Provincial Common Orientation

Enhancing Knowledge in the Care of Older Adults

Increase awareness ● Improve attitudes ● Increase knowledge & skills

Program Evaluation 2023-2024

Provincial Geriatrics Leadership Ontario

Table of Contents

Prepared by: Dr. Kelly Kay, PhD
Executive Director, PGLO
June 2024

Acknowledgement: Report structure is adapted from prior evaluative work completed for PGLO by Dr. Ryan DeForge.

List of Tables and Figures

Tables

Figures

1. Introduction

1.1 Purpose of the evaluation

The purpose of this course evaluation report is to systematically analyze and document the effectiveness of the Provincial Common Orientation to the Care of Older Adults (PCO) program, summarize feedback from participants, and identify areas for improvement.
By evaluating various aspects of the course, including content, delivery, resources, and overall participant satisfaction, this report aims to:

1. **Assess Learning Outcomes:** Determine whether the course met its stated learning objectives and outcomes. This includes evaluating the extent to which participants acquired the intended knowledge.

2. **Identify Strengths and Opportunities:** Highlight the strengths of the course that contribute to its success and identify any areas that require improvement.

This report synthesizes experiences and course data to enhance the educational experience for participants, support facilitators in their delivery of the program, and contribute to the overall quality and effectiveness of the PCO program.

1.2 Background Information

The PCO is a workforce training series for health and social care professionals new to or seeking a refresher in the care of older adults. The program combines online content (self-paced) and 11 weekly 90-minute sessions to discuss and apply content to realistic older adult experiences. Facilitation is led by interprofessional team members who are experts in geriatric assessment and care of older adults. Topics are addressed through 20 interactive modules covering content ranging from normal aging, ageism and communication to screening, assessment, care planning and intervention across geriatric syndromes.

The PCO content is derived from the Competency Framework for Interprofessional Comprehensive Geriatric Assessment (Kay et al., 2017)[1]. Knowledge translation of the Competency Framework into learning objectives that informed the PCO was led by PGLO's Provincial Knowledge to Action Committee (see Appendix 4). The PCO was piloted between January and March 2023, with 63 participants from Ontario's North Eastern region. Following this successful pilot, the program formally launched in Spring 2023.

Currently, the PCO is not externally marketed. Demand for the program stems from regional specialized geriatric services and partners who are orientating new staff, as well as provincial programs such as Home and Community Care Support Services, Geriatric Emergency Management teams and Community Paramedicine, among others. Increased registration over the three cohorts delivered in 2023-2024 is attributed to word-of-mouth and Ontario Health's Alternative Level of Care (ALC) mitigation efforts. Ontario Health's efforts have included organizational self-assessments against ALC leading practices,

[1] https://geriatricsontario.ca/initiatives/cga/

which have surfaced training needs in the care of older adults across many organizations. The PCO fills a critical workforce training gap and, by consolidating local orientation efforts, which can be time-consuming, into a standard high-quality provincial curriculum creates efficiencies in workforce training time and supports the recruitment of knowledgeable facilitators.

The PCO prepares the Ontario health and social care workforce to recognize and respond to the needs of older adults living with complex health conditions (e.g. dementia and frailty) based on their roles and program mandates. This innovative program addresses a gap in current undergraduate health and social care education programs, which lack sufficient exposure to older adult care and opportunities for interprofessional learning in the care of older adults. The PCO responds to growing demand from Ontario Health Teams and others to respond appropriately and proactively to population health needs.

1.3 Evaluation Design

The PCO evaluation framework aligns expected program outcomes with performance indicators that measure the achievement of that outcome. For this program, the following evaluation framework was developed, shown in Table 1:

Table 1: PCO Evaluation Framework

Learning Outcome	Alignment with Evaluation Tools/Questions
Improved ability to identify the roles and responsibilities of different partners on the care team	#of registrants #Registrant roles #Participants reporting value in interacting with each other during virtual in-class sessions
Improved knowledge of age-related changes	Weekly and Post-Tier Evaluation Surveys Knowledge check (quiz) #Participants attending related in-class session #Participants completing related online module
Improved ability to recognize and respond to ageism	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module
Improved ability to identify techniques for communicating with older adults	Weekly and Post-Tier Evaluation Surveys Knowledge check (quiz) #Participants attending related in-class session #Participants completing related online module
Improved ability to define frailty	Weekly and Post-Tier Evaluation Surveys Knowledge check (quiz) #Participants attending related in-class session #Participants completing related online module
Improved knowledge of how to ascertain what older adults want (goals of care)	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module
Improved skill in adapting processes of care	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module
Increased knowledge about function, frailty screening and functional inquiry	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module

	Post-Tier Knowledge Check (Quiz)
Improved ability to recognize and respond to geriatric syndromes	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module Post-Tier Knowledge Check (Quiz)
Improved knowledge of the importance of and resources to foster social connectivity	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module Post-Tier Knowledge Check (Quiz)
Improved ability to recognize and respond to the unique needs of caregivers	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module Post-Tier Knowledge Check (Quiz)
Improved ability to contribute to care plans, treatments and interventions	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module Post-Tier Knowledge Check (Quiz)
Improved knowledge of approaches to system navigation	Weekly and Post-Tier Evaluation Surveys #Participants attending related in-class session #Participants completing related online module Post-Tier Knowledge Check (Quiz)

2. Evaluation Methodology

2.1 Data collection methods

Registration data

Participants seeking to attend the PCO complete an online (Microsoft Forms) registration form in which they indicate:

- Preferred facilitated session day (Tuesday or Friday)
- First and Last Name
- Email
- Ontario Health Region
- Organization
- Current Role/Title
- Professional Designation (if applicable)
- Years of experience working with older adults and their care partners
- Self-description of their level of experience (i.e. beginner, novice, intermediate, advanced, expert)
- Learning goals
- How they heard about the PCO
- Confirmation of organizational support to participate in all 11 weeks of the PCO

Weekly attendance

Participants attending facilitated sessions are asked to "sign-in" to a virtual attendance form each week.

Course portal user logs

User logs are maintained in the online course portal, which has been built using the Learn Dash application. Logs track user log-in and progression through online content, scores (and completion) on knowledge checks and whether certificates have been achieved.

Weekly and Post-Tier Evaluation Surveys

A participant survey is provided each week in class (via an electronic Microsoft Form) or via the online course portal. Participants are also asked to complete an evaluation upon completion of all relevant modules on the last week of each Tier (e.g. after the 4th and 11th week). The contents of each survey are summarized in Table 2

Table 2: Contents of PCO Weekly and Post-Tier Evaluation Surveys

Weekly Evaluation Survey	Post-Tier Evaluation Survey
• Class date • Facilitators • Engagement • Relevance • Value in interacting with peers • Solidifying knowledge • Alignment with objectives • Examples of how participants plan to integrate learnings into practice • Pre and post-knowledge rating • Suggestions for improvement	• Questions from the Weekly evaluation survey (for the current week) • Enhancement of professional satisfaction • Improvement in quality of care to clients • Top three learning points from Tier • Topics well understood • Topics requiring more information • Suggestions for improvement

Knowledge checks

Formal knowledge checks (quizzes) are included prior to each Tier, post Tier (in lessons/weeks 4 and 11) and in the following lessons (weeks) to evaluate learning:

Table 3: Knowledge Checks by Tier

Tier 1	Tier 2
• Lesson 1 • Lesson 2 • Lesson 3	• Lesson 6

Lessons 7, 8, 9 & 10 explore geriatric syndromes through case studies and knowledge checks are not included in the online course portal for these lessons.

2.2 Program Contributors

Participants

The PCO was designed for the staff of:

- Ontario Health Teams (OHTs) that have prioritized a focus on older adults living with frailty

- Ministry of Health, Ministry of Long-Term Care and Ontario Health-funded programs focused on older adults (e.g. Community Paramedicine, Personal Support Workers, staff from Ontario atHome, Geriatric Emergency Management, etc.)
- Specialized Geriatric Services who have been recently recruited or who require refresher or review

Content may be applicable to and has been delivered to other health and social service roles (e.g. community and social service agencies, broader public services).

Facilitators

The PCO has a team of expert facilitators who support the program. Facilitators meet the following criteria:

- Member of a health professional regulatory college in good standing
- Minimum three years working as a geriatric assessor in a specialized geriatric service or equivalent
- Minimum three years of teaching or facilitating health professional training
- Highly developed facilitation and presentation skills
- Competent in the use of digital teaching modalities
- Experience with team teaching and co-facilitating
- Excellent virtual classroom management skills, including time management, participant engagement, and flexibility to rapidly adjust content emphasis to match learner needs
- Content expertise in some or all of the models of the Provincial Common Orientation and ability to add depth of experience to prepared materials
- Availability to participate in 80% of the classes of each assigned cohort

The 2023-2024 facilitator team included:

- three contracted health professionals (one occupational therapist and two Nurse Practitioners), who were paid by PGLO through one-time sponsorship funds provided by several Regional Geriatric Programs and an Ontario Health Team, and
- three staff from Regional Geriatric Programs (North East Specialized Geriatric Centre (1); North Simcoe Muskoka Specialized Geriatric Services (2)), whose time was provided in-kind by their respective organizations.

Content Developers

PGLO gratefully acknowledges the many Regional Geriatric Programs and Regional Specialized Geriatric Services partners whose content expertise and previous orientation material have informed the development of this Common Orientation. Wherever possible, the program references existing work and identifies the many already-developed, excellent resources that are available through the Specialized Geriatric Services network for learners to explore.

PGLO also acknowledges the significant contribution of the program facilitators to the development of the program learning materials and acknowledges the contributions of Shaen Gingrich, Heather MacLeod, Kelly Kay, Linda Rochon, Mary-Lynn Peters, Laura Harrison, Erin Charnish, Nicole Gallagher and Angie Lepine. Facilitators review and update each module prior to delivery in each new cohort, ensuring relevance and currency of material.

