MEMORANDUM

September 30, 2003

To: Pallium Professional Community Stakeholders

From: Dr. José Pereira, Pallium Project Leader

Re: Pallium Rural and Remote Health Innovations (RRHII) Project Report

Dear Colleagues,

I am pleased to share with you a copy of the Pallium Rural and Remote Health Innovations Initiative (RRHII) Project Report. With the submission of the RRHII Project Report to Health Canada, we have now completed all obligations associated with implementing this project.

It is through the active involvement of the colleagues in our professional community, such as yourself, that we have been able to advance Canadian hospice palliative care knowledge, skills and service provision. We have made some very promising progress that has received national attention. As you know, our efforts have led to:

- Innovative applications of needs assessment for hospice palliative care that are closely aligned with making real progress for improving the quality of patient care outcomes.
- Demonstrating new ways of using information and communications technologies to provide outreach and support to primary-level, health care professionals in rural and remote areas.
- Developing responsive curricula and modeling successful pilots for multi-professional education that mirror the team-based environment so essential to hospice palliative care.

The foundation building work that was undertaken with the original RRHII Contribution Agreement has provided the seeds for important pan-Canadian work to continue. We have received positive signals from Health Canada regarding the status of our $4 million, 3 year project application for continuing this work. I was advised in September 2003 that our Pallium PHCTF project application has been recommended to the Minister of Health for approval by the Primary Health Care Transition Fund (PHCTF) under the National Initiatives category. We continue to wait and hope for a successful outcome from that process in the near future.

I think we can all justifiably be very proud of the early work that was enabled by the $250,000 Contribution Agreement from the Rural and Remote Health Innovations Initiative (RRHII). We were able to lever considerable resource and relationship development with a relatively modest investment, and we were able to actively engage many rural stakeholders to examine how quality and responsive hospice palliative care could be made more accessible to rural Canadians.

Please do not hesitate to contact me if you have questions about the RRHII Project Report or, more generally, the future of the Pallium Project.
RRHII Project Report

Submitted to Health Canada, Population Health Fund & Office of Rural Health as final reporting for

The Pallium Project – RRHII Contribution Agreement A Health Human Resource CPD Initiative In Palliative Care

Project Reference # 6788-15-2000/0390420 funded under the National Projects category of the Rural and Remote Health Innovations Initiative (RRHII)

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ACKNOWLEDGEMENTS

The project development team and the Project Advisory Council (PAC) would like to gratefully acknowledge the many individuals, teams, and organizations who have been involved in the Pallium Project, from its very humble beginnings through to the vibrant professional community into which it continues to evolve.

We thank the Government of Canada for the catalytic financial contribution through Health Canada’s, Office of Rural Health, Rural and Remote Health Innovations Initiative (RRHII).

We thank the administrative staff of the Alberta Cancer Board corporate office and the Palliative Care Network Initiative (PCNI), for their generous organizational and project infrastructure support in serving as Project Sponsor for the RRHII Contribution Agreement, and as Administrative Hosting Authority for the Pallium Project.

We thank the academic faculty of the Institute for Professional Development, University of Alberta, for their very early support in concept development, and ongoing conceptual and facilitative leadership in project development and management.

We thank the staff at Health Canada’s, Palliative & End-of-Life Care Secretariat and in the office of the Honourable Sharon Carstairs, Government Leader in the Senate and Minister with Special Responsibility for Palliative Care. You demonstrated genuine interest, enthusiasm and encouragement, and served as invaluable navigators when we needed help to understand and move through the dynamic and rapidly evolving landscape of Canadian hospice palliative care.

We thank the “giants” of hospice palliative care education in North America, many whom have demonstrated a pioneering spirit for some 3 decades. You showed patience, wisdom and tremendous generosity with your time and insights as this project was conceived and implemented – as teachers, informal mentors, coaches, and companions of kindred spirit. Without your pioneering and early collective contributions to the field, we simply would not be in the enviable position we enjoy today in being able to build on your essential foundational work.

We are deeply appreciative of the community of clinicians, educators, academics, and non-governmental leaders who came together throughout the Project to provide insights, expertise, support, encouragement and continued commitment in what can only be described as a challenging “innovation expedition.” As a professional community, you demonstrated a spirit of generosity and genuine engagement that is an example for all colleagues in the life and social sciences, who are challenged to share in the responsibility of addressing challenging societal problems.

