Initiative #2: Physician Training
Final Evaluation Report 2006

Ontario's Strategy for Alzheimer Disease and Related Dementias

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1.0 Overview of Initiative #2: Physician Training

In 1999, the Ontario government announced a five-year strategy aimed at improving the quality of life of individuals with Alzheimer Disease and related dementias (ADRD) and their family members. Over $68 million was allocated to the ten point strategy which focused on: education for health care providers, caregivers and the public; service enhancements and expansions; and research activities and knowledge exchange.

The Physician Training initiative was one of the ten initiatives. Its goals were to enhance training of family physicians, undergraduate medical students, and residents in early detection and diagnosis of ADRD, improved practice patterns, and optimal use of community and specialized services. Under the leadership of the Ontario College of Family Physicians and the Physician Education Steering Committee, a set of educational strategies were designed to address these goals:

- Establish a Dementia Curriculum to be incorporated into undergraduate, postgraduate & continuing medical education (CME) programs of Ontario medical schools
- Opinion Leader Program
- Peer Presenter Program
- Family Medicine Preceptor Program
- Advance Care Planning Education Sessions
- Alzheimer Disease and Related Dementias Website

The following provides a summary of each of these strategies including: the goals; activities undertaken; evaluation plan; and highlights of results from the evaluation. Detailed summaries of the evaluation findings are reported elsewhere.

2.0 Establishment of an Alzheimer Disease and Related Dementias Curriculum

One goal of the Physician Training initiative was to establish a dementia curriculum. The intent was: 1) to share the curriculum with Ontario medical schools such that the information could be incorporated into their undergraduate, postgraduate and continuing medical education programs and 2) to use the curriculum to support the education strategies within the Physician Training initiative (e.g., the Opinion Leader and Peer Presenter Programs). To help achieve these outcomes, a Curriculum Advisory Committee and Curriculum Review and Design Committee were established. These committees included Program Coordinators (e.g., undergraduate, postgraduate and continuing medical education) and faculty members (e.g., neurology, geriatric medicine and psychiatry, and family medicine) from each of Ontario's medical schools, as well as representatives from the Ontario College of Family Physicians and the Alzheimer Society of Ontario.

The first task of the committees was the development of a set of educational objectives related to dementia for medical school students and family medicine residents. These objectives were used to guide the development of the dementia curriculum. Committee members then began to identify and review existing dementia curriculum. Materials were reviewed from each Ontario medical school, other medical schools across the country, and curricula located on the Web. In reviewing these materials, the committee members selected the most appropriate information, identified gaps, and revised the information as needed. In addition, they developed supporting educational materials so that the curriculum was available in a variety of formats suitable for different learning styles and opportunities (e.g., self-learning, small group case-based learning, formal presentations, discussion groups).

The curriculum and supporting learning materials, along with the educational objectives, were made available to each of the medical schools in Ontario. The materials were also shared with the opinion leaders and peer presenters for these individuals to use as needed in their educational activities.

Work on the curriculum and supporting educational materials continued throughout the 5-year Alzheimer Strategy. After the end of the Alzheimer Strategy, an editorial committee was established to ensure that the dementia curriculum is kept current.

3.0 The Opinion Leader Program

3.1 Purpose

The principle purpose of the Opinion Leader Program was to enhance the knowledge base and confidence of selected family physicians and support them in becoming more effective opinion leaders in regards to dementia care in their communities. The opinion leaders were expected to take a lead role in their communities by assisting other physicians through formal and informal “hallway consultations”, by sharing their knowledge on dementia including how to access specialized resources when needed, and by modeling best practices in dementia care.

3.2 Opinion Leader Selection Process

In selecting potential opinion leaders, physicians identified as having a particular interest in dementia and/or the ability to influence practice changes amongst their peers were sought. Nominations of opinion leaders from key informants (including selected individuals at universities and hospitals, the Long-Term Care Physicians Association, geriatric specialists, and others) as well as self-nominations were accepted. Nominees were asked to submit a letter or detailed curriculum vitae that described their education and experience related to ADRD. The Opinion Leader / Peer Presenter Subcommittee of the Physician Education Steering Committee used a set of criteria developed to assess the suitability of nominees, along with the requirement to have geographic representation across the province, to select the final complement of opinion leaders.

3.3 Opinion Leader Program Overview

The Opinion Leader Program involved two educational components: participation in a 2-day CME workshop and the establishment of regional mentoring groups.

The purpose of the educational workshop was twofold: 1) to ensure baseline knowledge among the opinion leaders in issues related to ADRD (e.g., assessment and diagnosis, use of cholinesterase inhibitors, management of driving, capacity assessment) and 2) to educate participants about the Opinion Leader program and their roles and responsibilities.

The purpose of the mentoring groups was to provide the opinion leaders with on-going advice and support to meet their learning needs as well as the needs of physicians in their local communities. This relationship was intended to last for the duration of the Opinion Leader Program (approximately one year). A Mentoring Agreement was developed and shared with the opinion leaders and mentors at the beginning of the program. The Agreement outlined the mutual responsibilities of the geriatric specialists (mentors) and opinion leaders (mentees) and spoke to issues related to the content of mentoring, timeliness of response, modalities of interaction, confidentiality, record-keeping, and conflict resolution.

During the workshop, the mentoring groups had an opportunity to meet and discuss their plans for establishing a means of communication. The method of communication and frequency of contact was left to the discretion of the mentoring groups, although there was an expectation that mentors would be in contact with one or more of the opinion leaders an average of one hour per week.

As a result of the support provided during the workshop and through the mentoring relationship, it was expected that the opinion leaders would serve as informal educational resources to other physicians in their communities.

3.4 Overview of the Evaluation of the Opinion Leader Program

The evaluation of the Opinion Leader program included the following components:

1. evaluation of the CME workshop (feedback form completed at the end of the workshop)

2. a series of questionnaires completed by the Opinion Leaders to assess knowledge of ADRD, obtain feedback on the mentoring relationship, and gather information on their role as an Opinion Leader in their local community

Questionnaire	When Administered	Content
Pre-workshop	- prior to workshop	- personal and practice characteristics of the participants - knowledge and comfort in dealing with issues related to ADRD - use of good dementia practices (e.g., use of cognitive status tests, consideration of driving safety for those with dementia, etc.) - their status as an opinion leader in their community (e.g., do they see themselves as a resource to other physicians, confidence in serving as an opinion leader in dementia)
First Follow-up	- approx. 2 months post-workshop	- repeated questions from pre-questionnaire re: knowledge and comfort in dealing with ADRD issues - repeated questions from pre-questionnaire re: use of good dementia practices - feedback on the mentoring relationship - their involvement as an opinion leader in their local community
Second Follow-up	- approx. 6 months post-workshop	- repeated questions re: the mentoring relationship - repeated questions re: their involvement as an opinion leader in their local community
Third Follow-up	- approx . 12 months post-workshop	- repeated questions re: the mentoring relationship - repeated questions re: their involvement as an opinion leader in their local community - asked to identify specific physicians that they felt they had influenced in their role as an opinion leader

3. a questionnaire completed by physicians identified by the opinion leaders as those they had influenced (physicians were asked if they had been influenced by the opinion leader in the area of ADRD, how they were influenced, and if their interactions with the opinion leader led to any changes in their practice).

3.5 Characteristics of the Opinion Leaders

A total of 401 family physicians were nominated as opinion leaders. Of these, 86 (21.4%) were selected and agreed to participate in the opinion leader program (53 in Phase 1 and 33 in Phase 2).

The majority of participants were male (79%) and the average number of years in practice was 20.6 (SD=11.3, range: 1 – 47 years). Over half of the opinion leaders were working in a long-term care facility at the start of the mentoring program, and the majority of participants were working in suburban or urban settings (see Table 1).

Table 1: Demographic and Practice Characteristics

Characteristic	N=86
Gender	
male	79.1% (68)
female	16.3% (14)
Number of years in practice	
mean (SD)	20.6 (11.3)
range	<1 – 47 years
% (#) currently practicing in a long-term care facility	54.7% (47)
Practice Setting:	
urban	31.4% (27)
rural	25.6% (22)
suburban	38.4% (33)
other **	5.9% (4)

* Percentages may not sum to 100% because of missing values.
** "Other" includes: inner city and remote/isolated.

Six mentoring groups were established. Each group included all of the identified opinion leaders in that geographic region and geriatric specialists (i.e., geriatricians and geriatric psychiatrists) who served as mentors. The average number of opinion leaders per group was 14 (ranging from 2 to 19). The groups covered the areas of northwestern, northeastern, eastern, southern and southwestern Ontario as well as Toronto.

3.6 Response Rates

Response rates for each of the questionnaires completed by the opinion leaders are presented in Table 2. Rates ranged from 100% on the pre-questionnaire to 67% on the third follow-up questionnaire.

Table 2: Response Rate on Questionnaires

Questionnaire	Percentage (Number) Completing Questionnaire
Pre-workshop Questionnaire	100% (86 / 86)
First Follow-up	83.7% (72 / 86)
Second Follow-up	68.2% (58 / 85) *
Third Follow-up	66.7% (56 / 84) *

* One participant withdrew between the time of the first and second follow-up questionnaires and another withdrew between the second and third follow-ups.

3.7 Evaluation Highlights

3.7.1 Feedback on CME Workshop

A total of 86 participants attended the opinion leader workshops. Sixty of these individuals completed the Session Feedback Form, representing a response rate of 70%.

Table 3: Response Rate on Session Feedback Form

Number of Opinion Leaders who Attended Workshop	# Session Feedback Forms Completed	Response Rate
86	60	69.8%

Feedback was sought from the Opinion Leaders on each of the CME sessions held during the workshops. The Opinion Leaders were asked to rate:

1. the extent to which the learning objectives were met (using a 5-point scale where 1="not at all" and 5="completely");
2. how relevant the information presented was to their practice (using a 5-point scale where 1="not at all relevant" and 5="very relevant"); and
3. the session overall (using a 5-point scale where 1 = "poor", 2 = "fair", 3 = "good", 4 = "very good", and 5 = "excellent").

Average ratings for all three factors in each of the CME sessions were 4.0 or greater.