Administrators

The PCO is administered by Provincial Geriatrics Leadership Ontario (PGLO). The administrative team includes the PGLO Executive Director (who holds a PhD and is an experienced facilitator and instructional designer) and a temporary contracted program assistant, whose time in 2023-2024 was supported by a one-time grant from the federal Digital Skills for Youth Program and one-time sponsorship funds provided by several Regional Geriatric Programs and an Ontario Health Team.

Administrative tasks include (but are not limited to):

- Course calendar creation
- Facilitator recruitment
- Facilitator scheduling and reimbursement
- Course registration
- Digital instructional design
- Content revision
- Learning Management System maintenance
- Participant inquiries and assistance
- Virtual in-class technology support for all sessions
- Program promotion
- Program evaluation
- Back-up session facilitation (Executive Director)

3. Program Overview

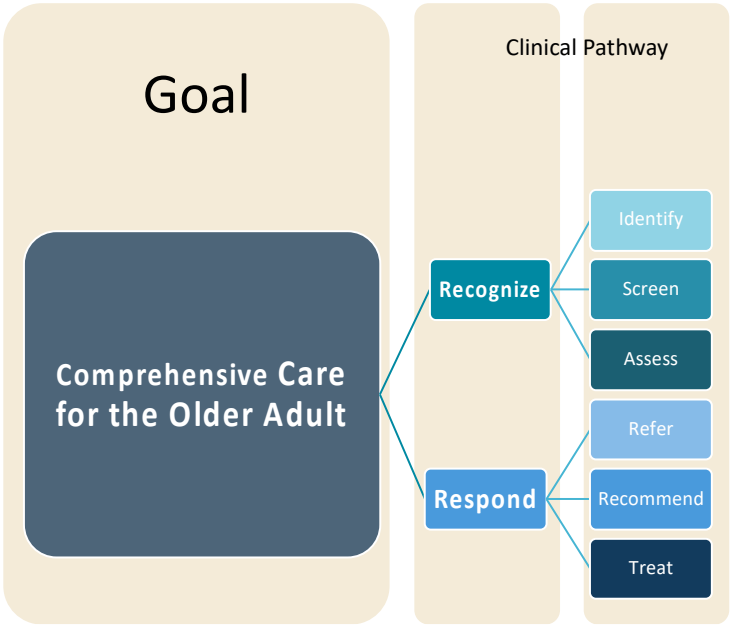
3.1 Program Objectives

The overall objectives of the Provincial Common Orientation are to support learners to increase awareness, improve attitudes, increase knowledge and increase skills in order to provide care that improves the older adult's care experience, achieves better health outcomes, improves staff experience and reduces health inequity and cost (Quintuple Aim[2]).

The **Recognize** and **Respond Framework** (Figure 1) is a foundational tenet of the program. This Framework suggests that regardless of professional designation, everyone plays a role in recognizing clinical conditions unique to older adults and in responding by integrating geriatric evidence, contextual elements, senior-friendly principles and individual goals. This Framework is reinforced during the facilitated sessions and case studies. The Framework also supports the interprofessional educational experience as learners from different professional backgrounds learn from one another about their different approaches and contributions to the care of older adults living with complexity.

[2] Itchhaporia, D. (2021). The evolution of the quintuple aim: Health equity, health outcomes, and the economy. *Journal of the American College of Cardiology, 78* (22), p. 2262-2264, https://doi.org/10.1016/j.jacc.2021.10.018.

Figure 1. Recognize and Respond Framework



3.2 Key Learning Outcomes

Each Tier has specific learning outcomes, summarized in Figure 2.

Figure 2: Learning Outcomes of the Provincial Common Orientation

Tier 1: Foundations in Geriatrics for Interprofessional Teams	**Tier 2: Enhanced knowledge and skill development in the care of older adults**
• Identify the roles and responsibilities of different partners on the care team (including caregivers) • Recognize age related changes (normal aging, atypical presentations, delirium, falls, sensory changes) • Recognize and respond to ageism • Identify techniques for communicating with older adults • Define frailty (including prevention, screening, and early identification) • Describe what older adults want (goals of care)	• Adapt processes of care (approaches to care for older adults) • Understand function and conduct a frailty screen and functional inquiry • Recognize and respond to geriatric syndromes (pain, continence, nutrition, polypharmacy, cognition, mental health, delirium, mobility, sleep, substance use) within professional role • Foster social connectivity • Recognize and respond to the unique needs of caregivers • Contribute to care plans, treatments, and interventions • Facilitate system navigation

Tier 1 content is organized into four sessions (one per week) covering nine (9) modules, and Tier 2 content is organized into seven sessions (one per week) covering 11 modules. See Appendix 1 for Weekly Modules and Learning Objectives.

3.3 Learning Design

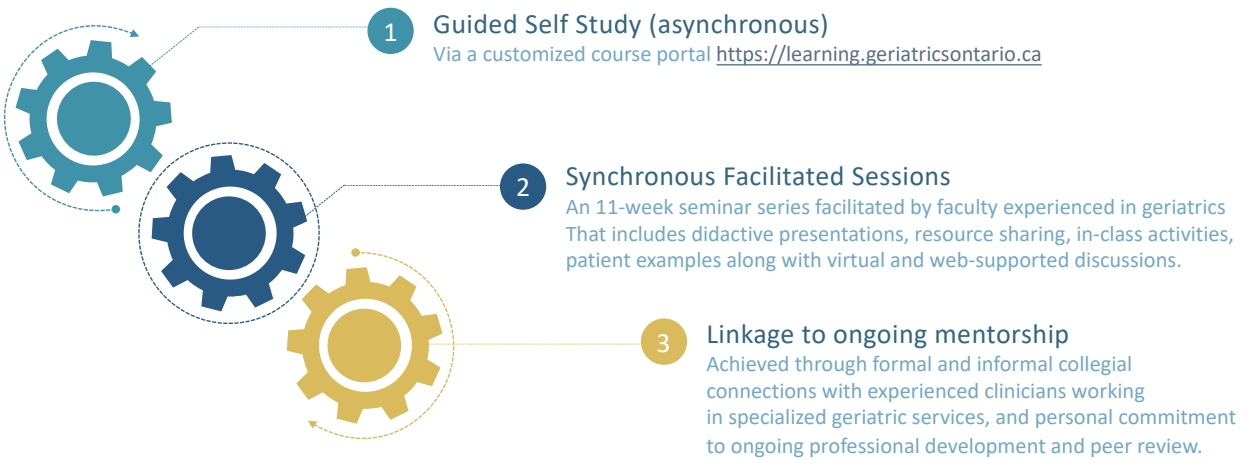
The PCO is structured as part of a tiered approach to learning (see Figure 3) that enables health and social care providers interested in the care of older adults living with frailty to engage in relevant and progressive professional development. The PCO is intended to support a holistic approach to geriatric care through learning activities that integrate the complex physical, cognitive, social and mental health concerns frequently experienced among older adults.

Figure 3: Tiered Model of Geriatrics Continuing Education in Ontario

This program evaluation report covers activities related to Tier 1 and Tier 2 only.

The format of Tier 1 and 2 actively engages learners in the development of their own competencies. This means that learners participate in three main learning activities: self-study, a facilitated learning series and formal and informal mentorship (see Figure 4).

Figure 4: Learning Design of the Provincial Common Orientation



3.3.1 Guided Self-study (Asynchronous)

Learners begin their participation in the PCO by completing a self-assessment to determine their learning needs in key geriatric topics. This may be completed informally (e.g. reflecting on current challenges, areas of uncertainty, etc.), or for regulated health professionals may include the use of the *"Self-Assessment Tool for the Competency Framework of the Interprofessional Comprehensive Geriatric Assessment,"* which can be downloaded from https://geriatricsontario.ca/resources/self-assessment-tool-for-the-competency-framework-of-the-interprofessional-comprehensive-geriatric-assessment/

Online Course Portal

Following self-assessment and identification of learning needs, participants engaged in the PCO commit to participating in weekly activities and readings. Prior to Fall 2023, participants were provided with links to readings and resources via the program outline document and encouraged to review these materials between facilitated sessions. Additional reference links were provided during facilitated sessions in Zoom chat functions. Copies of weekly presentations were also emailed to participants each week. There was no tracking of participant engagement in self-study.

Participants reported that receiving course information via various methods (email, chat messages, etc.) made it difficult to keep track of resources. Additionally, the facilitator and administrative team identified difficulty in determining the degree to which participants engaged in prior self-study. This lack of tracking impacted the in-class experience when significant in-class time was spent on content review rather than the desired focus on application.

In Summer 2023, PGLO partnered with Pinnguaq Association (Inuktitut for play), a learning and development company with roots in Nunavut that is focused on bringing technological experiences to Nunavummiut (residents of Nunavut), Indigenous communities, and diverse communities across Canada. This partnership enabled the development of PGLO's new learning management system and a customized course portal https://learning.geriatricsontario.ca/ to house all PCO resources and provide interactive exercises to support self-directed learning between facilitated sessions. The course portal was launched in time for the Fall 2023 cohort.

Participants enrolled in the facilitated series receive a user account to access the course(s) they have registered for (e.g. Tier 1: Foundations in Geriatrics for Interprofessional Teams, Tier 2: Core Geriatric Knowledge for Interprofessional Teams, or both). Participants then log in, navigate to the course portal and get started.