Finally, we thank our families, and the families of our collaborators, who have been supportive silent partners as we guided the development of this project. We respect the investment of many weekends and evenings necessary to be come together with busy clinicians, as a critical success factor in enabling this project to unfold in the manner in which it has.

Pallium Project Development Team
March 2003
GLOSSARY & KEY DEFINITIONS

CFPC  College of Family Physicians of Canada
CNA  Canadian Nurses Association
CPD  Continuing Professional Development
CHPCA  Canadian Hospice Palliative Care Association
CMC  Computer Mediated Conferencing
ELNEC  End-of-Life Nursing Education Curriculum
EPEC  Education for Physicians on End-of-Life Care (United States)
EPERC  End-of-Life Care Physician Education Resource Center (United States)
HCP  Health Care Professional
HHR  Health Human Resources
OJC  Online Journal Club
PAC  Project Advisory Committee (project governance advisory body)
PHCTF  Primary Health Care Transition Fund (Health Canada funding envelope)
RPN  Rural Palliative Network
RWC  Regional Weekend Course
RRHII  Rural & Remote Health Innovations Initiative (one-time Health Canada funding)

Hospice Palliative Care  Hospice palliative care strives to help patients and families:
- Address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears.
- Prepare for and manage self-determined life closure and the dying process
- Cope with loss and grief during the illness and bereavement.
(Canadian Hospice Palliative Care Association, 2002)

Rural/Remote  Typically associated with the distance from a referral hospital with core specialty services. Rural health care relates to the provision of health services to areas outside of metropolitan centres where there is not ready access to specialist, intensive and/or high technology care, and where resources, both human and material, are lacking. This service may be within hospitals, health centres, clinics or independent practices. It is best provided by a team of health care workers and is based on the principles of primary health care. Couper, I.D. (2003). Rural hospital focus: defining rural. Rural and Remote Health 3, 205. Available: http://rrh.deakin.edu.au
EXECUTIVE SUMMARY

The Pallium Project was conceived in 2000 as a demonstration and innovation project in health human resources (HHR), continuing professional development (CPD). The overarching aim was to improve care of those presenting with life-limiting illness in Canada, through demonstrating key innovations and a proof-of-concept for a system-linked CPD project. Pallium’s founding mission is that it exists to significantly improve access to education and training resources in palliative care for Canadian health care professionals and the Canadian public.

In February 2001, Health Canada announced $250,000 in catalytic funding for Pallium through the Rural and Remote Health Innovations Initiative (RRHII). The RRHII Contribution Agreement enabled eight Major Activities, including:

- Activity 1 – Needs Assessment
- Activity 2 – Resource Mapping
- Activity 3 – Web Portal
- Activity 4 – Telehealth Pilots
- Activity 5 – Module Development
- Activity 6 – Evaluation
- Activity 7 – CPD Model Development
- Activity 8 – Dissemination

Pallium’s jurisdictional catchment for the RRHII-project was Alberta, Saskatchewan, Manitoba and NWT and included the active involvement of stakeholders from several sectors, such as: health services delivery, academic health sciences, government, and non-governmental organizations.

Pallium’s RRHII-project took place at a time of exciting developments at the national-level, including:

- formation of a special ministerial portfolio in the federal cabinet to focus and champion hospice palliative care policy and high-level initiatives,
- the founding of the Canadian Virtual Hospice (CVH) project;
- a National Action Planning Workshop on End-of-Life Care; and
- release of the Canadian Hospice Palliative Care Association’s (CHPCA) Model to Guide Hospice Palliative Care.

Context played a very important strategic direction setting role in the implementation of the project, and sensitivity and sensibility was paid to overall project design and implementation relative to these exciting developments.

From March 2001 through March 2003, the Pallium Project implemented the Major Activities. This resulted in several innovations of note, including:

- a hospice palliative care professional Community of Practice (CoP);
- pioneering use of occupational analysis methods for needs assessment in hospice palliative care;
- the first rural Online Journal Club in Canada;
- a North American Rural Palliative Network;
- Canada’s first web-accessible palliative care teaching-learning resource clearinghouse; and
- innovative courseware in community-level provision of hospice palliative care as well as a values- and relational-based approach for courseware to help those providing service to aboriginal clients in rural/remote settings.