3.7.2 Opinion Leader Knowledge and Comfort re: ADRD Issues

When asked to rate how comfortable they were in their ability to manage ADRD issues in their practice (using a 5-point scale, where 1 = "not at all comfortable"; 2 = "not very comfortable"; 3 = "fairly comfortable"; 4 = "very comfortable"; and 5 = "extremely comfortable"), the majority responded "fairly comfortable" on the pre-questionnaire and "very comfortable" on the first follow-up questionnaire (see Table 4). Paired t-test results indicated that the difference in means was statistically significant [$t(70)=-2.487$, $p < 0.05$].

Table 4: Comfort Level in Managing Alzheimer Disease and Related Dementias

	Pre-Workshop: Mean (SD)	First Follow-up: Mean (SD)	Mean Difference
Comfort in ability to manage ADRD issues in your practice	3.50 (.84)	3.69 (.65)	.19 *

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

The opinion leaders were then asked to rate how easy or difficult they found a variety of aspects of care using a 5-point scale (where 1 = "always difficult"; 2 = "often difficult"; 3 = "sometimes easy/sometimes difficult"; 4 = "often easy"; and 5 = "always easy"). For the areas of "assessment and diagnosis", "treatment" and "management" a number of questions were asked using the same response format. Within the "assessment and diagnosis" area participants were asked to rate how easy or difficult they found differentiating mild memory loss from dementia, diagnosing Alzheimer disease, diagnosing more unusual causes of dementia, assessing behavioural problems, capacity and competence and driving safety, informing patients of a diagnosis of ADRD, and informing family members of patients of a diagnosis of ADRD. Under the "treatment of dementia" category, they were asked about the ease or difficulty in deciding when to treat with cognitive enhancers, the use of cholinesterase inhibitors, monitoring the response to cholinesterase inhibitors, and the use of medications to manage behavioural challenges. Finally, under the "management of dementia" category, they were asked about the ease or difficulty in managing wandering, agitation, aggression and incontinence, and discussing advance care planning.

Within each overall area, results from the individual sub-questions were consistent; that is, mean follow-up scores were higher than the mean pre-scores (indicating greater ease from pre to post). As a result, a composite measure was calculated for each respondent by summing their scores for each of the sub-questions and then dividing by the number of sub-questions. Table 5 presents the results from these composite scores.

In each case, the post-workshop score was higher than the pre-workshop score, indicating that the respondents found greater ease in undertaking the task after the workshop than they had prior to the workshop. Paired t-test analyses indicated that the difference scores in each case were statistically significant: $t(36) = -3.424$, $p < 0.05$ for identifying those at risk for dementia, $t(55) = -3.681$, $p < 0.05$ for assessment and diagnosis of dementia, $t(67) = -5.840$, $p < 0.05$ for treatment of dementia, and $t(71) = -2.669$, $p < 0.05$ for management of dementia.

Table 5: Level of Ease/Difficulty with Various Aspects of Dementia

How easy or difficult do you find the following tasks?	Pre-Workshop: Mean (SD)	First Follow-up: Mean (SD)	Mean Difference
Identifying those at risk for dementia	2.97 (.93)	3.51 (.84)	.54 **
Assessment and diagnosis of dementia	2.90 (.57)	3.13 (.52)	.23 **
Treatment of dementia	3.24 (.72)	3.61 (.57)	.37 ***
Management of dementia	2.84 (.69)	3.00 (.71)	.16 **

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

3.7.3 Good Dementia Practices

The opinion leaders were then asked a series of questions on the pre-workshop and first follow-up questionnaires about good practices related to the care of their patients with dementia including: understanding of the term "dementia red flag"; use of the Mini Mental State Examination; keeping a registry of dementia patients; having a process for ongoing follow-up or periodic assessment; considering the need for driving safety assessment; discussing issues related to power of attorney and advance care planning; and having a process for monitoring and reviewing medications.

For a number of the good dementia practices, there was a statistically significant increase in the number of opinion leaders who reported following these practices on the first follow-up questionnaire versus the pre-workshop questionnaire. These included: understanding of the term dementia red flag; keeping a registry of dementia patients; having a process for ongoing follow-up or periodic assessment; and having a process for monitoring and reviewing medications. Increases from pre to post in the percent of opinion leaders following certain practices were also seen for discussing issues related to power of attorney and advance care planning, but these differences were not statistically significant. In terms of the practice of considering the need for driving safety assessment, there was an increase in the number reporting that they "always" consider this need, but two opinion leaders reported not considering this need on the follow-up questionnaire even though they indicated that they did consider this need on the pre-workshop questionnaire.

3.7.4 The Mentoring Relationship

On each of the follow-up questionnaires, the opinion leaders were asked a series of questions related to the mentoring relationship. The following provides an overview of these results.

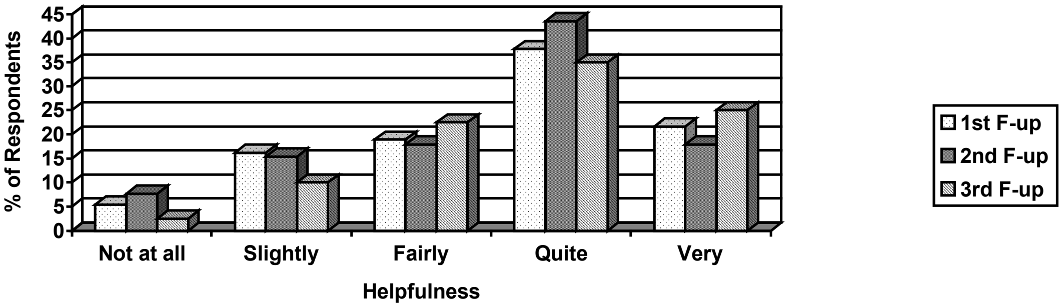
Contact between the opinion leader and mentors increased over time from 51% having contact at the time of the first follow-up questionnaire to 71% having contact at the time of the third follow-up questionnaire (see Table 6). In terms of contact frequency, the majority of opinion leaders reported being in contact with their mentor less than once per month.

Table 6: Frequency of Mentor Contacts

Have you been in contact with your mentor?	First Follow-up	Second Follow-up	Third Follow-up
Yes	51.4% (37/72)	67.2% (39/58)	71.4% (40/56)

The opinion leaders were asked to rate their mentoring relationship in terms of helping them understand issues related to ADRD (using a 5-point scale where 1 = "not at all helpful"; 2 = "slightly helpful"; 3 = "fairly helpful"; 4 = "quite helpful"; and 5 = "very helpful"). The majority of opinion leaders rated their mentoring relationship as "quite helpful" at each follow-up time (see Figure 1). Respondents reported that having opportunities to discuss issues and difficult cases with their mentors and colleagues were particularly helpful.

Figure 1: Helpfulness of Mentoring Rating



At each follow-up time, the majority of opinion leaders indicated that the relationship with their mentor was meeting their expectations (see Table 7). When expectations were not being met it was usually because of limited contact with the mentor and/or lack of a structured relationship. Seven respondents on the second follow-up questionnaire and three respondents on the third follow-up questionnaire reported having difficulty contacting their mentor.

Table 7: Opinion Leaders' Expectations of the Mentoring Relationship

Is your relationship with your mentor meeting your expectations?	First Follow-up (N=37)	Second Follow-up (N=39)	Third Follow-up (N=40)
Yes	83.8% (31)	74.4% (29)	85.0% (34)
No	10.8% (4)	17.9% (7)	10.0% (4)

* Note: Percentages may not total 100% because of missing values.

At each follow-up time, opinion leaders were asked if they felt more confident in dealing with issues related to ADRD compared with their level of confidence prior to the CME workshop. Those who responded 'yes', were asked if this increase was a result of the mentoring relationship. The percent reporting being more comfortable with ADRD issues increased over time from approximately 81% at time of the first follow-up to 98% at the third follow-up time (see Table 8). The majority of these individuals (66%, 57% and 64% on the first, second and third follow-up questionnaires, respectively) reported that their increased confidence was due "in part" to their mentoring relationship. The opinion leaders commented that the mentoring relationship helped to increase awareness of ADRD issues, increased opinion leader knowledge in specific areas of ADRD care, and increased their confidence in the opinion leaders' ability to manage such cases.

Table 8: Confidence Self-Assessment

Overall, do you feel more confident in dealing with issues related to ADRD compared with your level of confidence prior to the workshop?	First Follow-up (N=72)	Second Follow-up (N=58)	Third Follow-up (N=56)
Yes	80.6% (58)	87.9% (51)	98.2% (55)
No	13.9% (10)	10.3% (6)	1.8% (1)

* Note: Percentages may not total 100% because of missing values.

3.7.5 The Opinion Leader Role

In each of the follow-up questionnaires, the opinion leaders were asked to provide information on their activities as an informal educational resource for other physicians in their local areas. When asked to estimate the number of times in the 3 months preceding the survey that they had served as an educational resource to other physicians, the average estimates were 1.9 at the time of the first follow-up and 4.1 at the time of the second follow-up. The difference was statistically significant [t(44) = -2.200, $p < 0.05$].

Table 9: Number of Times Opinion Leaders Served as an Educational Resource

How many times in the last 3 months have you served as an educational resource to other doctors?	First Follow-up: Number of Times Serving as an Educational Resource	Second Follow-up: Number of Times Serving as an Educational Resource
Mean	1.93	4.13 *
Standard Deviation	2.9	7.7
Range	0 - 15	0 - 40

* Note: Percentages may not total 100% because of missing values.

On the pre-workshop questionnaire and second follow-up questionnaire, the opinion leaders were asked to rate how confident they felt in their role as an opinion leader (using a 5-point scale, where 1=not confident, 2=slightly confident, 3=fairly confident, 4=quite confident, 5=very confident). On the pre-questionnaire, the average rating was 3 compared with an average rating of 3.4 on the second follow-up questionnaire (see Table 10). The mean difference was statistically significant [t(56)=-2.317, $p < 0.05$].