Figure 5: Screen Shot of Learning Platform

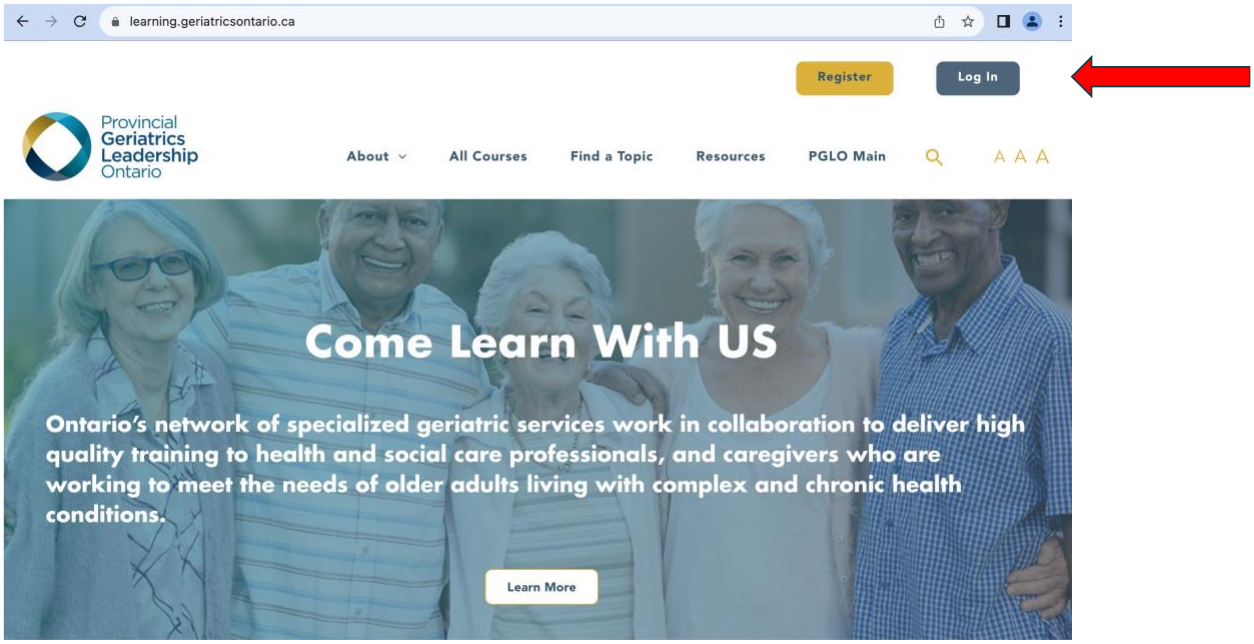
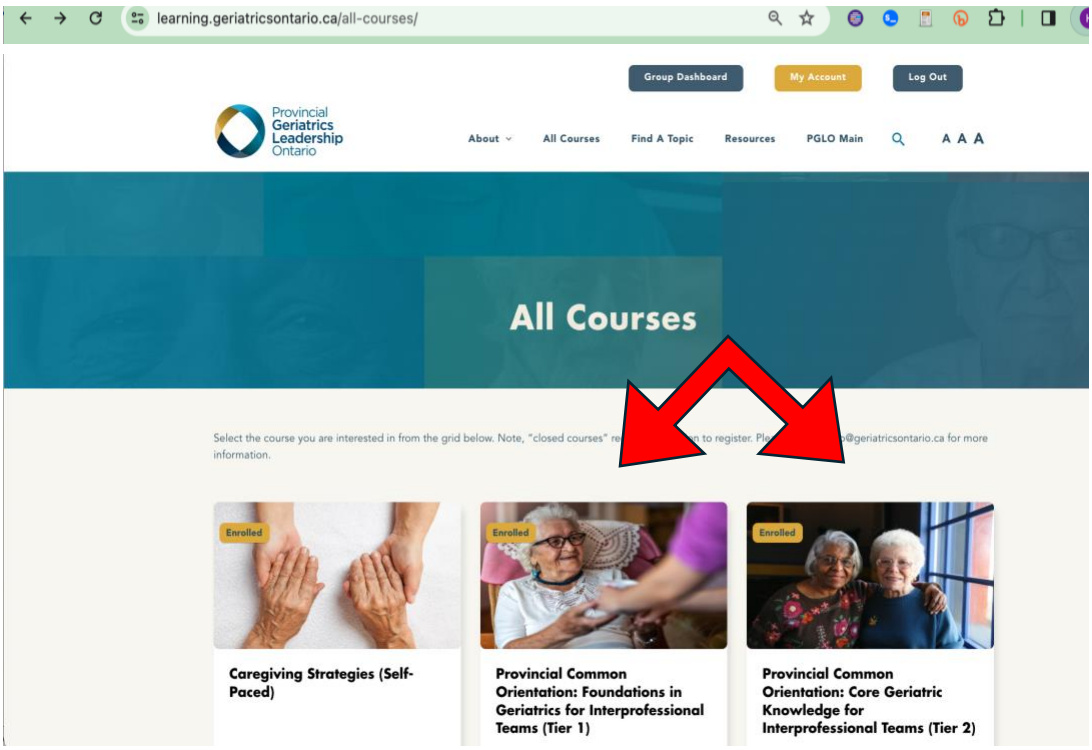


Figure 6: Screen Shot of Course Pages



Self-study is self-paced and asynchronous and is required prior to and during participation in the Facilitated Learning Series. Participation in self-study is monitored by a custom group dashboard available in the Learn Dash application.

Participants may also wish to engage in independent self-study on topics of interest or to address personal knowledge gaps. Many links and resources are included in the online course portal for further exploration. Additionally, links are provided to additional relevant content:

- Compendium of Educational Offerings (Free, $)
- Geriatric Essentials eLearning (Free)
- Frailty Assessment, Mitigation and Prevention (Free)
- Regional Geriatric Program Central Geriatric Foundations eLearning($)
- Senior Friendly Care Learning Series (Free)

3.3.2 Facilitated Learning Series (Synchronous)

To understand and apply the recognize and respond framework, learners engaged in the PCO participate in a virtual series of synchronous facilitated learning sessions, which provide the opportunity to integrate topics reviewed in self-study, discuss key concepts, ask questions and learn to apply new knowledge to their health and social care practice. Participants attend virtual facilitated learning sessions once weekly for eleven weeks, and sessions are led by expert facilitators. Sessions are delivered on Fridays and Tuesdays from 1:30 to 3:00.

New content is introduced on Fridays and repeated on Tuesdays. This allows an opportunity for participants to make up sessions they might need to miss. Zoom links for both sessions are posted in the online course portal, and this scheduling flexibility was designed to meet the needs of shift workers (e.g. Community Paramedics). Given the interactive nature of the facilitated sessions, they are not video recorded.

Facilitators use the Zoom platform and various modalities to create an engaging online learning environment. These modalities include:

- On-screen annotation
- Chat responses
- Large group discussion
- Breakout rooms
- Polls
- Videos
- Case studies

Participants are oriented to the use of Zoom and its features (e.g. annotation, chat) and encouraged to use them throughout the eleven weeks. To ensure participants can use all relevant features, they are encouraged to participate via a desktop version of Zoom and discouraged from connecting via telephone alone.

Facilitators strive for a balance of large and small group discussions to appeal to different learning styles and provide opportunities for interprofessional collaboration. Participants are encouraged to share their

expertise and resources with one another and to reflect on case studies from their different professional, geographic and cultural perspectives.

Due to cohort sizes, a minimum of two facilitators and one administrative support person attend each session (two sessions per week on Tuesdays and Friday afternoons). This ensures support for chat discussion, questions, and technology while one facilitator is engaged in teaching. New facilitators are also required to attend at least one session per week (i.e. all modules) to become familiar with the content, instructional design and flow.

The learning outcomes and an outline of modules and objectives for Tier 1 (four weeks) and Tier 2 (seven weeks) are included in Appendix 1.

3.3.3 Ongoing Mentorship

Formal and informal mentorship opportunities are coordinated by the network of specialized geriatric services organizations and local SGS expert clinicians to continue building opportunities for professional development and peer review. Participants are introduced to resource personnel from local Regional Geriatric Programs and Regional Specialized Geriatric Service entities during the last facilitated session (week 11).

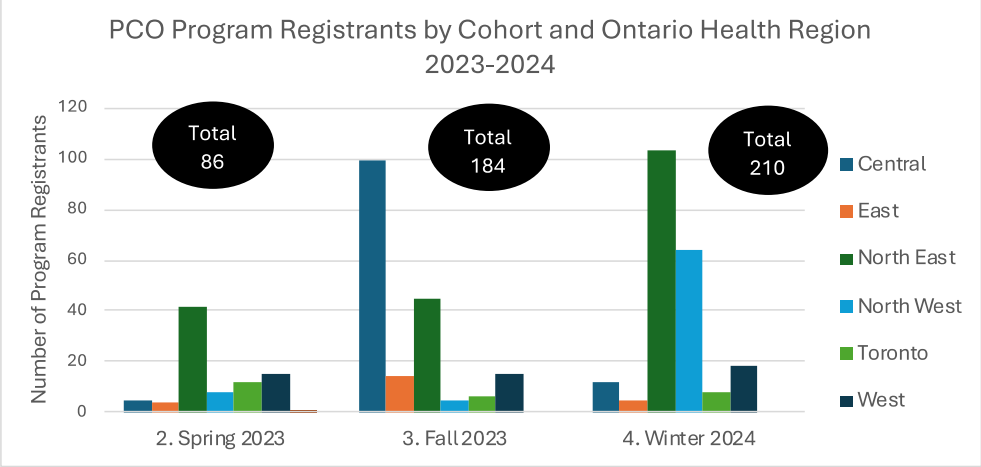
Participants are encouraged to contact their local Regional Geriatric Program or Specialized Geriatric Services to explore mentorship opportunities by visiting https://geriatricsontario.ca/regional-programs/.

4. Findings 2023-2024

4.1 Course Registration

In 2023/2024, there were three cohorts of the PCO (Cohort 2 Spring 2023, Cohort 3 Fall 2023 and Cohort 4 Winter 2024).