Major achievements cited in the summative participatory evaluation process include:

- the development of educational materials;
- increased awareness of palliative care, and
- collective ownership of the project development process.

The summative evaluation process also found three main effects of the RRHII-funded project are:

- increased awareness of palliative care, particularly for rural areas;
- the achievement of local learning for rural palliative caregivers, and
- the development of partnerships and collaborations.

Stakeholders have advocated for continuation of the processes that have been established and building on the momentum that has been created by the project. To this end, the project development team has worked with stakeholders through to a point where an application and full-proposal for a 3 year, $4.2 million
project has been invited and submitted under the National Initiatives envelope of the Primary Health Care Transition Fund (PHCTF).

Major barriers to overcome in building Canada’s hospice palliative care capacity include the “system readiness” necessary to engage and fulfill the commitments entailed with health care reform, especially the February 2003 First Minister’s Accord on Health Care Renewal, and the service expectations for hospice palliative care. There is considerable work to be done on matters addressing the organizational culture and leadership disposition such that widespread diffusion of integrated and interdisciplinary hospice palliative care can be enabled.

There is also considerable work to be done in continuing to transform hospice palliative care CPD from a predominantly Education Model paradigm, to a broader capacity-building paradigm. Rural/remote HCPs learn in a variety of ways, only one which is participation in formal continuing education programs. The context of professional practice is important to learning and more thought and effort could be invested in developing workplace and professional learning systems that support “just-in-time” learning and knowledge management, to mitigate the effects of working in relatively low-volume environments vis-à-vis primary-level, hospice palliative care.

The “democratization” of specialist clinical and care information often compels reluctantly empowered consumers and colleagues to challenge physician and care team member inaction and decision choice about hospice palliative care for themselves and loved ones. It strains relationships and perpetuates further defensive responses on the part of HCPs. One of the most profound barriers to remove in hospice palliative care CPD/service provision is the professional/organizational cultural impediments that “disables” physicians and other members of the care team from admitting that they do not know how to deal with a patient concern – in the moment!

The reality is this behavior continues to be perpetuated by many health education cultures and curricula that still do not value hospice palliative care as core to health science education. How can we realistically hold HCPs to account for being aware and competent for something that most were never exposed to in the first place? More realistically, rural/remote HCPs need to be empowered as “knowledge managers,” with skills to know who, how, and where to go get appropriate information and consultative support on a just-in-time basis, and integrate said knowledge into a safe, ethical and effective response.

The RRHII-project also demonstrated that national solutions which involve considerable inter-jurisdictional interdependence and inter-sectoral collaboration can have impact. They can also provide a useful means for the Government of Canada to collaborate in areas where there is considerable complexity due to the constitutional division of powers and the pursuit of shared interests within Canada’s model of a federated nation-state. Moreover, meaningful partnership models are essential to building and sustaining collaboration for both relational and substantive contributions to project development.

An emerging framework for accountable and responsive palliative care that is system-linked is presented. It situates an integrated approach to CPD within a deep appreciation for the role of contextual factors in the form of social, economic, political and technical forces. It also addresses multi-faceted strategies for facilitating workplace and professional learning.

Suggested directions for the future of the Pallium Project and Canadian hospice palliative care are:

1. A National Approach – Adoption of the CHPCA’s Model to Guide Hospice Palliative Care as the foundation for CPD and organizational development.

2. Links to Primary-care Reform – Leverage the opportunities presented by the emphasis placed on primary-health care reform.

3. Targeted Health Human Resource Investment in Rural Canada – Given chronic short staffing and complexity of practices that require considerable depth and breadth, continue to invest financial and relational resources in rural/remote CPD generally, using aspects of the Pallium framework to support workforce renewal and development.
4. **Focused Engagement of Canadian Health Education Leaders** – The real opportunity for systemic change will come from commitments by health education leaders to give hospice palliative care its due and integrated consideration as a core curriculum item that is clearly linked to the continuum of care.