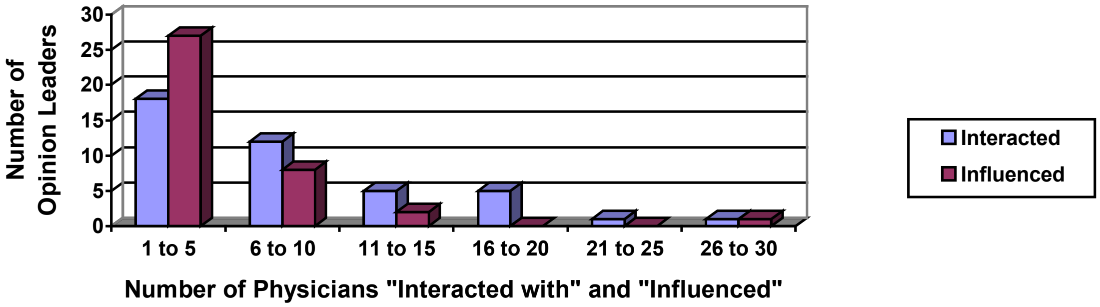
Table 10: Confidence as Opinion Leader

How confident are you in serving as opinion leader?	Pre-Questionnaire: Confidence Rating	Second Follow-up: Confidence Rating
Mean	3.02	3.36*
Standard Deviation	1.1	1.1
Range	1 - 5	1 – 5

* Note: Percentages may not total 100% because of missing values.

On the final follow-up questionnaire, the opinion leaders were asked to estimate: (1) the number of physicians they had interacted with in their role as an opinion leader in dementia since the start of the opinion leader program and (2) how many of these physicians they thought they had directly influenced as a result of their role as an opinion leader. The opinion leaders reported that they had interacted with 386 physicians since the start of the opinion leader initiative (mean=7.3 physicians per opinion leader, sd=7.1) and had directly influenced a total of 192 physicians (mean=4.6 per opinion leader, sd=4.9).

Figure 2: Number of Physicians that the Opinion Leaders "Interacted With" and "Influenced"



The opinion leaders were then asked to name up to four physicians whom they believed they had influenced. The names of 110 physicians were provided (mean=3.0 per opinion leader, sd=1.4). (Note: Some opinion leaders provided the names of up to seven physicians.) The 110 "influenced physicians" were then surveyed. Completed questionnaires were received from 56 physicians (response rate: 50.9%).

The physicians identified as being influenced were asked whether their understanding of ADRD issues had been influenced by the opinion leaders. Almost 90% reported that it had. The areas identified most frequently as being influenced included: medications, diagnosis, capacity, the Mini-Mental State Examination, and issues related to long-term care (LTC) placement (see Table 11).

Table 11: Opinion Leaders' Influence on Understanding of ADRD Issues

Understanding of ADRD issues influenced by Opinion Leaders?	Percent (Number) of Responses (N=56)
No	10.7% (6)
Yes	87.5% (49)
If yes, area of influence	**Percent (Number) Identifying Each Area**
Medications	73.2% (41)
Diagnosis	67.9% (38)
Capacity	42.9% (24)
MMSE	42.9% (24)
Placement	41.1% (23)
Driving	37.5% (21)
Power of Attorney (POA)/ Advance Care Planning (ACP)	19.6% (11)
Other	12.5% (7)

The influenced physicians were then asked whether they had made any changes in terms of the care they provided to patients with ADRD as a result of their interactions with the opinion leaders. Almost 70% of the influenced physicians reported making a change to their practice. The types of changes cited most frequently included: improving their assessment (N=18); improving their medication management (N=16); having a heightened awareness of ADRD issues (N=9); improved understanding of issues related to driving and dementia (N=4); and having an increased focus on family involvement with care decisions (N=3).

Table 12: Opinion Leaders' Influence on Provision of Care to Patients with ADRD

Any changes to the provision of care for patients with ADRD?	Percent (Number) of Responses (N=56)
No	17.9% (10)
Yes	69.6% (39)

Interactions with the opinion leaders most frequently occurred through one-on-one interactions, informal group discussions, and formal educational activities. Informal one-on-one interactions and group discussions were reported as the most effective means of interaction (see Table 13).

Table 13: Type of Interactions with Opinion Leaders

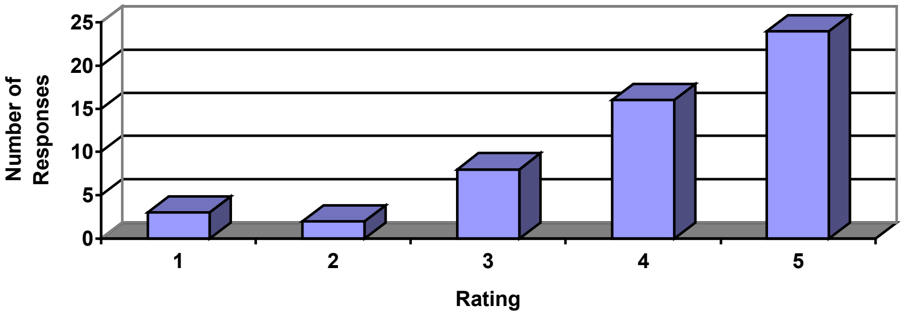
Methods of Interaction	a) Ways you have interacted with this Opinion Leader in an informal educational context	b) Most effective means of interaction in terms of an informal educational context
Informal one-on-one discussions	71.4% (40)	58.9% (33)
Group discussions (informal)	46.4% (26)	33.9% (19)
More formal educational activity	42.9% (24)	21.4% (12)
Telephone discussions	30.4% (17)	7.1% (4)
Other (specify) **	17.9% (10)	7.1% (4)

* Note: Percentages may not sum to 100% because of missing values.
** “Other” includes: dinner presentations, family meetings, chart reviews, consulting reports, being on committees together.

The influenced physicians were then asked whether they were going to continue to contact their opinion leader in the future when they had questions about ADRD. Over 90% of the physicians reported that they would continue to contact the opinion leader.

Finally, when asked to rate how effective this type of initiative was in helping to increase their knowledge in a particular area, almost 72% of the influenced physicians rated it as “effective” or “very effective”.

Figure 3: Effectiveness of Opinion Leader Initiative in Increasing Knowledge



Note: 1=not at all effective, 2=not that effective, 3=somewhat effective, 4=effective, 5=very effective

4.0 The Peer Presenter Program

4.1 Purpose

The overall goal of the Peer Presenter Program was to enhance the knowledge and confidence levels of family physicians and general practitioners across Ontario related to ADRD through formal educational activities (i.e., interactive and didactic education sessions).

4.2 Overview of Peer Presenter Program

Individuals who were serving as Opinion Leaders under Initiative #2 – Physician Training were invited to participate in the Peer Presenter Program. Opinion Leaders who expressed an interest attended a workshop where they learned more about the program and about small group facilitation.

To assist the peer presenters in undertaking their role, the peer presenters were provided with educational materials developed by the Curriculum Design Committee (including presentation notes, PowerPoint slides, and case studies). In addition, a staff member from the Ontario College of Family Physicians was available to assist the peer presenters with the organization and marketing of their education events. Peer presenters were expected to provide a minimum of two educational sessions through the Peer Presenter Program. The Peer presenters were provided with an honorarium to help offset the time required to prepare for and administer the educational event.

Two Peer Presenter workshops were held – one in September 2004 and the other in March 2005. A total of 36 individuals participated in these workshops.

4.3 Overview of the Evaluation of the Peer Presenter Program

The primary focus of the evaluation of the Peer Presenter Program was on those who participated in the educational activities undertaken by the peer presenters.

It was anticipated that the peer presenters would undertake one or two types of educational sessions: interactive, small group sessions or didactic sessions (e.g., hospital grand rounds). An evaluation strategy for each type of educational activity was developed.

The evaluation of interactive, small group sessions included the following:

- a pre-session questionnaire to assess the participants' knowledge and level of confidence related to the topic covered in the session;
- a session feedback questionnaire to gather feedback on the session as well as information on how the participant planned to apply what was learned in the session; and
- a follow-up questionnaire to again assess the participants' knowledge and level of confidence related to the session topic.

The evaluation of didactic sessions included the following:

- a session feedback questionnaire to gather feedback on the session as well as information on how the participant planned to apply what was learned in the session (this questionnaire was the same as that used for the interactive education sessions).

The peer presenters were responsible for administering the session evaluation forms for the interactive and didactic sessions. The pre-session and follow-up questionnaires used with the interactive education sessions were administered by the Ontario College of Family Physicians or the group responsible for coordinating the peer presenter's event.

Completed questionnaires were sent to the Evaluation Consultant and were coded, entered and analyzed. The following provides a summary of the results.

4.4 Overview of Education Sessions

4.4.1 Interactive Education Sessions

Between March 1, 2004 and September 30, 2005, there were 48 interactive education sessions conducted by the peer presenters. The number of attendees was provided for 16 of these sessions but was unavailable for 32 of the 48 sessions (e.g., because attendance was not taken or because this information was not submitted by the peer presenter). An estimate of the minimum number of participants in the 48 sessions was therefore calculated. For each session where the number of participants was not known, the greatest number of questionnaires submitted for that session (either pre-workshop, session evaluation or follow-up questionnaire) was used as the estimate for the number of participants in that session. Using these estimates along with the number of participants in the other 16 sessions, it was estimated that at least 638 physicians participated in the 48 peer presenter interactive education sessions.

For the 48 sessions, 309 pre-questionnaires, 466 session evaluation forms, and 205 follow-up evaluation forms were completed (see Table 14).

Table 14: Information about the Interactive Education Sessions

Type of Session	Number of Sessions	Estimated Number of Participants *	Number Completing Questionnaires	
Interactive	48	638 **	Pre Session Follow-up	309 537 284

* The number of participants is underestimated since information on the number of attendees was not provided for 32 of the 48 sessions. See explanation above.
** Estimate includes 49 participants from 2 sessions where the wrong form was used for one or more of the evaluations. Data from these questionnaires were not used in the analyses presented in this report.

A wide range of topics was covered in the 48 interactive sessions including the assessment and diagnosis of dementia, treatment and management, and challenging behaviours (see Table 15).