Figure 7: PCO Program Registrants by Cohort and Ontario Health Region 2023-2024

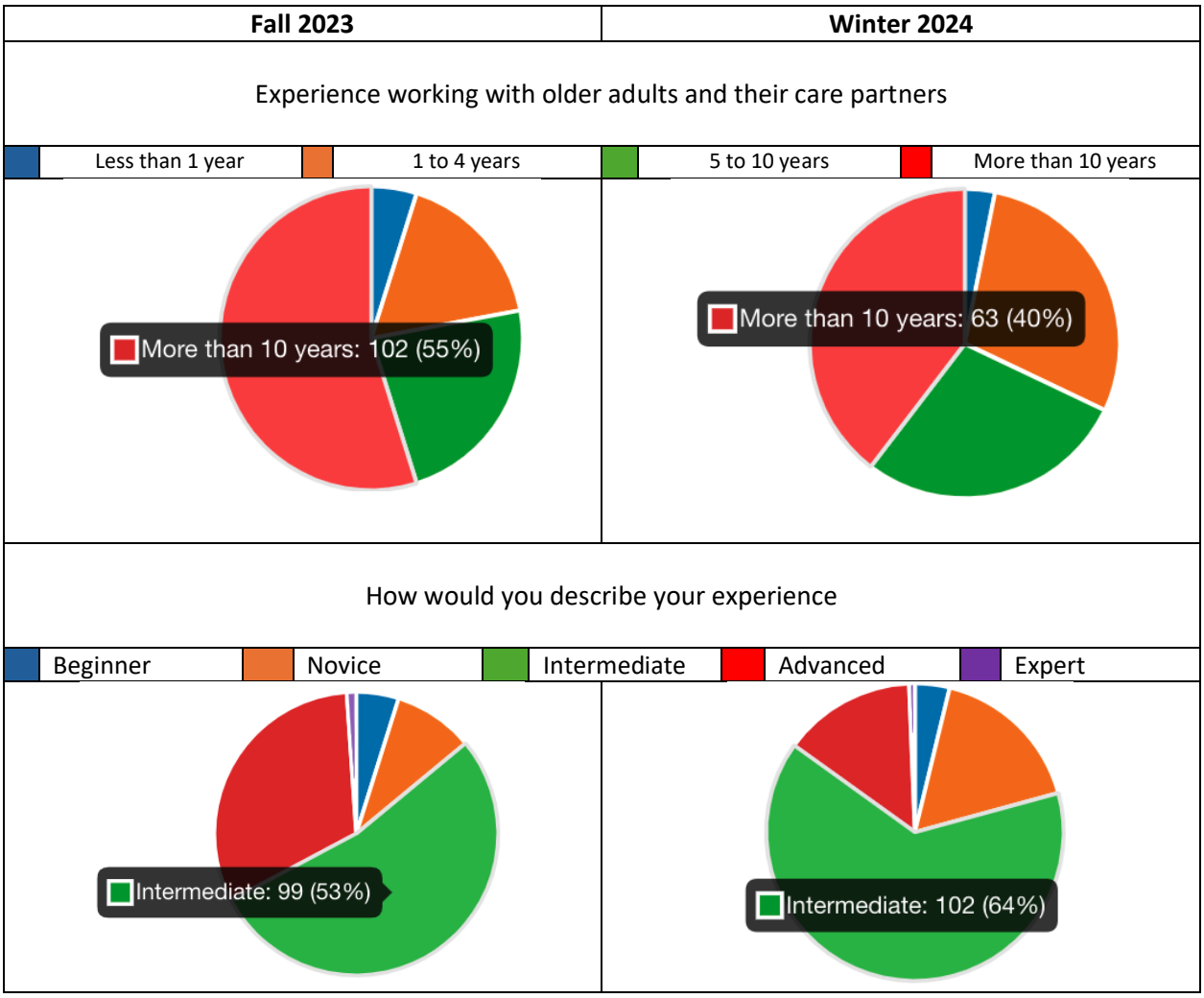


The PCO saw 480 participants from 96 unique organizations. Nineteen, or nearly 20%, of organizations sent participants to more than one cohort. Appendix 2 provides details of participating organizations by cohort for the 2023-2024 fiscal year.

4.2 Cohort descriptions

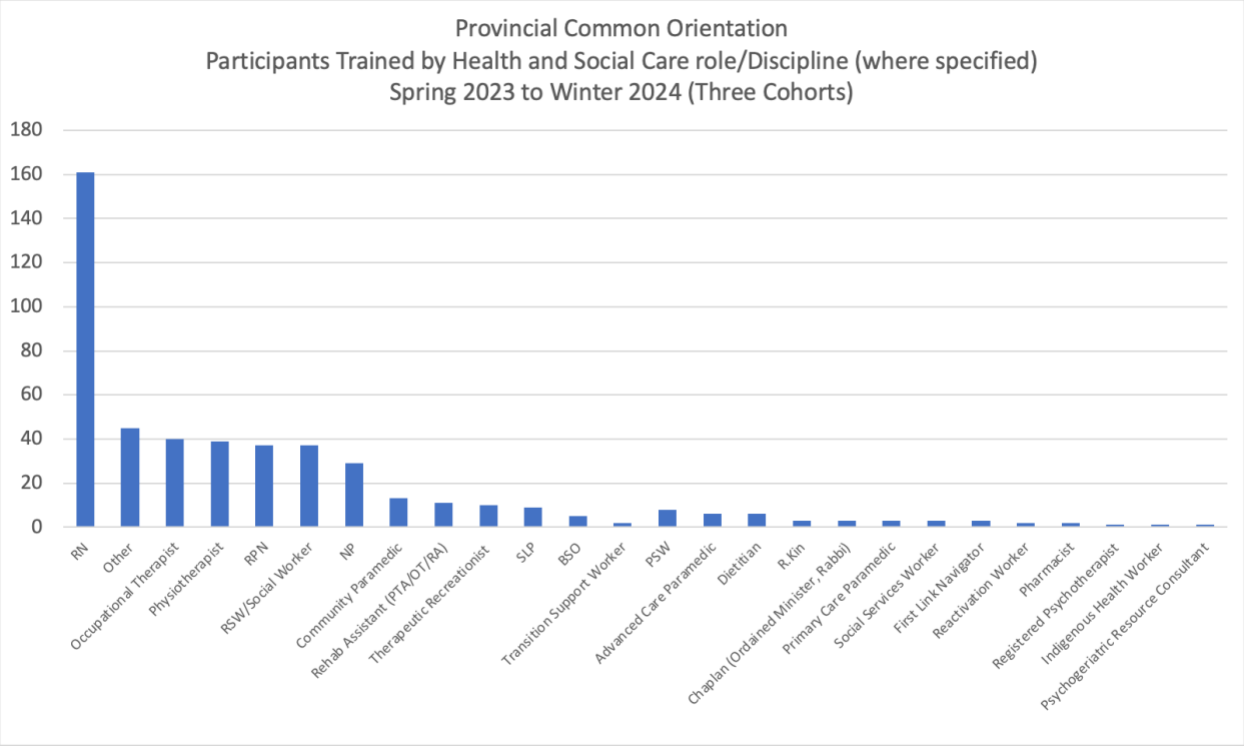
In the Fall 2023 and Winter 2024, following an update to the registration form, participants identified their experience working with older adults upon registration.

Figure 8: Fall 2023 and Winter 2024 Participant Self-Reported Experience



Overall, more than 26 different health and social service roles participated in the program.

Figure 9: Participant Roles by Discipline 2023-2024



4.3 Online Self-Study and Facilitated Session Attendance

Beginning in the Fall 2023 cohort, participant engagement in self-study was monitored through the PGLO Learning Management System, which tracks user log-in, module completion and the completion of knowledge checks (quizzes). In addition, attendance is taken at each facilitated session via a MS Form sign-in sheet.

In Fall 2023, 167 out of 187 (89%) participants registered to access the course portal in Tier 1, and 161 out of 187 (86%) participants registered to access the course portal in Tier 2. Of those who registered for access to the portal in Fall 2023, 63% and 62% completed all or part of the self-study activities in Tier 1 and Tier 2, respectively.

In Winter 2024, 191 out of 210 (91%) participants registered to access the course portal in Tier 1, and 188 out of 210 (90%) participants registered to access the course portal in Tier 2. Of those who registered for access to the portal in Winter 2024, 79% and 70% completed all or part of the self-study activities in Tier 1 and Tier 2, respectively. Overall, there was a 34% increase in utilization of the course portal in Tier 1 and a 20% increase in utilization of the course portal in Tier 2 between the Fall 2023 and Winter 2024 cohorts.

This increased use of the course portal was enabled by changes to the curriculum offered in the Facilitated Sessions to move static content (e.g. fact-filled slides) to the course portal, facilitator reinforcement of the course portal during in-class (virtual) sessions, and the addition of dedicated

support (e.g. Program Assistant) to help users log-in and navigate the course portal. Table 4 summarizes online course portal use.

Table 4: Online Course Portal Use

	Fall 2023				Winter 2024			
	Tier 1	**%**	**Tier 2**	**%**	**Tier 1**	**%**	**Tier 2**	**%**
Enrolled Portal Users	167		161		191		188	
Completed all modules (certificate earned)	89	53%	64	40%	135	71%	90	48%
In Progress	16	10%	36	22%	15	8%	41	22%
Not Started	62	37%	61	38%	41	21%	57	30%

More than half of all participants met the goal of attendance at 80% of all facilitated sessions in each of the three cohorts offered in 2023-2024. Of those who registered for the program, between 79% and 93% attended, which exceeds the usual participation levels seen in online learning programs. The number of participants attending 100% of all sessions grew in each cohort, from 9 individuals (in Spring 2023) to 47 individuals in Winter 2024. Table 5 summarizes session attendance in the Facilitated Sessions.