5. **Inter-departmental Collaboration on the Digital Divide** – Collaborate with Heritage Canada and the Office of the Commissioner of Official Languages, to invest in thoughtful policy research, program directions and experimentation to reduce the overall disparity in access to health care-related resources in both Official Languages. Moreover, collaborate with aboriginal stakeholders on demonstration projects to make hospice palliative care information available in oral (digital audio) and text (printer friendly-versions) in various media formats and in the major languages of Canada’s Aboriginal people.

While Pallium represents a glimmer of hope of the way we might work together to build capacity and provide better service for those who are at a most vulnerable time in their life’s journey, its work has just begun. Much is left to do to impact the system/organizational culture and system development changes required to assure all Canadians, irrespective of place of residence or socioeconomic status, are afforded the opportunity to face life-threatening illness and death, with dignity, in relative peace and comfort, free from needless pain and suffering.

This summative Project Report will illustrate how Pallium’s stakeholders worked through the RRHII-project to achieve outcomes consistent with the goals articulated in the RRHII program envelope. It will also demonstrate specific innovations consistent with that which was committed in the original proposal/application.

This Project Report serves several purposes. At one level it is a historical and archival document. At another level it is a vehicle to capture reflections, self-evaluation, and third-party, independent and unedited participatory evaluation information. Perhaps most importantly, however, it is a tool to help stimulate thinking, reflection and dialogue in Canada, about how CPD might evolve in other areas. This can help support health human resources policy that is linked to Health Care Renewal and system reform, as well as aid thinking about the accountability linkages between continuously developing and renewing people as part of sustainable health care system development in Canada.
PROJECT HIGHLIGHTS

• Health Canada announces the Pallium Project has been awarded $250,000 in catalytic funding for a proof-of-concept and demonstration project under the aegis of the Office of Rural Health’s, Rural and Remote Innovation’s Initiative (February 2001).

• Leading hospice palliative care authority sources from Canada and the United States convene at a Pallium Project Launch symposium with rural palliative care opinion leaders and specialist colleagues from western Canada, to examine current best practice and map out specific regional strategies for achieving Pallium RRHII-related project commitments (April 2001).

• Senator Sharon Carstairs, Government Leader in the Senate, and Minister with Special Responsibility for Palliative Care, launches the Pallium.ca web-site and online “learning lab” at the Calgary Health Region’s, Palliative Care Open House (September 2001).

• Representatives from the divisions of palliative medicine and extension/continuing studies units at the universities of Alberta, Calgary, Saskatchewan and Manitoba convene to discuss collaboration on the development of an inter-disciplinary post-graduate palliative care credential (January 2002).

• The Ian Anderson Continuing Education Program and the Pallium Project co-produce an Information Exchange and Faculty Development Session entitled Constructing Responsive Palliative Care Professional Education, led by Dr. Larry Librach, W., Gifford-Jones Professor in Pain Control and Palliative Care, University of Toronto & Director, Temmy Latner Centre for Palliative Care, Mount Sinai Hospital (February 2002).

• Hospice palliative care clinicians and specialists from Alberta, Saskatchewan, Manitoba and NWT convene in Calgary to map major areas of responsibility and major tasks associated with providing hospice palliative care in primary-care practice and secondary-level, rural settings in DACUM occupational analysis workshops (January & February 2002).

• 12 family physicians, registered nurses and a pharmacist, from Alberta, Saskatchewan and Manitoba participate in a 3 month demonstration of Pallium’s first Online Journal Club (OJC), using web-based computer mediated conferencing as the medium for participation (March 2002).

• Pallium’s project development team and several stakeholders participate in the Health Canada sponsored, invitational National Action Planning Workshop on End-of-Life Care (March 2002).

• Info-task Incorporated and the University of Alberta, Institute for Professional Development deliver Current state and infrastructure for e-learning in palliative and end-of-life care: Selected Canadian jurisdictions, as a “road map” for seeding innovation using tele-health technologies (May 2002).

• The Pallium Project submits a Letter of Intent (LoI) under the National Initiatives envelope of Health Canada’s, Primary Health Care Transition Fund, proposing a 3 year, $4.2 million project to extend the foundation building work of the project (August 2002).

