Trainer" model?

THANK YOU FOR COMPLETING OUR QUESTIONNAIRE.   PLEASE USE THE BACK OF THIS PAGE FOR ANY ADDITIONAL COMMENTS OR SUGGESTIONS ABOUT PALLIATIVE CARE EDUCATION OR "TRAIN THE TRAINER."

COORDINATORS - INTERVIEW SCHEDULE

Northern Health Human Resources Research Unit
Evaluation of Palliative Care Education Programs In Northern Ontario

POST-PROGRAM INTERVIEW OF COORDINATORS

 On-Site Interview Schedule - DATE: _____
                                        _____

1. INTERVIEW LOG:

Name of Coordinator: _____
                           _____

Position/Title: _____
                           _____

Organization: _____
                           _____

Telephone: _____
                           _____

Fax: _____
                           ____

Mailing Address: _____
                           _____

                           _____
                           ____

City: _____

_____

Postal Code: _____

_____

Time: _____

_____

Tape-Recording: _____

_____

_____

_____

Administrator Interview Guide

AS YOUR PALLIATIVE CARE EDUCATION PROGRAM IS NOW COMPLETE,
WE ARE INTERESTED IN HEARING YOUR ASSESSMENT OF THE PROGRAM, ITS
PARTICIPANTS AND FACILITATORS OR INSTRUCTORS.

1. WE ANTICIPATE THAT THIS INTERVIEW WILL TAKE ABOUT 30 TO 40
MINUTES OF YOUR TIME. THIS SURVEY CONTAINS QUALITATIVE IN-DEPTH
QUESTIONS, SO PLEASE DON'T HESITATE TO MODIFY YOUR ANSWERS, ADD
EXAMPLES OR ASK QUESTIONS.

2. FIRST, WE WOULD LIKE TO CONFIRM SOME GENERAL INFORMATION
ON THE TYPE OF PALLIATIVE CARE PROGRAM YOU ARE PRESENTING:

Program Title: _____
                      _____

P r o g r a m   S t r u c t u r e :
_____
_____

Target Population: _____
                          _____

Dates/Sites: _____
                    _____

NEXT, WE WOULD LIKE SOME INFORMATION ON THE DEVELOPMENT OF
YOUR EDUCATION PROGRAM.

3. Who was involved in the development of this palliative care education program?

Individual initiative   Agency initiative   Existing PC organization   Inter-agency organization

Grassroots organization developed specifically for this issue   Other

Name of individuals/organizations/others involved in development:

_____

(ASK FOR COPIES OF DOCUMENTS ON PROGRAM, CURRICULUM AND EVALUATION, IF NOT ALREADY OBTAINED)

4. Was a steering/planning committee organized to help plan the program?

   Yes   No

   If yes, when was committee organized?   _____

   _____

If yes, could you provide us with the names of steering committee/organization's members, their agency affiliation, etc.?

   Yes   No   (IF YES, ATTACH LIST OR RECORD NAMES ON BACK OF PAGE)

5. How did your organization become involved as the principal sponsor of this program?

_____

_____

NEXT, WE HAVE A FEW QUESTIONS ABOUT THE WAY THE PROGRAM WAS STRUCTURED AND PARTICIPANTS CHOSEN.

6. When your program was being planned, did you consider any alternative formats?

   Yes   No   If yes, alternatives: _____
                                                           _____

7. What were the advantages of choosing this type of program structure?

8. How were participants chosen?

   Self-selected   Agency-selected   Agency-volunteer

                           O t h e r   m e t h o d s   o f
   selection:_____

9. What were the criteria used for choosing participants?   _____
                                                                 _____
                                                                  _____

10. How many participants were expected to participate in the program?

_____

11. How many actually attended the program?   _____
                                                                _____

      (ASK FOR LIST OF PARTICIPANTS, MAILING ADDRESSES, TELEPHONE NUMBERS, IF AVAILABLE, FOR POST-PROGRAM INTERVIEWS, FOLLOW-UPS, ETC.)

NEXT, WE WOULD LIKE TO HEAR YOUR VIEWS ON PARTICIPANTS, FACILITATORS AND INSTRUCTORS.

12. In your opinion, did participants have an adequate understanding of palliative care issues and concepts prior to the program?

      Yes   No   Details: _____
                                         _____

13. Were there any types of participants who would have benefited by further pre-program orientation to palliative care?

      Yes   No   Details: _____
                                         _____

14. If you were to present a palliative care education program again, would you use different criteria to select participants?