Table 15: General Topic Areas of Interactive Sessions

- Assessment / Diagnosis (including practical office-based assessment) (14)
- Treatment and Management (8)
- Challenging Behaviours (8)
- Overview of Alzheimer Disease / Dementia (7)
- Dementia and Driving (6)
- Advance Care Planning (2)
- Starting, Monitoring, Switching and Stopping Cholinesterase Inhibitors (1)
- Various topics (1)
- Other * (5)

* Numbers sum to more than 48 because some topics covered more than one area.
**“Other” includes: identifying and treating risk factors for dementia; dementia and depression; delirium and dementia; Lewy-body dementia; fronto-temporal dementia.

4.4.2 Didactic Education Sessions

In terms of didactic sessions, there were 7 sessions held between March 1, 2004 and September 30, 2005. Information on the number of attendees was only available for one of the seven sessions. A total of 74 questionnaires were completed by participants in the 7 sessions; however, in one session the wrong questionnaire was used. Forty individuals participated in this session; therefore, the total number of questionnaires available for analysis was 34 (see Table 16).

Table 16: Information about the Didactic Education Sessions

Type of Session	Number of Sessions	Number Completing Questionnaire *
Didactic	7	74 received 34 used **

* The response rate was not calculated since the number of participants was only known for one session.
** Data from only 34 of the 74 questionnaires received were entered and analyzed because for one session (where there were at least 40 participants) the wrong evaluation form was used.

The topics presented in the seven didactic sessions are summarized in Table 17. The assessment and treatment of dementia was the topic presented most frequently.

Table 17: General Topic Areas of Didactic Sessions

- Assessment / Treatment (including Practical Office Based Assessment) (3)
- Overview of Alzheimer Disease (1)
- Starting, Monitoring, Switching and Stopping Cholinesterase Inhibitors (1)
- Dementia and Driving (1)
- End of Life Care in Dementia (1)

4.5 Highlights of Evaluation Results

4.5.1 Interactive Sessions

Pre-Session Questionnaire

Participants were asked to complete the pre-session questionnaire prior to attending the interactive session. As indicated above, 309 completed questionnaires were received.

On the pre-workshop questionnaire, participants were asked to rate two things: (1) their current level of knowledge of the topic area of the session they planned to attend and (2) their level of confidence in the topic area of the session they planned to attend. The first rating was made on a 5-point scale where 1=poor, 2=fair, 3=good, 4=very good and 5=excellent. The second rating was also made on a 5-point scale; in this case 1=not confident, 2=slightly confident, 3=fairly confident, 4=quite confident and 5=very confident. Results from these two ratings are presented in Tables 5 and 6.

The majority of respondents rated their level of knowledge in the topic area of the sessions they planned to attend as “fair” or “good” (average rating of 2.5).

Table 18: Rating of the Level of Knowledge in the Topic Area

How would you rate your current level of knowledge regarding the topic area?	Poor (1)	Fair (2)	Good (3)	Very Good (4)	Excellent (5)	Mean (SD)
	10.0% (31)	42.4% (131)	35.3% (109)	9.7% (30)	1.0% (3)	2.5 (.84)

* Percentages may not sum to 100% because of missing values.

In terms of confidence, the average rating (2.5) was similar with the majority of respondents rating their level of confidence as "slightly confident or "fairly confident" (see Table 19).

Table 19: Rating of the Level of Confidence in the Topic Area

How would you rate your current level of confidence in the topic area?	Not Confident (1)	Slightly Confident (2)	Fairly Confident (3)	Quite Confident (4)	Very Confident (5)	Mean (SD)
	13.3% (41)	34.9% (108)	38.8% (120)	11.0% (34)	0	2.5 (.86)

* Percentages may not sum to 100% because of missing values.

In the final question on the pre-session questionnaire, participants were asked to indicate how they thought the session they were to attend would make a difference to their practice. They were also asked to outline the steps they would need to take in order to integrate this new knowledge into their practice. Responses to these questions are presented in Table 20.

Table 20: Impact of the Session on Participants' Practice

How the session would make a difference to their practice:

- Increased knowledge/understanding (e.g., of types of dementia, symptoms, medications, behaviours, therapy options, etc.) (94)
- Improved skills (e.g., screening, management, approach to patients with dementia) (74)
- Increased confidence/comfort (e.g., re: medications, assessment, driving issues, etc.) (52)
- Improved support/communication with patients and caregivers (22)
- Use / Improved use of assessment tools (17)
- Better use of consultants (15)
- Improved decision-making (12)
- Improved quality of life / quality of care for patients (11)
- More time spent with dementia patients (3)
- Able to care for more patients myself (3)
- Earlier identification (3)
- Other **
- Unsure / Don't know (13)

Steps participants will need to take in order to integrate this knowledge into their practice:

- Use the knowledge gained (soon) (35)
- Establish a strategy/approach to the assessment, treatment and/or management of patients with dementia (or those suspected of having dementia) (18)
- Share information learned with peers, colleagues (10)
- Read additional materials (8)
- Use assessment tools in practice (9)
- Learn from other participants (8)
- Change my practice as required (e.g., re: screening practices, use of tools, medications) (7)
- Review materials as needed; have materials readily available (7)
- Have discussions with patients and caregivers (5)

- Review treatments and behavioural strategies being used with current patients (make changes where appropriate) (5)
- Other ***
- Don't know (5)

* Note: More than one response could be provided by participants.
** "Other" includes: comparing how my practice meets standards; dealing with the psychosocial aspects of dementia; hope to identify more who need their driver's license revoked.
*** "Other" includes: having regular follow-ups with patients with dementia; improving documentation.

Session Evaluation Questionnaire

The session evaluation form was administered at the end of the interactive education activity. A total of 537 participants completed this questionnaire.

In the first question, participants were asked to rate the extent to which the learning objectives of the session were met (using a 5-point scale where 1=not at all and 5=completely). The average rating was 4.3, indicating that the learning objectives were met (see Table 21).

Table 21: Learning Objectives

To what extent were the learning objectives met?	
Mean	4.3
Standard Deviation	0.64
Range	2 – 5

Participants were then asked to rate the relevance of the information presented in the session (using a 5-point scale where 1=not at all relevant and 5=very relevant). The average rating was 4.4 indicating that the information presented in the sessions was relevant to the respondents' practice (see Table 22).

Table 22: Relevance of Information Presented

How relevant was the information presented in this session to your practice?	
Mean	4.4
Standard Deviation	0.77
Range	1 – 5

Participants were then asked if the format of the session was suitable for the information being presented. Ninety-six percent of the respondents reported that the format of the session was suitable (see Table 23).

Table 23: Suitability of Session Format

Was the format of the session suitable for the information presented?	
No	2.0% (11)
Yes	96.1% (516)

* Percentages may not sum to 100% because of missing values.

Participants were then asked if they were going to make any changes to their practice as a result of what they learned in this session. Those who responded "yes" were then asked to indicate what change(s) they planned to make. Responses to these questions are presented in Table 24.

Almost 80% of the respondents reported that they planned to make changes to their practice as a result of what they learned in the education session they attended. The types of changes they identified included: changes related to the assessment of dementia; changes related to medication use; and changes related to the use of assessment tools and other resources.

Table 24: Changes to Practice

Will you make any changes to your practice as a result of what you learned in this session?	
No	13.4% (72)
Yes	78.8% (423)

* Percentages may not sum to 100% because of missing values.

In the final question on the Session Evaluation Form, participants were asked to rate their understanding of the aspect of dementia addressed in the session "now" (i.e., at the end of the session) compared with their understanding "prior to the session". Ratings were made on a 5-point scale (where 1=much less clear than before, 2=less clear than before, 3=about the same, 4=clearer than before and 5=much clearer than before). Results are presented in Table 25.

Almost 91% of the respondents indicated that their level of understanding about the topic was "clearer than before" or "much clearer than before" the session.

Table 25: Understanding of the Topic

How would you rate your understanding of this aspect of dementia now compared with your understanding prior to the session?	Much less Clear than Before (1)	Less Clear than Before (2)	About the Same (3)	Clearer than Before (4)	Much Clearer than Before (5)
	0.2% (1)	0.4% (2)	7.8% (42)	63.2% (339)	27.6% (148)

* Percentages may not sum to 100% because of missing values.

Follow-up Questionnaire

The follow-up questionnaire was administered to the participants approximately 2-3 months after the session. A total of 284 participants completed this questionnaire.

Participants were asked to provide at least one example of how they applied what they learned in the session to their practice. They were then asked to identify what factors helped them in applying what they learned and what obstacles or challenges they faced in trying to apply what they learned. Responses to these questions are summarized in Tables 26a, 26b and 26c.

Table 26a: Examples of How Participants Applied what they Learned

- Examples related to assessment / screening (84)
- Examples related to medications (63)
- Examples related to driving assessments (41)
- Examples related to the use of assessment tools (46)
- Examples related to POA / ACP (12)
- Examples related to Education / Support / Communication with Family (10)
- Other examples (19)

* Note: More than one response could be provided by participants.

Table 26b: Factors that Helped the Participants Apply what they Learned

- The information presented in the session / the resources provided in the session / greater understanding gained from the session (108)
- Group discussion during the session (19)
- Increased confidence in diagnosis and treatment (14)
- Developing a strategy/approach to dealing with dementia (5)
- Recognition of the legal responsibilities re: fitness to drive, ACP (9)
- Examples provided/discussed during the session (9)
- Other **

* Note: More than one example could be provided.

** Examples of "other" includes: reassurance form presenter that action was appropriate; renewed interest in dementia promoted case-finding; course presentation; support of a multidisciplinary team; having a patient(s) in my practice with dementia.

Table 26c: Challenges / Obstacles faced in trying to Apply what they Learned

- Time (e.g., to conduct proper assessment, to review material from session, to administer MMSE, to counsel families, etc.) (86)
- Patient / Family resistance (e.g., to accepting diagnosis of dementia, to start new/another medication, appoint a POA, etc.) (42)
- No challenges faced (38)
- Medication-related challenges (e.g., dose suggested in session by specialist too high – resulted in adverse effects; large number of meds residents are on when admitted to LTC – takes time to sort out issues; assessing response to treatment; interaction of medications; using meds you're not as familiar with; cost of medications; finding appropriate medications to assist with behaviours) (21)
- Patient / Family compliance (e.g., re: medications, assessments, follow-up assessments) (14)
- Amount of information to remember; subjective nature of dementia – need more time to become adept (8)
- Infrequent exposure to patients with dementia (7)
- Dealing with frustrated/angry patients/family members (6)
- Dealing with loss of independence of seniors (5)
- Knowing the patient well and having to inform of diagnosis, take away license, etc. (4)
- Other **

* Note: More than one example could be provided.