• A beta-test version of the Canadian Clearinghouse of Palliative Care Teaching-Learning Resources is delivered (August 2002).

• Twenty-five clinician-educators from Alberta, Saskatchewan and Manitoba convene to collaborate on final program development and engage in initial facilitator-training for Clinical Introduction to Palliative and End-of-Life Care in Primary-Care Practice (September 2002).
Twenty rural health care professionals and the first cohort of Manitoba-based Pallium-faculty deliver a three-day, small-group retreat based Regional Weekend Course (RWC) pilot of the Clinical Introduction courseware in collaboration with the Parkland Regional Health Authority in Dauphin, Manitoba (September 2002).

Representatives of the Pallium Project present several juried oral presentations and a juried poster presentation at the 14th International Congress on Care for the Terminally-ill in Montréal (October 2002).

Dr. José Pereira, Pallium Project Leader, is awarded the Canadian Hospice Palliative Care Association’s (CHPCA) 2002 Award of Excellence, in part, citing his facilitative and catalytic leadership in helping to improve hospice palliative care in rural practice (October 2002).

The College of Family Physicians of Canada (CFPC) awards MAINPRO-C accreditation to the University of Calgary, Office of Continuing Medical Education and Professional Development as administrator and quality assurance oversight steward of the Clinical Introduction to Palliative and End-of-Life Care in Primary-Care Practice courseware (October 2002).

Gaye Hanson, Pallium Aboriginal Relations Consultant, delivers a one-hour provincial “tele-rounds” education outreach session, via video conference throughout Alberta, on aboriginal palliative care topics, in collaboration with Lakeland Regional Health Authority, Regional Palliative Care Program’s, Monthly Tele-rounds initiative (November 2002).

Dr. José Pereira, Pallium Project Leader, is invited to co-chair the National Working Group on Education for Formal Caregivers, one of five national working groups integral to the development of a Canadian Strategy on Palliative & End-of-Life Care (November 2002).

Some 180 health care providers from across the Northwest Territories convene in Yellowknife for a Territorial Palliative Care Conference co-produced by the Government of the Northwest Territories, Department of Health and Social Services and the Pallium Project (February 2003).

The Pallium Project is invited by the Primary Health Care Transition Fund (PHCTF) to submit a full proposal, based on its August 2002 Letter of Intent, for a 3 year, $4.2 million project under the National Initiatives envelope category (February 2003).

Twenty-two health care professionals from the recently formed Sunrise Health Region (SHR) convene in Yorkton, Saskatchewan, to participate in an industry-sponsored version of the Clinical Introduction course, in its small-group learning-based Regional Weekend Course format and produced by the SHR’s palliative care service unit (March 2003).

The Rural Palliative Network (RPN) is relaunched using Blackboard computer mediated conferencing (CMC) platform under an operating agreement with the ACB Tom Baker Cancer Centre/University of Calgary’s, Centre for Distance Learning in Palliative and Supportive Care (March 2003).

Course Planning Manual & Courseware for Providing Hospice Palliative Care with Aboriginal Clients in Rural and Remote Settings is delivered in its Version 1.0 format (March 2003).

Clinical Introduction to Palliative and End-of-Life Care in Primary-Care courseware available for use throughout Canada by Pallium-prepared clinical educator faculty (March 2003).

RRHII- Project funding and Contribution Agreement Terms of Reference conclude and project transition/reporting (post-March 2003).
INTRODUCTION

The provision of quality care for those experiencing life-threatening or life-limiting illness is a growing concern. Quality hospice palliative care for those with life-threatening and life-limiting illness represents a profound societal challenge.

The Senate Sub-committee to Update Of Life and Death reported only 5% of dying Canadians receive integrated and interdisciplinary palliative care. The Sub-committee noted some 220,000 Canadians die each year. It also noted that 75% of all deaths occur in people over 65 years of age and that currently, 75% of deaths take place in hospitals/long-term care facilities.

The number of people in Canada dying annually is expected to grow, is clearly linked to the demographics of Canada’s aging population, and will reflect greater incidence of expected deaths. The demographics further suggests that engaging those experiencing life-threatening and life-limiting illness, in a compassionate, cost-effective and sustainable manner, necessitates a rethinking of our individual and collective abilities and responsibilities for improved population health.