Table 5: Synchronous Facilitated Learning Session Attendance	***Spring 2023***	***Fall 2023***	***Winter 2024***
% sessions attended by participants (on average)	71%	65%	75%
% sessions attended by at least half of the cohort (median)	82%	82%	82%
Number of participants attending 100% of sessions	9	30	47
% of those registered who attended	93%	79%	81%

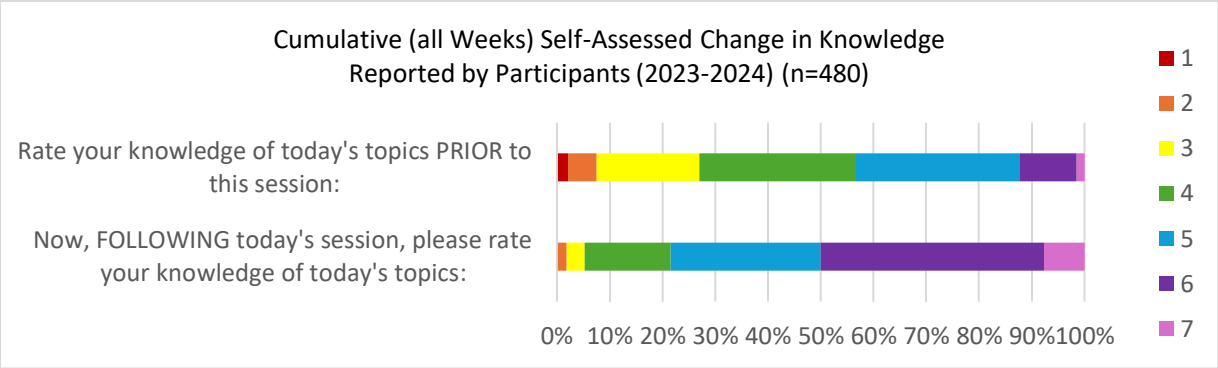
4.4 Knowledge Acquisition

There was a demonstrated change in knowledge reported in all cohorts. Each week, participants are asked to rate their knowledge of the week's topics prior to and after participating in the lesson content. PGLO received 2002 responses from participants, of which 78% signalled knowledge change, as summarized in Table 6.

Table 6: Change in Self-Reported Knowledge	**# of Responses**	**% of Responses**
One (1) point change	1064	53
Two (2) points change	396	20
Three (3) points change	78	4
Four (4) points change	18	1

Figure 10 illustrates the general shift in self-reported knowledge (see Appendix 3 for details by cohort and week) for 2023-2024.

Figure 10: Cumulative Shift in Knowledge 2023-2024



Quizzes (called check-ins) can provide an objective measure of knowledge acquisition. In 2023-2024, 60% of participants who completed the Tier 2 **pre**-course online quiz earned greater than 76% (or 10 out of 13), and 80% of participants who completed the Tier 2 **post**-course online quiz earned greater than 76% (or 10 out of 13). This is an objective and positive measure of change in knowledge.

4.5 Participant Experience

Participants were invited to share feedback after each week and Tier (13 occasions). Of the 802 comments received during 2023-2024, 77% (621) were compliments and kudos.

Selected Participant Kudos

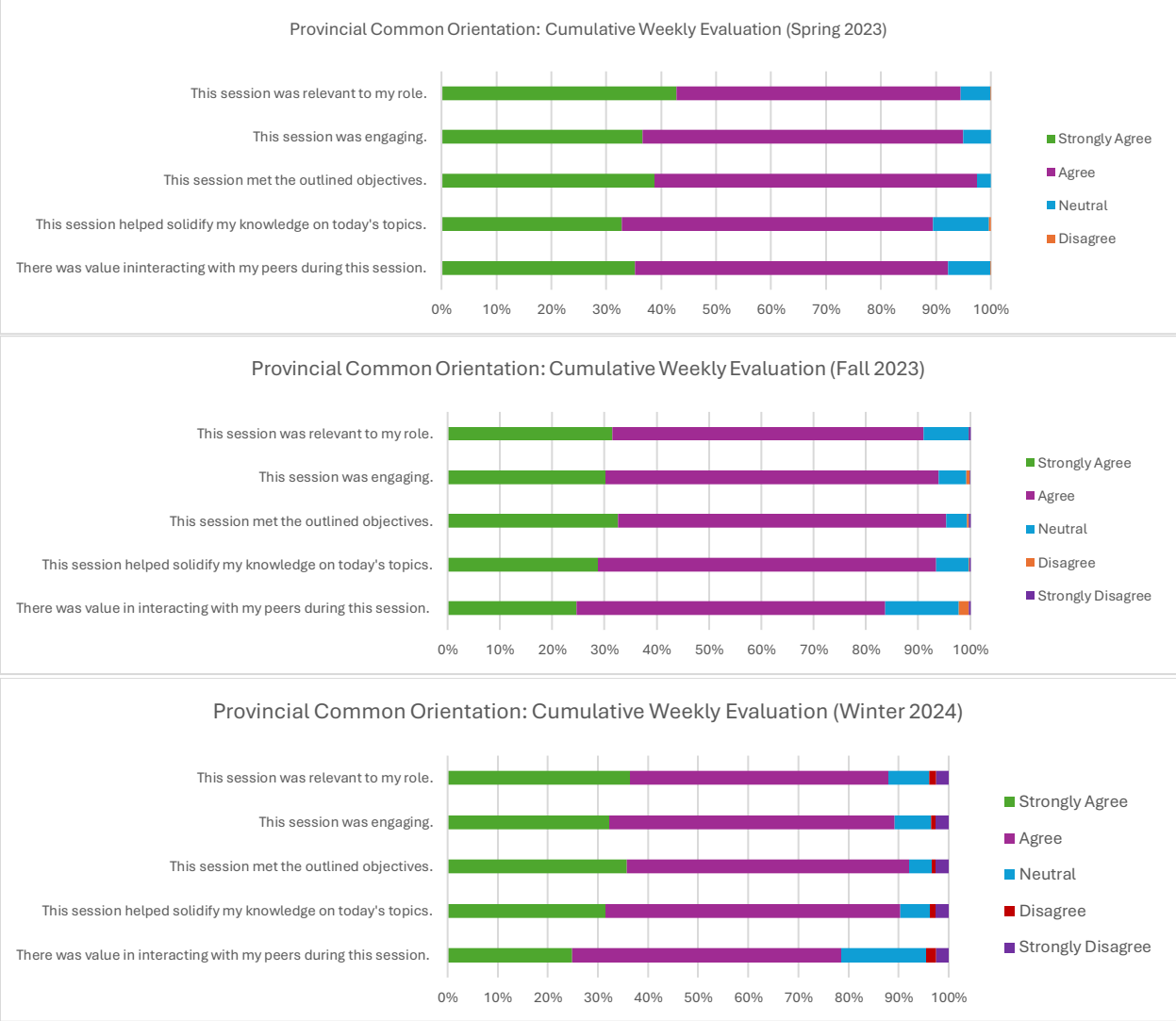
- "Very helpful and always engaging."
- "Very well done and engaging; no suggestions at this time."
- "Very interesting; not sure I would add or change anything."
- "Very engaging, lots of good info provided as well as real-life examples."
- "Very engaging, love the incorporation of learning such as breakout rooms, surveys and activities."
- "Very rewarding session."
- "Great session, no improvements needed."
- "Session encouraged engagement and participation."
- "This is the best course I've ever taken, and would like to take it again."
- "Keep doing exactly what you are doing, excellent facilitation."
- "Loved the"..." pace," "annotations," "pre-work," "course."
- "I enjoyed the breakout rooms."
- "Breakout rooms are a great way to connect with others."

Through weekly evaluations, participants reflected on the relevance of topics, engagement, knowledge acquisition and the value of interacting with peers.

In general, across all cohorts:

- Roughly 90% of participants expressed that the content was relevant and engaging, met the objectives, and helped them solidify their knowledge regarding the topic.
- Between 79% and 90% of participants valued the opportunity to interact with their peers.

Figure 11: Cumulative Weekly Evaluations (Spring 2023, Fall 2023, Winter 2024)



Participants were also asked to rank their experience in two domains: professional satisfaction and quality of care provided to their clients. Table 6 summarizes the results and demonstrates that between 70% and 95% of participants in Tier 1 and between 87% to 100% of participants in Tier 2 agree or strongly agree that participating in the sessions enhanced their professional satisfaction and the quality of care they provide.

Table 7: Professional Satisfaction and Quality of Care	*Spring 2023*	*Fall 2023*	*Winter 2024*
Tier1 Post-Tier Evaluation			
% Agree or Strongly Agree			
Participating in the Tier 1 sessions has enhanced my professional satisfaction.	74%	94%	89%
The quality of care I provide to my clients has improved as a result of my participation in the Tier 1 sessions	74%	95%	88%
Tier 2 Post-Tier Evaluation			
% Agree or Strongly Agree			
Participating in the Tier 2 sessions has enhanced my professional satisfaction.	100%	100%	89%
The quality of care I provide to my clients has improved as a result of my participation in the Tier 2 sessions	100%	100%	87%

4.6 Participant Suggestions for Improvement

Participants were invited to share suggestions for improvement after each week and Tier (13 occasions). In 2023-2024PGLO received 802 responses via evaluation form comment fields. Of these responses, 181 (22%) were suggestions for improvement, which were reviewed and addressed iteratively throughout the year. Table 8 summarizes the main themes of participant suggestions and program design changes made to address this feedback.