** Examples of "other" includes: procedures involved in reporting to the Ministry; gathering information from family members; limitations of MMSE; language or cultural barriers or education level; not knowing the patient well; the fact that we can't do much to stop the progression of dementia; self-doubts/insecurities; limited community resources; rural location – challenge to get forms because of limited access to Internet; learned very little from session; etc.

Participants were then asked to make two ratings – the first regarding their knowledge about the topic area of the session they attended and the second regarding their level of confidence in this area. These two questions and the rating scales used were the same as those used in the pre-session questionnaire.

When the ratings from all of the respondents are considered (N=284), the majority rated their level of knowledge as "good" or "very good" (average rating 3.4) (see Table 27a).

Table 27a: Rating of the Level of Knowledge in the Topic Area after the Session – All Respondents (N=284)

How would you rate your current level of knowledge regarding the topic area?	Poor (1)	Fair (2)	Good (3)	Very Good (4)	Excellent (5)	Mean (SD)
	0	7.7% (22)	43.0% (122)	43.7% (124)	3.9% (11)	3.4 (.70)

* Percentages may not sum to 100% because of missing values.

When the ratings of those who completed *both* the pre-session and follow-up questionnaires are considered (N=160), the average rating on the pre-session questionnaire was 2.5 and the average rating on the follow-up questionnaire was 3.4. This difference was statistically significant (see Table 27b).

Table 27b: Comparison of Pre and Follow-up Knowledge Ratings (N=160)

Pre-Session Questionnaire Average Rating (SD)	Follow-up Questionnaire Average Rating (SD)	Mean Difference (follow-up – pre)
2.5 (.81)	3.4 (.72)	0.97 ***

* p<0.05; ** p<0.01; *** p<0.001

Similar comparisons were made with the ratings involving level of confidence in the topic area of the sessions attended. When data from all of the respondents are considered, the majority rated their level of confidence as "fairly confident" or "quite confident" (see Table 28a).

Table 28a: Rating of the Level of Confidence in the Topic Area after the Session – All Respondents (N=284)

How would you rate your current level of confidence in the topic area?	Not Confident (1)	Slightly Confident (2)	Fairly Confident (3)	Quite Confident (4)	Very Confident (5)	Mean (SD)
	0	4.6% (13)	46.5% (132)	43.7% (124)	3.5% (10)	3.5 (.65)

* Percentages may not sum to 100% because of missing values.

When the ratings of those who completed *both* the pre-session and follow-up questionnaires are considered, the average rating on the pre-session questionnaire was 2.5 and the average rating on the follow-up questionnaire was 3.5. This difference was statistically significant (see Table 28b).

Table 28b: Comparison of Pre and Follow-up Confidence Ratings (N=159)

Pre-Session Questionnaire Average Rating (SD)	Follow-up Questionnaire Average Rating (SD)	Mean Difference (follow-up – pre)
2.5 (.84)	3.5 (.67)	1.02 ***

* p<0.05; ** p<0.01; *** p<0.001

4.5.2 Didactic Sessions

In the first question, participants were asked to rate the extent to which the learning objectives of the session were met (using a 5-point scale where 1=not at all and 5=completely). The average rating was 4.6, indicating that the learning objectives were met (see Table 29).

Table 29: Learning Objectives

To what extent were the learning objectives met?	
Mean	4.6
Standard Deviation	.56
Range	3 – 5

Participants were then asked to rate the relevance of the information presented in the session (using a 5-point scale where 1=not at all relevant and 5=very relevant). The average rating was 4.8 indicating that the information presented in the sessions was relevant to the respondents' practice (see Table 30).

Table 30: Relevance of Information Presented

How relevant was the information presented in this session to your practice?	
Mean	4.8
Standard Deviation	.50
Range	3 – 5

Participants were then asked if the format of the session was suitable for the information being presented. Ninety-seven percent of the respondents reported that the format of the session was suitable (see Table 31).

Table 31: Suitability of Session Format

Was the format of the session suitable for the information presented?	
No	0
Yes	97.1% (33)

* Percentages may not sum to 100% because of missing values.

Next, participants were asked if they were going to make any changes to their practice as a result of what they learned in this session. Those who responded "yes" were then asked to indicate what change(s) they planned to make. Eighty-five percent reported that they planned to change their practice. Examples of the types of changes included: changes in their assessment of patients and changes related to medications, particularly the use of anticholinergics (see Table 32).

Table 32: Changes to Practice

Will you make any changes to your practice as a result of what you learned in this session?	
No	8.8% (3)
Yes	85.3% (29)

* Percentages may not sum to 100% because of missing values.

In the final question, participants were asked to rate their understanding of the topic area after the session compared with their understanding prior to the session. Ratings were made on a 5-point scale (where 1=much less clear than before, 2=less clear than before, 3=about the same, 4=clearer than before and 5=much clearer than before) and are presented in Table 33.

Over 94% of the respondents reported that their level of understanding after the session was "clearer" or "much clearer" than it was before the session.

Table 33: Understanding of the Topic

How would you rate your understanding of this aspect of dementia now compared with your understanding prior to the session?	Much less Clear than Before (1)	Less Clear than Before (2)	About the Same (3)	Clearer than Before (4)	Much Clearer than Before (5)	Mean (SD)
	0	0	5.9% (2)	67.6% (23)	26.5% (9)	4.2 (.54)

* Percentages may not sum to 100% because of missing values.

5.0 The Family Medicine Preceptor Program

5.1 Purpose

The overall goal of the Family Medicine Preceptor Program was to enhance the knowledge, skills and competencies of family medicine preceptors in the area of ADRD. It was anticipated that these enhancements would lead to improved opportunities for family medicine residents for education in the primary care of individuals with ADRD within a community-based family medicine context. It was also expected that they would be better positioned to participate in faculty development in the area of ADRD.

5.2 Overview of Family Medicine Preceptor Program

The Family Medicine Preceptorship Program included three components:

1. a one-day workshop
    - the goal of which was to enhance preceptors' knowledge of ADRD and provide them with strategies for teaching ADRD to family medicine residents

2. 3-4 half-day practicums
    - the purpose of the practicums was to increase preceptors' knowledge and understanding of the services available to assist those with dementia and their caregivers

3. monthly teleconferences
    - monthly teleconferences with geriatric specialists were expected to provide additional opportunities to increase preceptors' knowledge of ADRD, and provide a forum to discuss successes and challenges associated with educating family medicine residents about ADRD.

The workshop was piloted in May 2003 with preceptors from Queen's University and the University of Ottawa. Based on the results from the pilot session, the workshop was increased to one and one-half days in length. The provincial rollout of the program began in Winter 2004.

5.3 Evaluation Overview

The evaluation of the Family Medicine Preceptor Program included the following components:

1. a pre-workshop questionnaire aimed at gathering information on the characteristics of the preceptors, assessing preceptors' knowledge of ADRD, identifying barriers to teaching family medicine residents, and gathering information on their preceptor roles;

2. a post-workshop questionnaire to gather feedback on the one-day workshop; and

3. a follow-up questionnaire to assess any changes in knowledge related to ADRD and gather information on preceptor activities.

There is also a plan to gather feedback on the practicum and teleconference components of this program. However, at the time this report was written only a few preceptors had participated in a practicum and the teleconferences had not yet begun.

The following provides a summary of the results from the evaluation data available to date (i.e., January 2006).

5.4 Highlights of Evaluation Results

5.4.1 Response Rates

A total of 4 sessions were conducted involving family medicine preceptors from McMaster, Toronto, Ottawa and Queen's Universities, and the Northern Ontario School of Medicine in Sudbury. Table 34 provides an overview of the number of participants in each of the sessions and the questionnaire response rates.

Table 34: Response Rate on Questionnaires

Site	Number of Participants	Percent (Number) Completing Pre-Workshop Questionnaire	Percent (Number) Completing Follow-up Questionnaire
McMaster	4	75.0% (3)	25% (1)
Toronto	7	100% (7)	28.6% (2)
Queen's / Ottawa	10	90.0% (9)	40% (4)
Sudbury	31	80.6% (25)	N/A*

* At the time this report was written, the follow-up questionnaires had not been administered to the preceptors who participated in the Sudbury session.

5.4.2 Preceptor Demographic and Practice Characteristics

The preceptors who participated in the workshops had been in practice for an average of 17 years and had spent an average of about 7 years as preceptors to family medicine residents. Approximately 60% of the respondents were male and 41% practiced in a long-term care home. Over one-third of the preceptors practiced in an urban setting, one-quarter practiced in a suburban area, and over 20% practiced in a rural area (see Table 35).

Table 35: Demographic and Practice Characteristics

Characteristic	N=44
Gender	
male	59.1% (26)
female	40.9% (18)
Number of years in practice	
mean (SD)	17.1 (11.3)
range	<1 – 58 years
Number of years as Preceptor for Family Medicine Residents	
mean (SD)	6.9 (6.7)
range	Range: 0 – 26 years
% (#) currently practicing in a long-term care home	40.9% (18)
Practice Setting:	
urban	36.4% (16)
suburban	25.0% (11)
rural	22.7% (10)
other **	9.0% (4)

* Percentages may not sum to 100% because of missing values.
** "Other" includes: inner city and remote/isolated.

5.4.3 Preceptor Comfort Levels

On the pre-workshop questionnaire, preceptors were asked to rate how comfortable they currently feel in their ability to manage ADRD issues in their practice, using a scale of 1 to 5 (where 1 = "not at all comfortable"; 2 = "not very comfortable"; 3 = "fairly comfortable"; 4 = "very comfortable"; and 5 = "extremely comfortable"). The majority of preceptors reported being "fairly comfortable" (see Table 36).