Moreover, there is a projected 70% increase in cancer cases in Canada by the year 2015 and the current reality is that some 50% of those presenting with cancer will perish to cancer-related illness. There is also expected to be a marked increase in other chronic life-limiting illness, including end-stage organ failure (especially heart, lung, renal related organ failure), neurological illness (e.g., Alzheimer’s, MS, ALS) and immunological illness.

In cancer patients with life-limiting illness, over 80% experience pain, and in more than half of these cases, pain is severe if untreated. The average number of symptoms experienced by these patients is 9. Over 70% of patients with advanced Amyotrophic Lateralizing Sclerosis (ALS), experience breathing difficulties. Over 50% of patients with end-stage cardiac failure have been found to have severe depression, as well as severe breathing difficulties. The burden of symptoms causes needless suffering on these patients and their families when left unmanaged.

Many studies have consistently shown knowledge, skills and attitude deficits of health care professionals (HCPs) in caring for patients with life-limiting illness. The majority of primary health professionals currently in practice received no training in their undergraduate and graduate programs. They are not skilled in the management of treating chronic pain, psychological suffering and numerous communication deficits have been demonstrated. Moreover, most are totally unaware of the undue pain and suffering by their lack of knowledge and skill. Many have not come of age where there is more enlightenment and evidence about pain and complicated disease, and the proactive role health care professionals can play in mitigating undue pain and suffering.

At the same time, rural/remote HCPs are being called on to provide more appropriate and effective care to those experiencing life-threatening and life-limiting illness. Rural health care professionals (HCPs) are a critical bridge in the continuum of care. They are often the first to identify the early signs of life-threatening illness, through their work in community-based office and home-care practice, and have an...
opportunity to intervene early in engaging specialist
care at the secondary and tertiary-levels of the health
delivery system. They are also, more often by default
than design, central players in the active management
of their patients and families at those times when life-
threatening illness transitions into life-limiting illness.

Project Background
The Pallium Project was conceived in 2000 as a
demonstration project in health human resources,
continuing professional development (CPD). Its
overarching aim was to improve care of those
presenting with life-limiting illness in Canada,
through demonstrating key innovations and a proof-
of-concept for a system-linked CPD project. Its
intended jurisdictional operating catchment area was
Alberta, Manitoba, Saskatchewan and North West
Territories. It was oriented towards enhancing the
ability of rural/remote HCPs across disciplines to
provide accessible, effective, compassionate, timely
and appropriate care to those with life-limiting illness.

In February 2001, The Office of Rural Health and the
Population Health Fund at Health Canada, notified the
project development team of The Pallium Project that
a $250,000 Contribution Agreement had been
awarded. This Contribution Agreement was for the
catalytic work of the Project. It had been awarded
further to an August 31, 2000 application in a national
competition, in the Rural and Remote Health
Innovation’s Initiative (RRHII), National Projects
category. In March 2001, the Alberta Cancer Board
was established as a suitable Project Sponsor and
administrative hosting authority for the Pallium
Project RRHII Contribution Agreement.

The RRHII funding enabled several foundation
building and innovation/demonstration activities.
These activities were approved under the aegis of
eight Major Activities approved within the August 31,
200 application, through Health Canada’s competitive
review process, and are:

Activity 1 – Needs Assessment
Activity 2 – Resource Mapping
Activity 3 – Web Portal
Activity 4 – Telehealth Pilots
Activity 5 – Module Development
Activity 6 – Evaluation
Activity 7 – CPD Model Development
Activity 8 – Dissemination

The key organizing strategies for achieving the
RRHII-related project goals were: 1) inter-sectoral
collaboration and coordination, and 2) focused CPD
capacity-building initiatives characterized as
multifaceted, multi-tiered and multi-pronged. The
project was predicated on a value-decision that
responsibility for building palliative care capacity
should be shared by governments, health services
delivery, academic institutions, non-governmental
organizations, and individuals at different levels.