      Yes   No   If yes, how would you change criteria: _____
                                         _____

15. In your opinion, were facilitators/instructors adequately prepared to present information on palliative care philosophy and approaches?

      Yes   No   Details: _____
                                         _____

16. Were any problems encountered by program facilitators in presenting sensitive issues to participants, for example, in discussing family dynamics or spirituality?

      Yes   No   Details: _____
                                    _____

17. Were facilitators/instructors willing to modify content or delivery to meet participants' needs?

        Yes   No   Details: _____

                                          _____

18. Did facilitators/instructors spend time developing participants' listening and communication skills?

        Yes   No   Details: _____

                                          _____

19. Did facilitators/instructors enhance participants' learning experiences by providing supplementary resources, such as guest speakers, audiovisual presentations or manuals?

        Yes   No   Details: _____

                                          _____

20. Did facilitators/instructors encourage networking among participants?

        Yes   No   Details: _____

                                          _____

21. In your opinion, were facilitators/instructors able to create a positive, supportive environment for participants?

        Yes   No   Details: _____

                                          _____

22. Overall, were you pleased with the performance of instructors/facilitators during the program?

Yes   No   Details: _____

_____

NEXT, WE WOULD LIKE TO HEAR YOUR VIEWS ON THE PROGRAM CONTENT AND FORMAT.

23. Did program content generally appear to meet the needs of participants?

Yes   No   Details: _____

_____

24. Could you give some examples of program content which seemed particularly appropriate for participants?

Yes   No   Details: _____

_____

25. Alternatively, could you give examples of program content which did not seem to meet participants' needs?

Yes   No   Details: _____

_____

26. If you were to present this Palliative Care Education program again, would you change the contents in any way, removing or adding topics from the curriculum?

Yes   No   Details: _____

_____

27. Which types of program content were best suited to workshop, classers, sessions or teleconference formats?

Workshops: _____
_____

Classes: _____
_____

Sessions: _____
_____

Teleconference _____
_____

28. In your opinion, were there any palliative care topics or issues included in the program which might have been delivered more effectively using another format?

Yes   No   If yes, examples: _____
_____

AT THIS TIME, WE WOULD ALSO LIKE TO HEAR YOUR VIEWS ON THE "TRAIN THE TRAINER" MODEL FOR PALLIATIVE CARE EDUCATION PROGRAMS. ACCORDING TO THE ONTARIO MINISTRY OF HEALTH, THE "TRAIN THE TRAINER" MODEL OF PALLIATIVE CARE EDUCATION STIPULATES THAT INDIVIDUALS WHO RECEIVE FUNDING FOR TRAINING IN PALLIATIVE CARE MUST BE PREPARED TO OFFER INSERVICE TRAINING FOR THEIR COLLEAGUES (MOH, 1993: 9).

29. Given your knowledge of the agencies who sent participants to this program, can you think of any factors within the agencies that may facilitate or impede implementation of the Train the Trainer model?

Yes   No

If yes, examples of factors facilitating implementation?   _____
_____

If yes, examples of factors creating barriers to implementation?   _____
_____

30. Based upon your knowledge of the agencies who sent employees to this program, could
you suggest the names of agency administrators who might have additional insights into
implementing the Train the Trainer model?

Yes   No   If yes, list names, titles, agency affiliation, telephone numbers below:

_____
_____

_____
_____

31. Based on your overall experience with this palliative care education program, what is
your opinion of the Train the Trainer model?

Very   Favourable   No opinion   Unfavourable   Highly
Favourable   Unfavoura
ble

Comments: _____

32. If funds became available, would your organization consider sponsoring another
palliative care education program based on the Train the Trainer model?

Yes   No   Why or why not?   _____
_____

33. Based on your experience, do you have any suggestions or recommendations to other
organizations who might be considering presenting similar programs in future?

Yes   No   If yes, suggestions: _____
_____

34. Considering the resources required, do you think that the Ministry of Health should allocate funding for further palliative care education programs based on the Train the Trainer model?

     Yes   No   Why or why not?   _____

                       _____

35. As a final part of our interview, we would now like to confirm some information about your organization's own evaluation of the education program. (I N F O R M A T I O N OBTAINED IN PRIOR TELEPHONE CONTACTS WITH COORDINATORS)

Type of internal evaluation/s used: _____

     _____

Preliminary results of evaluation: _____

     _____

Date when evaluation will be completed: _____

     _____

Date when evaluation report will be available: _____

     _____

Date when evaluation documents will be sent to NHHRRU: _____

     _____

     _____

WE VERY MUCH APPRECIATE THE ASSISTANCE THAT YOU HAVE GIVEN US DURING THIS EVALUATION, PARTICULARLY THE TIME YOU HAVE TAKEN TO PARTICIPATE IN OUR INTERVIEWS.