Table 36: Comfort Level in Managing Alzheimer Disease and Related Dementias

	Not at all comfortable 1	**Not very comfortable 2**	**Fairly comfortable 3**	**Very comfortable 4**	**Extremely comfortable 5**	**Mean (SD)**
Ability to manage ADRD	0	18.2% (8)	59.1% (26)	9.1% (4)	11.4% (5)	3.1 (.86)

* Note: Percentages may not sum to 100% because of missing values.

The preceptors were then asked to rate how easy or difficult they find a variety of aspects of care using a 5-point scale (where 1 = "always difficult"; 2 = "often difficult"; 3 = "sometimes easy/sometimes difficult"; 4 = "often easy"; and 5 = "always easy"). For the areas of "assessment and diagnosis", "treatment" and "management" a number of questions were asked using the same response format. Within the "assessment and diagnosis" area participants were asked to rate how easy or difficult they found differentiating mild memory loss from dementia, diagnosing Alzheimer disease, diagnosing more unusual causes of dementia, assessing behavioural problems, capacity and competence and driving safety, informing patients of a diagnosis of ADRD, and informing family members of patients of a diagnosis of ADRD. Under the "treatment of dementia" category, they were asked about the ease or difficulty in deciding when to treat with cognitive enhancers, the use of cholinesterase inhibitors, monitoring the response to cholinesterase inhibitors, and the use of medications to manage behavioural challenges. Finally, under the "management of dementia" category, they were asked about the ease or difficulty in managing wandering, agitation, aggression and incontinence, and discussing advance care planning.

For each overall area, a composite measure was calculated for each respondent by summing their scores for each of the sub-questions and then dividing by the number of sub-questions. Table 37 presents the results from these composite scores. Average scores on the composite measures ranged from 2.7 for the management of dementia to 3.1 for identifying those at risk for dementia. All of the average scores indicated that, on average, the preceptors found these aspects of dementia care "sometimes easy/sometimes difficult".

Table 37: Level of Ease/Difficulty with Various Aspects of Dementia

How easy or difficult do you find the following tasks?	**Mean (SD)**
Identifying those at risk for dementia	3.1 (.80)
Assessment and diagnosis of dementia	2.8 (.60)
Treatment of dementia	2.9 (.79)
Management of dementia	2.7 (.69)

Preceptors were then asked about practice barriers that detracted them from being able to care effectively for persons with ADRD. Almost three-quarters of the respondents reported that practice barriers existed. The specific practice barriers identified are summarized in Table 38).

Table 38: Are there Practice Barriers?

Are there practice barriers that detract you from your ability to care effectively for persons affected by ADRD?	Percent (Number) of Preceptors
No	22.7% (10)
Yes	72.7% (32)
If yes, what are the barriers?	**Percent (Number) Identifying this as a Barrier (N=32)**
Inadequate Time	71.9% (23)
Inadequate Specialist Support	50.0% (16)
Inadequate Community Resources	50.0% (16)
Inadequate Remuneration	43.8% (14)
Inadequate Physician CME	25.0% (8)
Inadequate Patient Education Resources	15.5% (5)
Other	15.6% (5)

* Note: Percentages may not total 100% because of missing values.

5.4.4 Role as a Preceptor for Family Medicine Residents

Preceptors were asked to estimate the number of times in the 3 months preceding the survey they had served as a resource to family medicine residents regarding the care of a patient with dementia. The average number of times was 2, ranging from 0 to 10 (see Table 39).

Table 39: Acting as Resource to Family Medicine Residents

	Number of Times Acting as a Resource to Family Medicine Residents in Previous 3 Months re: Care of Dementia Patients
Mean	2.0 times
SD	2.6
Range	0 – 10 times

The preceptors were then asked to rate their level of confidence in serving as a preceptor to family medicine residents regarding the care of a patient with dementia using a 5-point scale (where 1 = "not at all confident", 2 = "slightly confident", 3 = "fairly confident", 4 = "quite confident" and 5 = "very confident"). The average rating was 2.6, or between "slightly" and "fairly" confident (see Table 40).

Table 40: Ratings of Confidence in Ability to Act as Preceptor

	Not Confident 1	Slightly Confident 2	Fairly Confident 3	Quite Confident 4	Very Confident 5	Mean (SD)
Ability to act as a Preceptor re: care of patients with dementia	11.4% (5)	31.8% (14)	36.4% (16)	11.4% (5)	2.3% (1)	2.6 (.93)

* Note: Percentages may not total 100% because of missing values.

When asked if there were barriers that detracted them from their ability to undertake their role as preceptor to family medicine residents regarding the care of a patient with dementia, 71% of the preceptors said “yes” (see Table 41). When asked to identify what barriers existed, over two-thirds of the preceptors reported inadequate time and over 50% reported “inadequate personal knowledge” as barriers.

Table 41: Barriers to Undertaking Preceptor Role

Are there barriers that detract you from your ability to undertake the role of preceptor to family medicine residents regarding the care of a patient with dementia?	**Percent (Number) of Preceptors**
No	15.9% (7)
Yes	70.5% (31)
If yes, what are the barriers?	**Percent (Number) Identifying this as a Barrier (N=31)**
Inadequate time	67.7% (21)
Inadequate personal knowledge	51.6% (16)
Inadequate access to suitable teaching materials	32.2% (10)
Inadequate remuneration	32.3% (10)
Inadequate community resources	25.8% (8)
Inadequate specialist support	25.8% (8)
Inadequate patient education resources	9.7% (3)

* Note: Percentages may not total 100% because of missing values.

The preceptors were also asked if there were barriers that detracted them from their ability to participate in faculty development. Twenty preceptors (46%) reported that such barriers did exist (see Table 42). “Inadequate time” was identified as a barrier by 95% of the preceptors and “inadequate remuneration” by 40% of the preceptors.

Table 42: Barriers to Participating in Faculty Development

Are there barriers that detract you from your ability to participate in faculty development?	**Percent (Number) of Preceptors)**
No	38.6% (17)
Yes	45.5% (20)

* Note: Percentages may not total 100% because of missing values.

5.4.5 Post-Workshop Questionnaire

At the time this report was written, only seven preceptors from the first three sessions had completed the post-workshop questionnaire. The questionnaires for the preceptors in the fourth session (Sudbury) had not yet been distributed. Because of the small number of completed questionnaires, caution must be taken in drawing conclusions from these data.

Comparison of Preceptor Comfort Levels on the Pre-Workshop and Post-Workshop Questionnaires

The following provides a comparison of the data on preceptor comfort levels from the pre and post workshop questionnaires. The data presented only include scores from preceptors who completed both the pre and post workshop questionnaires. Therefore, the maximum number of respondents included in any comparison is seven. Because of the small number of respondents included in the calculations, statistical analyses were not conducted.

When asked to rate how comfortable they were in their ability to manage ADRD issues in their practice (using a 5-point scale, where 1 = "not at all comfortable"; 2 = "not very comfortable"; 3 = "fairly comfortable"; 4 = "very comfortable"; and 5 = "extremely comfortable"), the average score was 3.8 on the pre-questionnaire and 3.6 on the post-questionnaire, a difference of -0.2 (see Table 43).

Table 43: Comfort Level in Managing Alzheimer Disease and Related Dementias

	Pre-Workshop: Mean (SD)	Post-Workshop: Mean (SD)	Mean Difference
Comfort in ability to manage ADRD issues in your practice	3.80 (.84)	3.60 (.89)	-.20

The preceptors were then asked to rate how easy or difficult they found a variety of aspects of care using a 5-point scale (where 1 = "always difficult"; 2 = "often difficult"; 3 = "sometimes easy/sometimes difficult"; 4 = "often easy"; and 5 = "always easy"). For the areas of "assessment and diagnosis", "treatment" and "management" a number of questions were asked using the same response format. Within the "assessment and diagnosis" area participants were asked to rate how easy or difficult they found differentiating mild memory loss from dementia, diagnosing Alzheimer disease, diagnosing more unusual causes of dementia, assessing behavioural problems, capacity and competence and driving safety, informing patients of a diagnosis of ADRD, and informing family members of patients of a diagnosis of ADRD. Under the "treatment of dementia" category, they were asked about the ease or difficulty in deciding when to treat with cognitive enhancers, the use of cholinesterase inhibitors, monitoring the response to cholinesterase inhibitors, and the use of medications to mange behavioural challenges. Finally, under the "management of dementia" category, they were asked about the ease or difficulty in managing wandering, agitation, aggression and incontinence, and discussing advance care planning.

Within each overall area, results from the individual sub-questions were consistent; that is, mean follow-up scores were higher than (or equivalent to) the mean pre-scores. As a result, a composite measure was calculated for each respondent by summing their scores for each of the sub-questions and then dividing by the number of sub-questions. Table 44 presents the results from these composite scores.

In each case, the post-workshop score was higher than the pre-workshop score, indicating that the respondents found greater ease in undertaking the task after the workshop than they had prior to the workshop.

Table 44: Level of Ease/Difficulty with Various Aspects of Dementia

How easy or difficult do you find the following tasks?	Pre-Workshop: Mean (SD)	Post-Workshop: Mean (SD)	Mean Difference
Identifying those at risk for dementia	3.25 (.50)	3.25 (.96)	0
Assessment and diagnosis of dementia	2.61 (.52)	3.00 (.63)	.39
Treatment of dementia	3.04 (.39)	3.32 (.64)	.29
Management of dementia	2.69 (.30)	3.00 (.76)	.31

Role as a Family Medicine Preceptor

On both the pre-workshop and post-workshop questionnaires, the preceptors were asked to estimate the number of times in the preceding three months they had served as a resource to family medicine residents regarding the care of a patient with dementia. The average number of times was 3.6 on the pre-workshop questionnaire and 7.4 on the post-workshop questionnaire (see Table 45).

Table 45: Acting as Resource to Family Medicine Residents

	Number of Times Acting as a Resource to Family Medicine Residents in Previous 3 Months re: Care of Dementia Patients	
	Pre-Workshop	**Post-Workshop**
Mean	3.57 times	7.43 times
SD	3.6	8.2
Range	0 – 10 times	2 – 25 times

The preceptors were then asked to rate their level of confidence in serving as a preceptor to family medicine residents regarding the care of a patient with dementia using a 5-point scale (where 1 = "not at all confident", 2 = "slightly confident", 3 = "fairly confident", 4 = "quite confident" and 5 = "very confident"). The average rating was 2.6 on the pre-workshop questionnaire (or between "slightly" and "fairly" confident) and 4.0 (or "quite confident") on the post-workshop questionnaire (see Table 46).