Table 8: Participant Feedback and Program Response

Participant Theme	**Program Response**
Enhanced Learning Environment • Participants consistently expressed a desire for more time and resources to deepen their understanding. • Requests for additional sessions, handouts, and ample time for discussion Participant Quotes: "Would love to be able to have extra sessions when you miss class." "This session felt rushed; we didn't have much time to discuss system navigation." "As always, such important topics, but would need more time to cover the material."	• Increased offerings to two times per week (Fridays, repeated Tuesdays) to allow participants an opportunity to make up a missed class • Reviewed and transferred information-dense slides from presentations to online course portal for self-study to free up in-class time for discussion • All presentations, handouts, case studies and links uploaded to the online course portal to ensure easy and ongoing participant access to resources

Practical Application and Engagement • There is a strong emphasis on practical application, with participants suggesting working through case studies and scenarios relevant to their roles. • Engagement-related feedback underscores the importance of interactive elements and peer sharing. Participant Quotes: "Use of case study is very helpful and everyone sharing clinical experience and expertise." "More practical examples of successful engagement in rural communities." "More interaction, breakout group discussions." "It was frustrating that I was the only one in my breakout group to come off mute."	• Increased the number of case studies, particularly in Tier 2, and facilitators intentionally include case examples when presenting content • Include one breakout session (approximately 10 minutes) in each module. • Recognizing there is strong conflicting feedback about breakout groups (e.g. some participants do not like them, some love them, some do not participate when placed in a breakout group), thus facilitators use breakout groups judiciously and reinforce the value of interacting with peers from different organizations and disciplines during this time.
Technical Challenges and Support Needs • Some participants encountered various technical issues, including difficulties navigating features. • Request for clearer instructions and better support to facilitate sessions. Participant Quotes: "I got kicked off 2 times." "If the explanations to use the annotations was a bit slower - I could not find the stamp at first."	• Participants emailed .pdf technical instructions in advance of the course • Participants were advised to use a desktop version of Zoom (not a web version or a telephone connection) • Annotate feature in Zoom demonstrated in class • Program staffing was adjusted to include a program assistant in every session who provided real-time technical support to participants • Participants invited to remain after class for one-to-one technical support
Structural Improvements and Organization • Suggestions include recording sessions • Intentional design of small group learning "Can the sessions be recorded and uploaded to this site?" "Ensure multiple disciplines are in the breakout rooms."	• Participants advised that sessions are not recorded as they are interactive and that they have the flexibility to attend another session for make-up • Participants seeking asynchronous learning are directed to other RGP resources (e.g. https://geriatricsontario.ca/resources/continuing-geriatric-education-links/) • Breakout groups randomly assigned each class to allow maximum opportunity to interact with different participants/disciplines • Facilitators reinforce that content is intentionally an orientation/overview and provide resources for additional learning via the online course portal

"Maybe separate the orientation/overview from the actual course content."	

4.7 Facilitator Experience

In general, facilitators teach between 1 and 6 modules per week per cohort. Facilitators also attend additional weeks to provide back-up support to those actively teaching, providing assistance with managing course flow, supporting content delivery, and answering participant questions. Since the introduction of a program assistant, the use of facilitators for technical support has been largely eliminated.

Facilitators also participate in a weekly one-hour dry run of content that is to be delivered the following week. This allows new facilitators to rehearse in front of colleagues and receive coaching, and the facilitator team can revise content by incorporating new evidence and participant feedback or correct issues with timing and flow. Facilitators are expected to join in as many of the dry run sessions as they can to support overall facilitator development and content improvement.

Facilitators report great pride in their role in developing and delivering the PCO. Their motivation to facilitate this course is captured in part by these selected quotes:

- "The content is great and I would have loved this when I was first in Geriatrics. The facilitator group is smart, fun and we continue to update the content to make it better and better. I enjoy teaching and bringing my own work experiences for the students."
- "Love of geriatric care and passion to build capacity in this area."
- "This is so enjoyable and doesn't feel like "work." Thanks for the continued opportunity!!"

Facilitators also generally agree or strongly agree that

- Their interactions with online participants are satisfying
- They are satisfied with the quality of the online learning environment for participants
- Facilitators are given sufficient time to design and develop content
- The necessary technology tools (software) are provided for facilitating online
- They have adequate technical support for facilitation
- They are satisfied with the online facilitation procedures that have been implemented
- They are satisfied with the content quality of the online course
- They would recommend being a facilitator for this course to their colleagues

4.8 Facilitator Suggestions for Improvement

Facilitators provide suggestions for improvement iteratively during each week's dry run. In addition, facilitators have suggested (via a facilitator experience survey):

- Incorporating live polls/responses for more engagement
- Using technology such as Menti or Kahoot

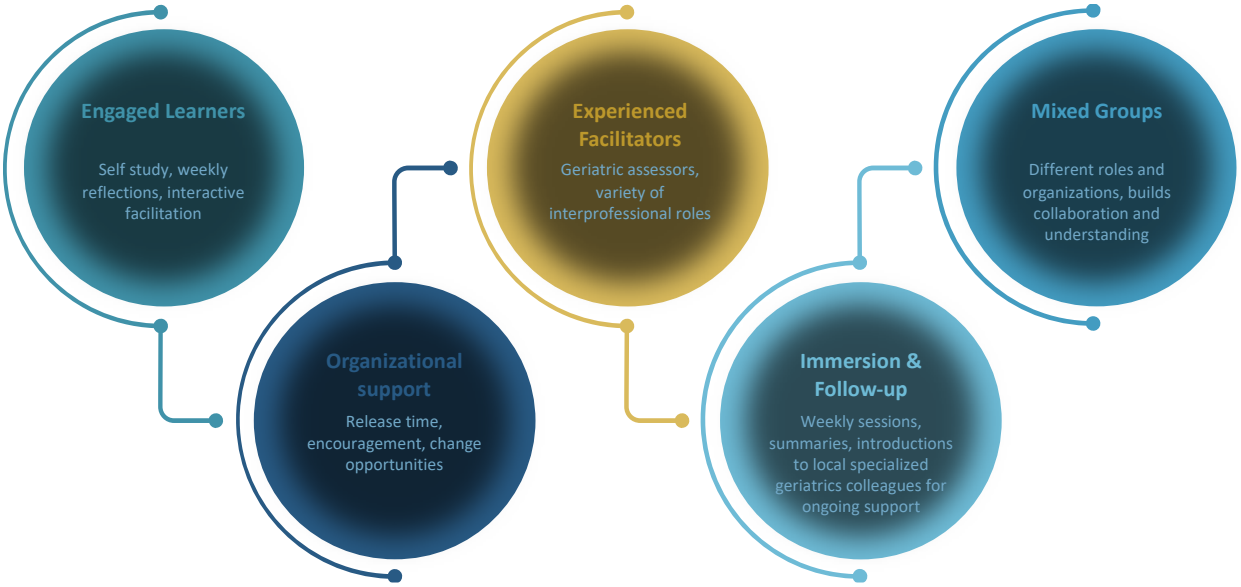
5. Conclusions & Recommendations

This program evaluation assessed the impact of a Provincial Common Orientation to the Care of Older Adults, focusing on several key objectives, including achievement of increased awareness and knowledge of societal issues and clinical skills relevant to the care of older adults. The overwhelmingly positive response from participants, with generally over 90% agreeing or strongly agreeing with the efficacy of the program as stated in the surveys, and demonstrated change in knowledge affirms the achievement of these objectives.

5.1 Interpretation of Findings

The program's evident success in increasing awareness, improving attitudes and increasing knowledge and skills can be traced back to its carefully designed curriculum and the supportive online environment it fosters. The significance of the networking opportunity it provides cannot be overstated. It provides health and social care professionals with a platform to share experiences, learn from each other, and form a community that transcends geographic and sector boundaries. Furthermore, the accessibility and relevancy of resources shared throughout the program have been instrumental in empowering practice. Figure 12 summarizes several of the program's success factors.

Figure 12: Success Factors of the Provincial Common Orientation to the Care of Older Adults



5.2 Significance of the Provincial Common Orientation

The insights drawn from this evaluation shine a light on health and social care workers' training needs and experiences. It has demonstrated the transformative potential of online (asynchronous) workforce training when combined with thoughtful, synchronous facilitation. The program, with its robust structure and multifaceted objectives, serves as an effective model for future initiatives aimed at supporting and empowering the health workforce to respond to the growing population of older adults living with complex health conditions in Ontario.

5.3 Recommendations

Program Improvements

Despite the program's successes, there is always room for improvement. Better time management strategies may be employed to ensure all topics are covered adequately while still allowing time for open discussion. Measures may also be implemented to further foster a balanced environment where everyone feels comfortable sharing their experiences and insights.

Future Scale-up

Expanding the reach of this program by replicating it with additional cohorts is a worthwhile endeavour. There is expressed demand from Ontario Community Paramedics and Ontario atHome (formerly Home and Community Care Support Services), which equates to over 1,000 new potential registrants. Program expansion would not only further validate the findings but also provide further insight into the program's adaptability and efficacy across diverse settings. The sustained impact of the program on the health and social care workforce's ability to respond to the needs of older adults in various settings also warrants exploration.

Policy and Practice

The findings advocate for the broader implementation of such health workforce training programs specific to the care of older adults. Sustained funding support for the program will help to ensure its availability to future cohorts and help its organizers (i.e. PGLO) respond to growing training demand.

In Closing

The program's success is a testament to its thoughtful design and execution, the strong foundation of its curriculum and the strength of its facilitator team. The program has demonstrated the potential of well-structured online initiatives to offer valuable support and empowerment to the health and social care workforce. As our understanding of older adults' needs continues to evolve, initiatives like these will remain crucial in providing the support that the population so greatly needs and deserves.

Appendix 1: Weekly Modules Learning Objectives

Tier 1: Foundations in Geriatrics for Interprofessional Teams Facilitated Learning Series

The primary goals of **Tier 1** facilitated sessions are to increase awareness, improve attitudes and increase knowledge. This level of training is appropriate for most health and social care professionals (e.g. 911 paramedics, home and community care professionals, social service professionals etc.). Depending on their role, not all participants in Tier 1 training will wish or need to continue on to Tier 2.