Several assumptions and design principles were used
to design the project. The project development team
and the Project Advisory Council (PAC)\(^6\) continually
revisited these design directions throughout the
project. These assumptions are:

- Local realities need to be addressed. That is,
  context and situational considerations in the
delivery of care is paramount in designing CPD
  which is responsive to improving quality of
  patient care and outcomes.

- The needs of those receiving care and the needs of
  HCPs as providers need to be identified and
  addressed in a way that is appropriate and
  effective for them.

- Care of the whole person that integrates the
  physical, psychological, social and spiritual needs
  of the patient and family is essential, therefore
  CPD needs to be sensible about integrating
  multiple disciplines.

- New paradigms for knowledge and skill
  development of HCPs call for thoughtful
  experimentation with information and
  instructional technologies to support CPD.

- Continuous needs assessment and formative
  evaluation, linked to continuous improvement, is a
  cornerstone of effective delivery and sustainability.

- Every reasonable effort should be made to avoid
  duplication and redundancy in the development of
  palliative CPD resources. Coordination on a
  meaningful scale across the prairie provinces and
  territories is a desirable aspiration.

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\(^6\) The RRHII-Project was governed collaboratively through a Project
Advisory Council (PAC), that provided input and feedback to the
Pallium Project Leader. Terms of Reference and membership of the
first Pallium PAC are presented in Appendix A.
Mission, Core Purposes, and Core Goals

In April 2001, a one-day project launch event was held at the University of Calgary, Health Sciences Centre. This event was oriented to providing presentations on the current best practice and lessons learned in palliative care education and professional development in Canada and the United States. Several leading authority sources in palliative care education made formal presentations and other stakeholders described current developments within the respective jurisdictions of the RRHII’s project’s scope. The afternoon involved a facilitated working session of key stakeholder representatives, using the basis of the Health Canada RRHII proposal as a beginning point.

The stakeholder representatives provided focused input that helped to further shape specific values, project mission inputs, suggested core purposes, and core goals. This process validated much of the general direction the project development team anticipated in the background research that informed the RRHII Contribution Agreement application. From that project launch event the following mission, core purposes and core goals were arrived at to guide the implementation of Pallium’s foundational activities.

Mission

Pallium exists to significantly improve access to education and training resources in palliative care for Canadian health care professionals and the Canadian public.

Core Purposes

1. A Canadian clearinghouse, knowledge exchange and Community of Practice for efficiently disseminating palliative care knowledge, skills and resources.

2. Coordinate, and facilitate the integration of, palliative care continuing professional development (CPD).

3. Collaborate among palliative care stakeholders on the adoption/adaptation of existing; and the creation of new, palliative care learning resources.

4. Facilitate strong, collaborative links with practitioners, policy makers, and scholars in palliative care research, public policy, clinical practice and education/professional development.

Core Goals

1. Map the local needs, issues and priorities related to rural and remote primary palliative care CPD and establish a framework approach for collaborative action.

2. Establish, nurture and coordinate a professional community of local multidisciplinary leaders/educators using information and communication technologies (ICTs) as a medium for communication, dialogue and dissemination about state-of-the-art, evidence-based practice.

3. Develop a repository of online CPD resources for primary health care professionals to address palliative care in a primary care context.

4. Develop an effective model for CPD at a distance through integrating traditional and emerging adult learning methods and emerging technologies.

Project Contextual Factors

During the operating window of the Pallium RRHII-project, several significant developments at the national-level occurred which impacted the context and specific direction and nature of the RRHII-project, and Pallium as a professional community. These include:

1. The appointment of Senator Sharon Carstairs, Government Leader in the Senate, as Minister with Special Responsibility for Palliative Care (March 2001).

2. Establishment of $1 million in funding, in part, to establish a national Palliative and End-of-Life Care Unit at Health Canada to focus Canadian policy development and cross-governmental coordination (June 2001).9

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7 Project Overviews are graphically represented in Appendix B.
8 Descriptive information about the April 27, 2001 Project Launch event is presented in Appendix C. Several of the presentations have been edited for time, and are available for listening as digital audio files on the companion Pallium RRHII Project Package CD-Rom.


5. Release of the Canadian Hospice Palliative Care Association’s (CHPCA) document A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice (June 2002).  

6. Announcement of an additional $500,000 from Western Economic Diversification to support further development of the Canadian Virtual Hospice (November 2002).  