Table 46: Ratings of Confidence in Ability to Act as Preceptor

Ability to act as a Preceptor re: care of patients with dementia	**Not Confident 1**	**Slightly Confident 2**	**Fairly Confident 3**	**Quite Confident 4**	**Very Confident 5**	**Mean (SD)**
Pre-Workshop Questionnaire	14.3% (1)	28.6% (2)	42.9% (3)	14.3% (1)	0	2.6 (.98)
Post-Workshop Questionnaire	0	0	28.6% (2)	42.9% (3)	28.6% (2)	4.0 (.82)

* Note: Percentages may not total 100% because of missing values.

6.0 Advance Care Planning for Family Physicians

6.1 Purpose and Program Overview

During the implementation of the Alzheimer Strategy, it was recognized that there was a need for further education for family physicians in the area of advance care planning (ACP). As a result, the ACP Program developed under Initiative #7 of the provincial Alzheimer Strategy was customized to deliver ACP workshops to physicians.

In fall 2003, ACP sessions were held for physicians in four areas: Sudbury, Toronto, Ottawa and London. The format of the sessions involved:

- a didactic session
- small group discussion of cases and
- reporting back the discussion of small group results to the larger group.

6.2 Overview of Evaluation

In order to evaluate the ACP sessions, participants completed three questionnaires:

Questionnaire	When Administered	Content
Pre-workshop Questionnaire	- prior to workshop	- characteristics of participants - previous training in ACP - understanding and confidence related to ACP - their role and the roles of others in their agency/organization re: ACP - agency/organization performance in promoting and supporting ACP - existence of agency/organization policies and procedures related to ACP
Session Evaluation Form	- immediately following workshop	- feedback on session - repeated questions re: understanding and confidence related to ACP - repeated questions: agency/organization performance in promoting and supporting ACP - plans to use information learned in session; anticipated challenges in utilizing session information
Follow-up Questionnaire	- approx. 3 months post-workshop	- how session information was applied and challenges faced - repeated questions re: understanding and confidence related to ACP - repeated questions: agency/organization performance in promoting and supporting ACP - determination of whether agency/organization policies and procedures were reviewed - plans to develop or revise policies and procedures re: ACP

6.3 Participants and Response Rates

A total of 48 physicians participated in the four sessions, ranging from 8 participants in the London session to 16 participants in the Ottawa session.

Table 47: Number of Physicians by Session

Session	Number of Physicians Participating
London	8
Ottawa	16
Sudbury	12
Toronto	12
TOTAL	48

The response rate on the pre-workshop questionnaire was 81%, 92% on the session evaluation form, and 65% on the follow-up questionnaire (see Table 48).

Table 48: Response Rates on ACP Questionnaires

Questionnaire	Response Rate (N=48)
Pre-workshop questionnaire	81.3% (39)
Session evaluation form	91.7% (44)
Follow-up questionnaire	64.6% (31)

6.4 Highlights of Evaluation Results

Pre-workshop questionnaire

In terms of the characteristics of those who participated in the ACP sessions, approximately 44% reported working in at least one LTC home. Of those, the average number of homes worked in was 1.6, ranging from 1 to 3 homes. Almost 13% of participants reported serving as a CCAC Medical Director, and almost 70% reported having hospital privileges.

When asked if they had any previous training in ACP, 21% of participants said "yes" (see Table 49).

Table 49: Previous training in ACP

Have you had any previous training in ACP?	
No	76.9% (30)
Yes	20.5% (8)

* Percentages may not sum to 100% because of missing values.

When asked if they played a role in ACP within their organization, almost 50% of participants said "yes". In describing the role that they played, most of the respondents said it was to discuss ACP issues with their patients and their families (see Table 50).

Table 50: Participant's Role in ACP

Do you play a role in ACP within your organization?	
No	33.3% (13)
Yes	48.7% (19)
If YES, please describe your role: - discuss ACP issues with my patients, their families, POAs (17) - available to assist nurses, residents, medical students (1) - as Medical Chief LTC (1) - identify need via FMM testing (1) - occasional capacity assessment for other patients (1)	

* Percentages may not sum to 100% because of missing values.

The participants were then asked if they had ever had a discussion with a patient about ACP. Almost 75% of respondents said "yes" (see Table 51). The average percent of their current patients with whom they have had such a discussion was 39%.

Table 51: Discussions with Patients regarding ACP

Have you ever had a discussion with a patient about ACP?	
No	15.4% (6)
Yes	74.4% (29)
If YES, with what percentage of your current patients would you have had such a discussion?	
Mean	39.1%
SD	40.4
Range	0 – 100%

Session Evaluation Form

When asked to rate the overall session on a scale of 1 to 5 (where 1="poor", 2= "fair", 3= "good", 4= "very good" and 5="excellent"), the average rating was 4.3 or between "very good" and "excellent" (see Table 52).

Table 52: Rating of Session

	Poor 1	**Fair 2**	**Good 3**	**Very Good 4**	**Excellent 5**	**Mean (SD)**
Overall, how would you rate today's session?	0	2.3% (1)	9.1% (4)	36.4% (16)	36.4% (16)	4.3 (.77)

* Percentages may not sum to 100% because of missing values.

The participants were then asked to identify the two most important things they learned in the session. These results are summarized in Table 53.

Table 53: Most Important Things Learned in the Session

- Issues related to SDMs (20)
- Legal aspects / legislation / terminology (17)
- Issues related to capacity / capacity board (13)
- Resources / Where to go for resources (6)
- Importance of discussing ACP; suggestions regarding how to discuss ACP issues (5)
- Issues related to the POA for Personal Care (4)
- Other (9)

In both the pre-training questionnaire and the session evaluation form, participants were asked to rate their confidence in a number of areas using a 5-point scale (where 1= "not confident", 2= "slightly confident", 3= "fairly confident", 4= "quite confident" and 5= "very confident"). A summary of these ratings are provided in Table 54.

The results show that in all cases, the average ratings on the session evaluation form were higher than those from the pre-training questionnaire. All of these differences were statistically significant.

Table 54: Comparison of Pre-training and Immediate Post-training Confidence Scores

How confident are you in ….	Pre-training Mean (SD)	Immediate Post-training Mean (SD)	Mean Difference (post-pre)
Your understanding of the legal obligations related to issues of consent and ACP?	2.3 (1.1)	4.0 (.65)	1.61 ***
Your ability to carry out your legal obligations related to ACP?	2.3 (1.0)	3.9 (.63)	1.66 ***
Your ability to initiate a conversation with an individual about issues of consent and ACP?	3.5 (1.2)	4.3 (.55)	0.77 ***
Your ability to facilitate ongoing ACP conversations?	3.3 (1.2)	4.1 (.67)	0.83 ***
Your ability to identify potential areas of conflict related to issues of consent and ACP?	2.5 (1.2)	4.0 (.75)	1.45 ***
Your ability to facilitate conflict resolution?	2.5 (1.1)	3.4 (.86)	0.87 ***
Your knowledge of the resources available to assist you in assisting others with issues of consent and ACP?	1.7 (.75)	3.9 (.87)	2.22 ***

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Similarly, participants were asked to rate their overall understanding of ACP on both the pre-training and session evaluation questionnaires using a 5-point scale (where 1= "poor", 2= "fair", 3= "good", 4= "very good" and 5= "excellent"). The results in Table 55 show that the average rating on the session evaluation form was higher than that on the pre-training form. This difference was statistically significant.

Table 55: Comparison of Pre-training and Immediate Post-training Understanding of ACP

	Pre-training Mean (SD)	Immediate Post-training Mean (SD)	Mean Difference (post-pre)
How would you rate your overall understanding of ACP?	2.1 (.84)	3.7 (.68)	1.63 ***

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

The participants were also asked to indicate how their level of understanding of ACP after the training session compared with their understanding prior to the training using a 5-point scale (where 1= “less than before”, 3= “about the same” and 5= “more than before”). All of the respondents rated this difference as a 4 or 5, indicating that they had a greater level of understanding immediately after the training (see Table 56).

Table 56: Level of Understanding Now Compared with Understanding Prior to Session

	Less now than before 1	2	About the Same 3	4	More than before 5	Mean (SD)
How does your level of understanding of ACP **now** compare with your level of understanding **prior** to today’s session?	0	0	0	29.5% (13)	65.9% (29)	4.7 (.47)

On both the pre-training and session evaluation questionnaires, the participants were asked to rate their agency’s/organization’s performance in terms of promoting and supporting ACP using a 5-point scale (where 1= “poor”, 2= “fair”, 3= “good”, 4= “very good” and 5= “excellent”). Table 57 shows that the average rating from the pre-training questionnaire was higher (although not significantly higher) than the average rating on the session evaluation form. This suggests that perhaps after gaining a better understanding of ACP, the participants realized that their agencies/organizations were not doing enough to support and promote ACP.

Table 57: Comparison of Agency/Facility Performance in Promoting & Supporting ACP

	Pre-training Mean (SD)	Immediate Post-training Mean (SD)	Mean Difference (post-pre)
How would you rate your agency’s / organization’s performance in terms of promoting and supporting ACP?	4.0 (2.8)	2.6 (1.1)	- 1.3

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Participants were then asked to rate their agency’s/organization’s policies and procedures in terms of promoting and supporting ACP using a 5-point scale (where 1=”poor”, 2= “fair”, 3= “good”, 4= “very good” and 5=”excellent”). The average rating was 2.8 or approaching “good” (see Table 58). Nine participants said that their agency/organization did not have any policies or procedures in place.

Table 58: Rating of Policies and Procedures in terms of Supporting and Promoting ACP

	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)	N/A
How would you rate your facility’s policies and procedures in terms of promoting and supporting ACP?	6.8% (3)	15.9% (7)	18.2% (8)	13.7% (6)	2.3% (1)	2.8 (1.1)	20.5% (9)

* Percentages may not sum to 100% because of missing values.