The learning outcomes of Tier 1 are as follows:

Tier 1: Foundations in Geriatrics for Interprofessional Teams
1.1. Identify the roles and responsibilities of different partners on the care team (including caregivers)
1.2. Recognize age related changes (normal aging, atypical presentations, delirium, falls, sensory changes)
1.3. Recognize and respond to ageism
1.4. Identify techniques for communicating with older adults
1.5. Define frailty (including prevention, screening, and early identification)
1.6. Describe what older adults want (goals of care)

Tier 1 is organized into four sessions that are typically offered once per week for 4 weeks. Below is the topical outline for the modules that comprise Tier 1.

Week	Tier 1 Modules & Learning Objectives
1	**Module 1: Welcome & Introductions**
	By the end of this module, you will be able to: • Describe the background and expectations for the Provincial Common Orientation and Tier 1 Foundations in Geriatrics for Interprofessional Teams • Begin to set personal knowledge goals relevant to the care and support of older adults living with complex health conditions • Identify learning outcomes, learning tasks and pre-requisites required to achieve personal knowledge goals and training expectations
	Module 2: Defining Frailty
	By the end of this module, you will be able to: • Define frailty holistically, and consider the implications of caring for someone living with frailty to your own practice • Identify strategies to prevent frailty and plan patient messages to encourage uptake of preventive care activities
	Module 3: Roles and Responsibilities of the Interprofessional Team
	By the end of this module, you will be able to: • Identify core competencies required for interprofessional teams • Describe roles and responsibilities of different health and social care professionals who might provide care to older adults living with frailty • Facilitate the inclusion of older adults and care partners on the team
2	**Module 4: Age Related Changes**
	By the end of this module, you will be able to:

	• Define normal aging • Identify age-related changes with a focus on delirium, falls, sensory changes • Link age-related changes with geriatric syndromes • Recognize atypical presentations of Illness in the older adult • Identify "Red Flags" signaling unsafe or urgent medical concerns in the older adult • Identify common chronic illnesses seen in older adults (e.g. CHF, COPD pathways, diabetes pathways) • Discuss approaches to chronic disease management and self-management in Ontario • Discuss the implication of chronic disease care for the geriatric patients (multi-focus versus traditional unidimensional)
	Module 5: Overcoming Ageism and Its Effects
	By the end of this module, you will be able to: • Identify myths and facts related to aging • Identify misconceptions of the aging population and ageism in healthcare.
3	**Module 6: Communication with the Older Adult**
	By the end of this module, you will be able to: • Demonstrate compassionate and patient-centered care • Identify core elements of Senior Friendly Care • Effectively communicate the unique needs of older adults • Recognize the significance of behavioural observations in dementia care • Collaboratively communicate and advocate for the unique needs of older adults with other care providers. • Apply communication strategies/skills for person centered communication.
	Module 7: What Older Adults Want
	By the end of this module, you will be able to: • Understand the perspective of older adults • Identify approaches to goal-based care planning and own role as advocate • Discuss "aging in place" as a concept and a motivation • Introduce Advance Care Planning
4	**Module 8: Early Identification, Screening, and Assessment**
	By the end of this module, you will be able to: • Discuss the basics of assessment in the older adult • Understand the importance of early identification and screening of frailty and other concerns • Perform and interpret an environmental safety scan at home • Perform and interpret the pictorial fit-frail scale and other frailty screeners • Consider next steps following screening, clarifying "responses" of different roles following screening
	Module 9: Tier 1 Wrap Up & Evaluation
	• Complete an evaluation of the education provided

Tier 2: Core Geriatric Knowledge for Interprofessional Teams
Facilitated Learning Series

The two main goals of the **Tier 2** facilitated sessions are to continue to increase knowledge by adding depth to the foundational knowledge obtained in Tier 1 and to increase skill by developing clinical skills to integrate into practice.

The learning outcomes of Tier 2 are as follows:

Tier 2: Core Geriatric Knowledge for Interprofessional Teams
2.1. Adapt processes of care (approaches to care for older adults)
2.2. Understand function and conduct a frailty screen and functional inquiry
2.3. Recognize and respond to geriatric syndromes (pain, continence, nutrition, polypharmacy, cognition, mental health, delirium, mobility, sleep, substance use) within professional role
2.4. Foster social connectivity
2.5. Recognize and respond to the unique needs of caregivers
2.6. Contribute to care plans, treatments, and interventions
2.7. Facilitate system navigation

Week	Tier 2 Modules & Learning Objectives
5	**Module 10: Introduction to Tier 2**
	By the end of this module, you will be able to: • Introducing Tier 2 learning goals and objectives • Introducing approach to learning • Identify desired personal level of mastery in the recognize/respond approach to care appropriate for own role
	Module 11: Process of Care
	By the end of this module, you will be able to: • Understand the role and importance of inter-disciplinary nature of geriatrics. • Review the elements of the Senior Friendly Care Framework related to processes of care • Complete a personal and organizational self-assessment of the current state of senior friendly processes of care related to one's own context
	Module 12: System Navigation
	By the end of this module, you will be able to: • Identify health, community, and social services in local area • Understand the importance and benefits of the 'warm hand off' the required individual and organization supports for enabling this
6	**Module 13: Frailty, Function and Functional Inquiry**
	By the end of this module, you will be able to: • Recap normal aging (from tier 1) • Recap holistic definition of frailty and strategies to prevent frailty (from tier 1) • Perform and interpret frailty screeners (i.e. the Clinical Frailty Scale) • Understand the meaning of baseline function and approaches to functional inquiry
7	**Module 14: Geriatric Syndromes (Part 1): 3D's Dementia, Delirium, Depression**
	By the end of this module, for each of the geriatric syndromes, you will be able to: • Define it (increase knowledge) • Apply new knowledge to their clinical interactions (ie. Impact on function and safety)(applying knowledge) • Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)

8	**Module 15: Geriatric Syndromes (Part 2): Mobility, Falls, Pain, Polypharmacy**
	By the end of this module, for each of the geriatric syndromes, you will be able to: • Define it (increase knowledge) • Apply new knowledge to their clinical interactions (ie. Impact on function and safety)(applying knowledge) • Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)
9	**Module 16: Geriatric Syndromes (Part 3): Continence, Nutrition & Sleep**
	By the end of this module, for each of the geriatric syndromes, you will be able to: • Define it (increase knowledge) • Apply new knowledge to their clinical interactions (ie. Impact on function and safety)(applying knowledge) • Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)
10	**Module 17: Sexuality**
	By the end of this module, you will be able to: • Recognize the need to support sexuality & intimacy in all older adults • Dispel myths and misconceptions about older adults and sexuality • Respond appropriately with practical supports for sexuality & Intimacy
	Module 18: Social Connectivity
	By the end of this module, you will be able to: • Differentiate between social isolation, loneliness, and social support (knowledge) • Understand the impact of social isolation on older adults (e.g. Impact on function and safety)(applying knowledge)
11	**Module 19: Caregivers**
	By the end of this module, you will be able to: • Recognize the importance/value of interacting with caregivers. • Understand the unique requirements of caregivers who support individuals living with frailty • Identify resources to support caregivers to meet their needs related to caring for the caregiver, pain, staying active, nutrition, bladder health, medication management, changes in thinking and behaviour and social engagement • Identify supports for caregivers to develop confidence in their approach and skills, personalize strategies related to specific aspects of care and access resources that meet their needs
	Module 20: Care Planning and Intervention
	By the end of this module, you will be able to: • Recap compassionate and person-centered care • Identify reliable sources of information to inform the personal history • Identify techniques for communicating with people living with dementia or aphasia for the purposes of assessment and treatment. • Identify strategies to gather information about a patient's beliefs, concerns, expectations and illness experience • Use information about behavioural interventions to inform a person-centered goal-based care plan • Identify strategies to check for patient and caregiver understanding, ability and willingness to follow through with recommended interventions • Apply approaches to providing feedback to the interprofessional team on the evaluation of the care plan to inform refinement of plan

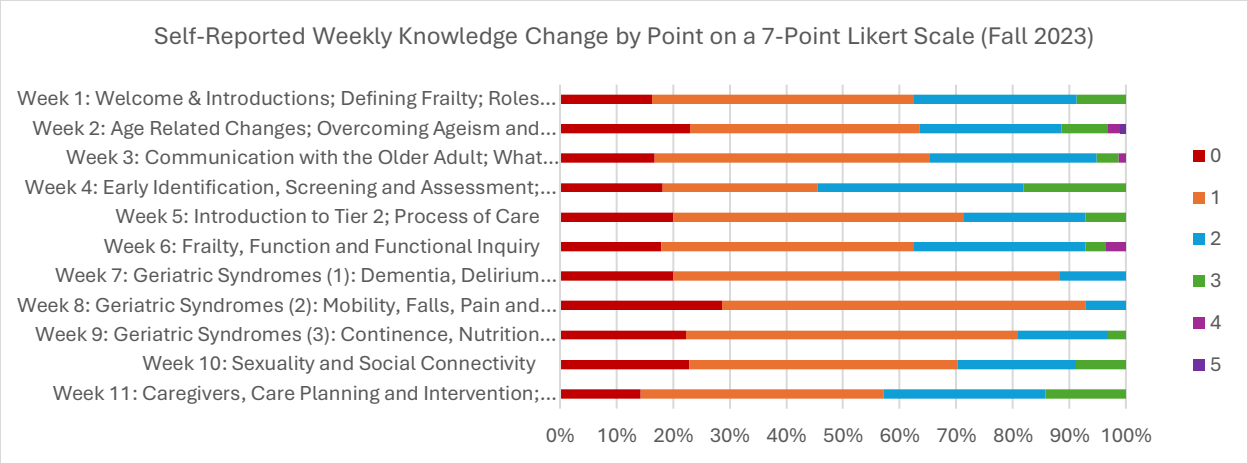
Appendix 2: Participating Organizations Provincial Common Orientation 2023/2024