ALTHOUGH OUR EVALUATION OF PALLIATIVE CARE EDUCATION PROGRAMS WILL CONTINUE UNTIL THE END OF JUNE, WE HOPE TO PRESENT OUR PRELIMINARY FINDINGS AT A FOCUS GROUP FOR COORDINATORS DURING THE LATE SPRING.

36. If the focus group is offered, would you be willing to participate?

     Yes   No   Don't Know

37. INTERVIEW LOG CONCLUDING INFORMATION:

Time interview completed: _____

_____

Interview Notes: _____

_____

COORDINATORS - ASSOCIATES' INTERVIEW SCHEDULE

Northern Health Human Resources Research Unit
Evaluation of Palliative Care Education Programs In Northern Ontario

POST-PROGRAM INTERVIEW OF ASSOCIATES
NOMINATED BY PROGRAM COORDINATORS

On-Site Interview Schedule - DATE:
_____

1. INTERVIEW LOG:

Name of Informant: _____
                        _____

Position/Title:

                        _____
                        _____

Organization: _____
                        _____

Telephone: _____
                        _____

Fax: _____
                        _____

Mailing Address: _____
                        _____

City: _____
                        _____

Postal Code: _____

_____

Time: _____

_____

Tape-Recording: _____

_____

AS THE PALLIATIVE CARE EDUCATION PROGRAM IS NOW COMPLETE, WE ARE INTERESTED IN HEARING ABOUT YOUR ROLE IN THE PROGRAM AND YOUR ASSESSMENT OF THE PROGRAM, ITS PARTICIPANTS AND FACILITATORS OR INSTRUCTORS.
WE ANTICIPATE THAT THIS INTERVIEW WILL TAKE ABOUT 30 TO 40 MINUTES OF YOUR TIME. THIS SURVEY CONTAINS QUALITATIVE IN-DEPTH QUESTIONS, SO PLEASE DON'T HESITATE TO MODIFY YOUR ANSWERS, ADD EXAMPLES OR ASK QUESTIONS.

FIRST, WE WOULD LIKE TO CONFIRM SOME GENERAL INFORMATION ABOUT YOUR ROLE IN THE PALLIATIVE CARE EDUCATION PROGRAM.

2. What role did you play in the development of this palliative care education program?

3. Did you have a steering or planning committee to assist you in planning this aspect of the program?

      Yes   No   If yes, when was committee organized? _____

_____

4. Other than yourself, who was involved in this steering/planning committee? ____

____

____

_____
_____
_____
_____
__

NEXT, WE HAVE A FEW QUESTIONS ABOUT THE WAY THE PROGRAM WAS
STRUCTURED AND PARTICIPANTS CHOSEN.

5. When your program was being planned, what were your main concerns?   _____
                                                                          _____
                                                                          _____
                                                                          ___

I
        Did you consider any alternative formats?   Yes   No

        f yes, alternatives: _____
                                                         _____

6. What were the advantages of choosing this type of program structure?   _____
                                                                            _____
                                                                            _____
                                                                            ___

7. How were participants chosen?

        Self-selected   Agency-selected   Agency-volunteer

        Other methods of selection: _____
                                                         _____

8. What were the criteria used for choosing participants?   _____
                                                                    _____
                                                                    _____
                                                                    ___

9. In your opinion, did participants have an adequate understanding of palliative care issues and concepts prior to the program?

      Yes   No   Details: _____
                                                  _____

10. If you were to present a palliative care education program again, would you use different criteria to select participants?

      Yes   No   If yes, how would you change criteria?   _____
                                                  _____

11. In your opinion, were facilitators/instructors adequately prepared to present information on palliative care philosophy and approaches?

      Yes   No   Details: _____
                                                  _____

12. Were any problems encountered by program facilitators in presenting sensitive issues to participants, for example, in discussing family dynamics or spirituality?

      Yes   No   Details: _____
                                                  _____

13.Were facilitators/instructors willing to modify content or delivery to meet participants' needs?

      Yes   No   Details: _____
                                                  _____

14. Did facilitators/instructors spend time developing participants' listening and communication skills?

      Yes   No   Details: _____
                                                  _____

15. Did facilitators/instructors enhance participants' learning experiences by providing supplementary resources, such as guest speakers, audiovisual presentations or manuals?