When asked if they planned to develop or revise (or if they had already developed or revised) any policies and procedures related to ACP within their agency/organization, almost 60% of respondents said “yes” (see Table 59).

Table 59: Development or Revision of Policies and Procedures related to ACP

Do you plan to develop or revise, or have you already developed or revised any policies and procedures related to ACP in this setting?	Percent (Number) of Responses
No	22.7% (10)
Yes	59.1% (26)

* Percentages may not sum to 100% because of missing values.

The participants were asked what they planned to do to further promote and support ACP within their agency/organization. These responses are summarized in Table 60.

Table 60: Plans to Further Promote and Support ACP

- Educate others (e.g., colleagues, public, patients) (16)
- Review / Amend ACP Process (11)
- Identify potential candidates for ACP / Discuss ACP with patients (not just older patients) (5)
- Continue to educate self regarding this issue (3)
- Other (5)

The participants were also asked to identify the immediate challenges they anticipated facing in trying to promote and support ACP within their agencies/organizations. The challenges that were identified are presented in Table 61.

Table 61: Anticipated Challenges in Trying to Promote and Support ACP

- Time (13)
- Organizational support (4)
- Hesitancy to change among colleagues (2)
- Discomfort with initiating conversations (2)
- Patient acceptance / perception [when raise issue of ACP] (2)
- Other (8)

Follow-up Questionnaire

Participants were asked to identify at least one example of how they applied what they had learned in the ACP session to their practice. Responses are summarized in Table 62.

Table 62: Examples of How Participants Applied what they Learned in the ACP Session

- Examples provided of how participants applied knowledge gained to specific situations (12)
    - assisted patient in working out POA and other issues
    - helped in discussions with palliative care patient and her family re: care wishes
    - capacity assessments (e.g., of patient with early dementia and bipolar disease – assessed she was capable of making decisions re: long-term care)
    - assisted in case involving discontinuation of a feed tube
    - assisted family with making decisions
- Used knowledge to help initiate discussions with patients re: ACP / to encourage patients and families to have these discussion / to help clarify issues related to ACP (e.g., difference between POA for finances vs. personal care) (7)
- Used knowledge in long-term care facility (6)
    - reviewed ACP policies and procedures
    - conducted chart audit to determine whether ACP was appropriate to residents' medical status
    - informal discussions with staff re: ACP

- I determine who is POA in almost all hospital admissions; encourage family to have these discussions (1)
- Include ACP as a question in mortality reviews to determine if respected or not (1)
- I am more confident presenting ACP options to patients; I have a better understanding of the role of the SDM (1)
- Shared information with other physicians (1)
- I did not learn anything new from the session (1)

Participants were then asked to identify the factors that helped them to apply this knowledge. The main factors identified included: factors related to the content of the CME session; factors related to the format of the CME session; and the impact of the CME session on physician confidence/comfort.

Participants were also asked to identify any obstacles or challenges they faced in trying to apply what they learned in the education session. The primary obstacles or challenges faced were: reluctance or fear; time constraints; and discomfort on the part of the physician. Four participants indicated that they had not yet faced any obstacles or challenges in trying to apply what they had learned.

In all of the questionnaires completed by those who participated in the ACP workshops (i.e., the pre-training, session evaluation and follow-up questionnaires), participants were asked to rate their confidence in a number of areas using a 5-point scale (where 1= “not confident”, 2= “slightly confident”, 3= “fairly confident”, 4= “quite confident” and 5= “very confident”). Ratings from the pre-training and follow-up questionnaires were compared using paired sample t-tests. These results are presented in Table 63.

In all but one case, the average ratings on the pre-training questionnaire were higher than the ratings on the follow-up questionnaire. However all of the differences were relatively small and none were statistically significant.

Table 63: Comparison of Pre-training and Follow-up Confidence Scores

How confident are you in ….	Pre-training Mean (SD)	Follow-up Mean (SD)	Mean Difference (post-pre)
Your understanding of the legal obligations related to issues of consent and ACP?	3.98 (.67)	3.89 (.74)	- .09
Your ability to carry out your legal obligations related to ACP?	3.98 (.73)	3.79 (.74)	- .19
Your ability to initiate a conversation with an individual about issues of consent and ACP?	4.38 (.59)	4.32 (.67)	- 0.06
Your ability to facilitate ongoing ACP conversations?	4.13 (.60)	4.14 (.71)	0.01
Your ability to identify potential areas of conflict related to issues of consent and ACP?	4.04 (.79)	3.82 (.67)	- 0.22
Your ability to facilitate conflict resolution?	3.56 (.89)	3.52 (.75)	- 0.04
Your knowledge of the resources available to assist you in assisting others with issues of consent and ACP?	3.91 (.86)	3.86 (.71)	- 0.05

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Similarly, participants were asked to rate their overall understanding of ACP on all three questionnaires using a 5-point scale (where 1= "poor" 2= "fair", 3= "good", 4= "very good" and 5= "excellent"). A comparison of the pre-training and follow-up ratings indicates that the average rating on the pre-training questionnaire was higher than that on the follow-up questionnaire. Again, the difference was small and not statistically significant (see Table 64).

Table 64: Comparison of Pre-training and Follow-up Ratings re: Understanding of ACP

	Pre-training Mean (SD)	Follow-up Mean (SD)	Mean Difference (post-pre)
How would you rate your overall understanding of ACP?	3.74 (.76)	3.69 (.80)	- 0.05

$* p < 0.05$; $** p < 0.01$; $*** p < 0.001$

Participants were asked if, since the ACP educational session, they had reviewed any policies or procedures related to ACP in their agency/organization. Almost 40% of the respondents indicated that they had reviewed their agency/organization's ACP policies and procedures. Twenty-nine percent of respondents indicated that their agency/organization had no such policies or procedures (see Table 65).

Table 65: Have you Reviewed any Policies or Procedures related to ACP

Since you attended the ACP educational session, have you reviewed any policies or procedures related to ACP in your agency/organization?	Percent (Number) of Responses (N=31)
No	25.8% (8)
Yes	38.7% (12)
There are no policies or procedures related to ACP	29.0% (9)

* Percentages may not sum to 100% because of missing values.

When asked if they planned to develop or revise (or planned to advocate for the development or revision) of any policies and procedures related to ACP within their agency/organization, almost 60% indicated that they planned to do so (see Table 66). This finding is similar to the results in the session evaluation questionnaire where 59% of respondents reported that they planned to develop or revise their agency/organization's policies and procedures.

Table 66: Development or Revision of Policies and Procedures related to ACP

Do you plan to develop or revise (or plan to advocate for the development or revision) of any policies and procedures related to ACP in this setting?	Percent (Number) of Responses (N=31)
No	16.1% (5)
Yes	58.1% (18)
No, policies are not required or do not require revision	22.6% (7)

* Percentages may not sum to 100% because of missing values.

7.0 Alzheimer Disease and Related Dementias Website

As described in Section 2 above, the Initiative #2 – Physician Training Steering Committee's Curriculum Design/Review Working Group developed an ADRD curricula and corresponding learning materials for a comprehensive physician education program. It was decided that one way to disseminate these materials was through a high quality dementia website. A website subcommittee was established. It was hoped that the curricula materials could be integrated within an existing website. However, after reviewing various sites related to ADRD and geriatrics generally, it was concluded that a suitable website was not available. Thus, a decision was made to develop a website. An RFP process was undertaken.

The website aimed to be highly accessible, easy to maintain, responsive to users, and secure. Thus, the website was developed such that there was a "public face" on the home page with other resources accessible after login to specific user groups (faculty, learners, clinicians, etc.).

The information provided on this site is categorized according to the following:

- Educational Resources For Faculty
- Educational Resources For Learners
- Resources for Clinicians
- Clinical Tools
- General Information (e.g., teaching tips, bibliographies, research papers)
- Administrative Documents (including guides on how to use site features)

The educational resources are further sub-divided into the following content areas. These categorizations reflect the specific content areas identified in the initial needs assessment conducted by the Steering Committee:

- Mild Cognitive Impairment
- Alzheimer Dementia
- Non-Alzheimer Dementia
- Delirium
- Depression
- Behavioral Problems
- Driving issues
- Advance Care Issues
- Treatment Issues
- Consent and Capacity Assessment

Each of these content areas is then further divided into:

- Case Studies
- PowerPoint Presentations
- Curriculum resources (which include learning objectives, speakers notes, multiple choice questions, and handouts)
- Facilitated Learning Modules (including resources suitable for a small group interactive workshop).

All of the documents posted on the site are viewable and downloadable in print-friendly formats.

The website was also designed to facilitate collaboration and communication and includes features such a "chat/discussion room", support for whiteboard and online power point presentations, and internet based video-conferencing. It also has tools for event and other links management.

The site was launched in March 2004. The following provides a summary of the site utilization data between March 2004 and November 2005.

As of November 8, 2005, over 500 individuals had registered to the site (including medical school faculty, family physicians, other physicians, medical students, medical residents, and other health professionals). Between December 2004 and November 2005, there was an average of 1,650 visits per month and between 18,000 and 40,000 hits per month (see Figure 3). There are approximately 200 documents downloaded each month. Use of the site by those living outside of Ontario and among non-physicians has continued to grow.

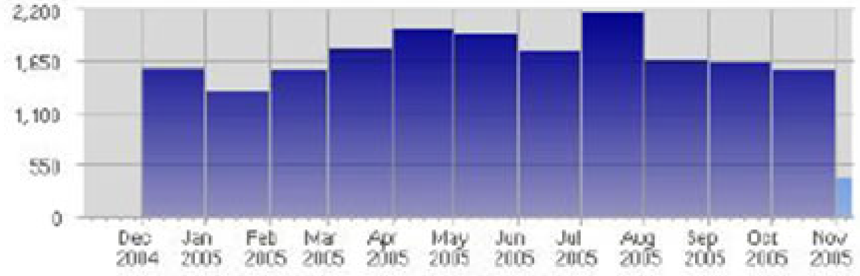


Figure 4: Visits to site Dec 1st 2004 – Nov 8th 2005

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