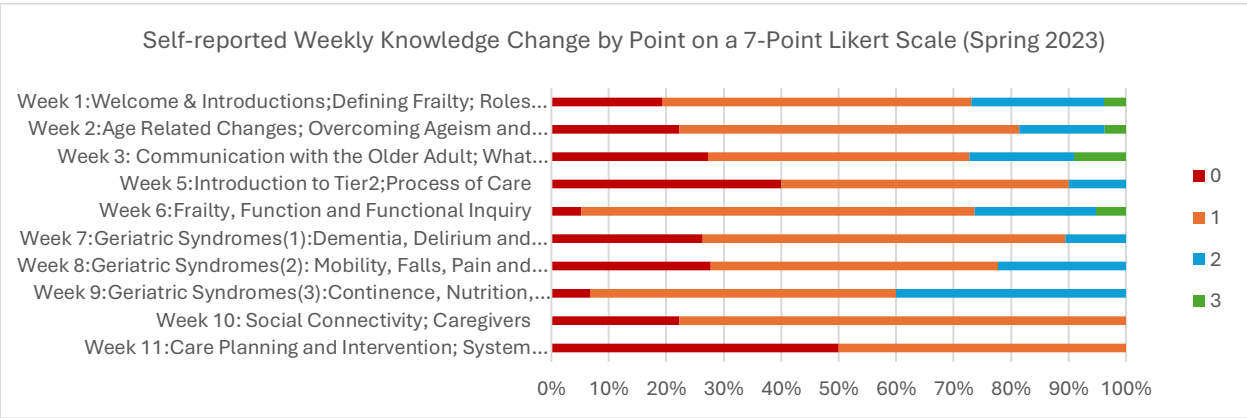
	Participants by Cohort			
Participating Organizations	**Fall 2023**	**Spring 2023**	**Winter 2024**	**Grand Total**
Algoma District Paramedic Services		1		1
Alzheimer Society	2			2
Alzheimer Society Cochrane-Temiskaming	2			2
Alzheimer Society Of Brant	1			1
Alzheimer Society of Chatham Kent	2			2
Alzheimer Society of Peel	5			5
Alzheimer Society of Timmins	4	1		5
Atikokan Health and Community Services			1	1
Baycrest Health Sciences	3	1		4
Bayshore Integrated Care Solutions			1	1
Blanche River Health	1			1
Bluewater Health			1	1
Brant Community Healthcare System	1			1
Canadian Mental Health Association		2		2
Canadian Red Cross			6	6
Carefirst Seniors and Community Services Association		1		1
Carlton Place District Memorial Hospital			2	2
City of Hamilton Paramedic Service	1			1
City of Kawartha Lakes	7			7
City of Ottawa, Garry J. Armstrong LTC Home	1			1
Collingwood General and Marine Hospital	1			1
Community Addiction and Mental Health Services of Haldimand-Norfolk- SGS Program			1	1
County of Renfrew paramedic service		2		2
Dilico Anishinabek Family Care			1	1
District Social Services Administration Board			1	1
Équipe de santé familiale Nord-Aski Family Health Team	1	3		4
Essex Windsor EMS Community Paramedic Department	1			1
Georgian Bay General Hospital	5			5
Geraldton District Hospital			6	6
Giishakaandoago "Ikwe Health Services (Tribal Area Health Services)			2	2
Halton Healthcare	12			12

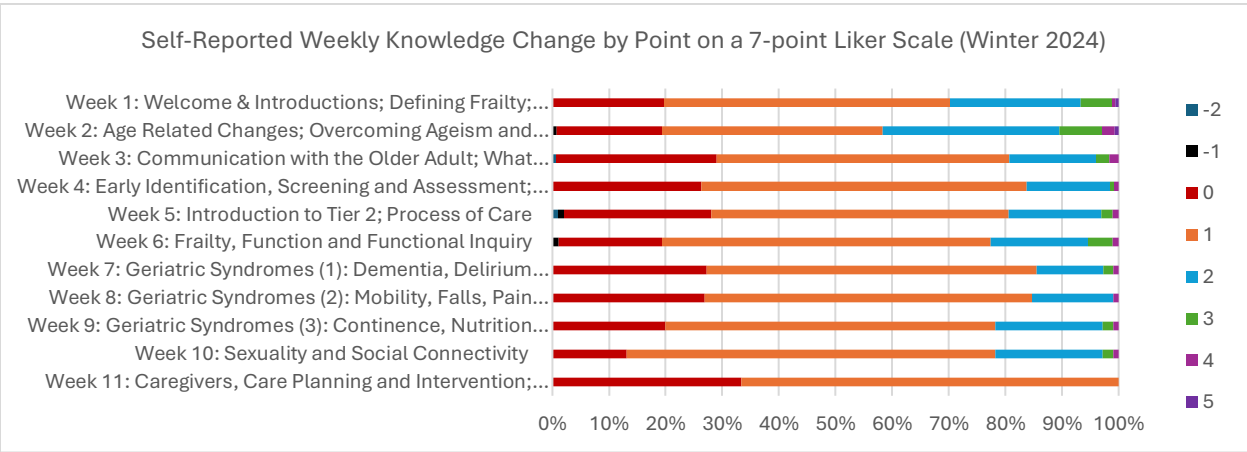
HCCSS NE	11	13	45	69
HCCSS NW			8	8
HCCSS WW	1			1
Headwaters Health Care			1	1
Health Sciences North	4	5	2	11
Health Sciences North - North East Specialized Geriatric Centre	2		10	12
Hogarth Riverview Manor St. Joseph's care group			1	1
Hôtel-Dieu Grace Healthcare		7		7
La Verendrye Hospital - Riverside Health Care			1	1
Lake of the Woods District Hospital			1	1
LAMP Community Health Centre		1		1
LOFT Community Services	1			1
Mackenzie Health	26	2	4	32
Muskoka Algonquin Healthcare	5			5
New Vision Family Health team	1	3		4
Niagara Emergency Medical Services			2	2
Niagara Health			2	2
Nipigon District Memorial Hospital			1	1
Norfolk County Paramedic services			1	1
North Bay Regional Health Centre	5	3	11	19
North of Superior Healthcare Group - The McCausland Hospital site			2	2
North Shore Family Health Team			4	4
North Shore Health Network		2	1	3
North Simcoe Muskoka SGS	3			3
North York General Hospital		8		8
Northumberland County Community Paramedic Program	2			2
Oak Valley Health	3			3
Oakville Trafalgar Memorial Hospital	1			1
Ontario Health		1	1	2
Orillia Soldiers' Memorial Hospital	11			11
Partners In Rehab			1	1
Providence Care Hospital			1	1
Providence Healthcare			2	2
Reena		1		1
Region of Waterloo Paramedic Services	1			1
Regional Municipality of Durham	2			2
Riverside Health Care			2	2
Royal Victoria Regional Health Centre	13		3	16

Saint Elizabeth			1	1
Sault Area Hospital	8	2	5	15
Sault Ste Marie Community Paramedicine			1	1
Sioux Lookout Meno Ya Win Health Centre			3	3
Southlake Regional Health Centre	7			7
SPRINT Senior Care		3		3
St Joesph's Healthcare Hamilton			1	1
St. Joseph's Care Group	5	6	27	38
St. Joseph's Continuing Care Centre - Sudbury		1	10	11
St. Joseph's Health Care London	1	1	1	3
St. Joseph's Healthcare Hamilton			7	7
Stevenson Memorial Hospital	1			1
Sunnybrook Health Sciences Centre	1			1
Superior North EMS- Community Paramedicine		1	2	3
Temiskaming Community Paramedicine	1			1
Temiskaming Hospital			8	8
Thunder Bay Regional Health Sciences Centre			1	1
Timmins and District Hospital	4	3	2	9
Toronto Paramedic Services			2	2
Trillium Health Partners	8		7	15
Unity Health Toronto			1	1
West Nipissing General Hospital			1	1
West Park Healthcare Centre			1	1
West Parry Sound Health Centre		10		10
Western York Region OHT	1			1
William Osler Health System	5			5
Yee Hong Centre for Geriatric Care		2		2
Grand Total	**184**	**86**	**210**	**480**

Appendix 3: Self-reported Weekly Knowledge Change by Cohort







Appendix 4: CGA Knowledge to Action Committee Members (2018-2023)

Name		Title	Organization
Miriah	Botsford	Nurse Practitioner	North West Specialized Geriatrics Services
Carla	Brittos	Advanced Practice Nurse	North Simcoe Muskoka SGS
Alison	Denton	Program Manager	North West Regional Seniors' Care
Michelle	Doherty	Education Coordinator	Regional Geriatric Program Central
Sabeen	Ehsan	Director of Quality	Seniors Care Network
Chris	Gabor	Education Coordinator	Regional Geriatric Program Central
Shaen	Gingrich	Geriatric Knowledge Translator	North East Specialized Geriatrics Centre
Alekhya	Johnson	Knowledge-to-Practice Project Manager	Regional Geriatric Program of Toronto
Kelly	Kay	Executive Director	Provincial Geriatrics Leadership Ontario
Heather	MacLeod	Knowledge Translation Specialist	Regional Geriatric Program of Eastern Ontario
Tamara	Nowak-Lennard	Clinical Manager	North Simcoe Muskoka SGS
Danielle	Petruccelli	Clinical Manager, Complex Care & Orthopedics	Hamilton Health Sciences
Jenny	Siemon	Director	Regional Geriatric Program Central
Marion	Tabanor	Psychogeriatric Resource Consultant	Peterborough Regional Health Centre