Yes   No   Details: _____

_____

16. Did facilitators/instructors encourage networking among participants?

Yes   No   Details: _____

_____

17. In your opinion, were facilitators/instructors able to create a positive, supportive environment for participants?

Yes   No   Details: _____

_____

18. Overall, were you pleased with the performance of instructors/facilitators during the program?

Yes   No   Details: _____

_____

NEXT, WE WOULD LIKE TO HEAR YOUR VIEWS ON THE PROGRAM CONTENT AND FORMAT.

19. Did the program content generally appear to meet the needs of participants?

Yes   No   Details: _____

_____

20. you give some examples of program content which seemed particularly appropriate for participants?

Yes   No   Details: _____

_____

21. Alternatively, could you give examples of program content which did not seem to meet participants' needs?

Yes   No   Details: _____

_____

22. If you were to present this Palliative Care Education program again, would you change the contents in any way, removing or adding topics from the curriculum?

Yes   No   Details: _____

_____

23. Which types of program content were best suited to workshop, classers, sessions or teleconference formats?

Workshops:

_____

_____

Classes: _____

_____

Sessions: _____

_____

Teleconference: _____

_____

24. In your opinion, were there any palliative care topics or issues included in the program
which might have been delivered more effectively using another format?

Yes   No   If yes,
                       examples:_____
                       _____

AT THIS TIME, WE WOULD ALSO LIKE TO HEAR YOUR VIEWS ON THE
"TRAIN THE TRAINER" MODEL FOR PALLIATIVE CARE EDUCATION
PROGRAMS. ACCORDING TO THE ONTARIO MINISTRY OF HEALTH, THE
"TRAIN THE TRAINER" MODEL OF PALLIATIVE CARE EDUCATION
STIPULATES THAT INDIVIDUALS WHO RECEIVE FUNDING FOR TRAINING IN
PALLIATIVE CARE MUST BE PREPARED TO OFFER INSERVICE TRAINING
FOR THEIR COLLEAGUES (MOH, 1993: 9).

25. Given your knowledge of the agencies who sent participants to this program, can you
think of any factors within the agencies that may facilitate or impede implementation of
the Train the Trainer model?

      Yes   No

      If yes, examples of factors facilitating implementation?   _____
                                                                        _____

      If yes, examples of factors creating barriers to implementation?   _____
                                                                           _____
                                                                           _____
                                                                           ____

26. Based upon your knowledge of the agencies who sent employees to this program,
could you suggest the names of agency administrators who might have additional insights
into problems associated with implementing the Train the Trainer model?

      Yes   No

If yes, list names, titles, agency affiliation, telephone numbers below:

_____

_____

27.   Based on your overall experience with this palliative care education program, what is your opinion of the Train the Trainer model?

Very   Favourable   No opinion   Unfavourable   Highly
Favourable   Unfavourable

Comments: _____

28. If funds became available, would your organization consider sponsoring another palliative care education program based on the Train the Trainer model?

Yes   No   Why or why not?   _____

29.Based on your experience, do you have any suggestions or recommendations to other organizations who might be considering presenting similar programs in future?

Yes   No   Suggestions: _____

30. Considering the resources required, do you think that the Ministry of Health should allocate funding for further palliative care education programs based on the Train the Trainer model?

Yes   No   Why or why not: _____

31. WE VERY MUCH APPRECIATE THE ASSISTANCE THAT YOU HAVE GIVEN US DURING THIS EVALUATION, PARTICULARLY THE TIME YOU HAVE TAKEN TO PARTICIPATE IN OUR INTERVIEWS.

32. INTERVIEW LOG CONCLUDING INFORMATION:

Time interview completed: _____

Interview Notes: _____

ADMINISTRATOR INTERVIEWS - TELEPHONE INTERVIEW SCHEDULE

Northern Health Human Resources Research Unit

"Evaluation of Palliative Care Education Programs"

Administrator Telephone Interview Schedule

1) As an administrator, how satisfied were you with the palliative care education program presented to your agency employees?

2) From an administrative point of view, what were the advantages and disadvantages of having your staff participate in "Train the Trainer" model of palliative care education programs?

3) Following the program, has your agency taken any actions to implement the "Train the Trainer" model of palliative care education?

4) As a result of the present palliative care initiative, is your agency planning to make any palliative care organization or policy changes?

5) In your opinion, should further funding be allocated for palliative care education initiatives based on the "Train the Trainer" model?

For Further Information, Please Contact:

Northern Health Human Resources Research Unit
Health Sciences North, Lakehead University
955 Oliver Road
Thunder Bay, Ontario P7B 5E1

(807) 343-2136