The announcement of these national developments in hospice palliative care had a direct impact on the plans and timing of several Pallium RRHIII activities. In particular, the announcement and early development of the Canadian Virtual Hospice (CVH) project, required considerable re-working and adjustment of the timing of several of the specific activities the Pallium project development team proposed related to use of the web as a medium for rural/remote hospice palliative care outreach. Early efforts were successful in collaborating.  

The Pallium Project leader was invited to serve on CVH’s national steering committee. Extensive comparative analysis and liaison was undertaken early to avoid duplication between Pallium’s web development efforts and CVH. Pallium sought an agreement in principle, with CVH, to collaborate on future development of CVH as a partner in education and training-related services and content at a pan-Canadian level.  

The Pallium Project Leader and the Pallium Project Consultant were invited, along with other stakeholders in the Pallium Project, to participate in issue exploration and action planning during the pan-Canadian National Action Planning Workshop on End-of-Life Care in March 2002. Throughout the duration of the project, the Project was implemented with a particular sensitivity and sensibility to national directions, especially the evolving Canadian Strategy on Palliative and End-of-Life (an outcome of the March 2002 national action planning workshop).  

In autumn 2002, the Pallium Project Leader was invited to co-chair a National Working Group on Education for Formal Caregivers, as one of five working groups central to the development of a Canadian Strategy on Palliative and End-of-Life Care.  

Less central to the implementation of the Pallium RRHIII-project, but also important contextual developments that occurred throughout the duration of the project were significant high-level policy signals derived from the tabling of several national reports. These include the October 2002 Senate Standing Committee of Social Affairs, Science and Technology report The Health of All Canadians – The Federal Role (i.e., the Kirby Report) and the Final Report of the Commission on the Future of Health Care in Canada (i.e. the Romanow Report), which was released in early November 2002.  

The Kirby Report noted several recommendations in a chapter titled, Expanding Coverage to Include Palliative Home Care:  

- A $250 million/year co-funded National Home Care Program;  
- A compassionate leave income support program for employed Canadians who choose to take time away from paid employment to provide care to a dying relative at home;  
- Expanding tax measures to lessen the financial burden associated with purchasing services associated with providing care to family members with life-limiting illness;
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- Expanding the Canada Labour Code to allow for family crisis situations that include providing care to family members with life-limiting illness; and
- The Federal government, in its role as employer, demonstrate leadership for its own employees by providing job protection for those who need to care for a family member with life-limiting illness.

In February 2003, the First Minister’s Accord on Health Care Renewal also resulted in several commitments to new programs and funding. In particular, end-of-life care commitments play a prominent role in Health Care Reform, and is relevant to rural/remote HCPs (and is discussed in more detail herein).

Context played a very important strategic direction setting role in the implementation of the project. The impact of context dictated a request for project extensions. Two project extensions were requested by the project development team and granted by the Population Health Fund (with no additional funding) over the life of the project. All efforts were made during the RRHII-project to be sensitive to, and sensible about, context. The result of this strategy assured careful consideration always, coordination where possible, and integration when necessary with new developments. It was also governed by a need to complete additional analysis/due diligence, to mitigate the risk in duplicating public funding for targeted palliative-care related capacity building.
DESCRIPTIVE ACCOUNTING FOR PROJECT ACTIVITIES

The Pallium Project proposal was approved based on eight core Major Activities. This section of the project report revisits the stated objectives and proposed activities, and accounts for the corresponding activities that were developed and implemented.

Note to Reader: Where practical and technically-feasible, major deliverables (e.g., courseware) and legacy objects (i.e., documents, audio clips, etc.) associated with the major activities are organized by major activity area on the companion Pallium RRHII Project Package CD-ROM\(^\text{13}\) that accompanies this text-based report.

Objective 1: To map the local needs, issues and priorities related to rural/remote palliative care CPD, and establish a framework approach for collaborative action.

Activity 1: Needs assessment – A) Undertake a stakeholder consultation symposium as a needs assessment and foundation building event to identify local issues, map out needs and establish project priorities with collaborating partners. B) Undertake a cross-sectional representative survey of patients, their families and HCP assessing their educational needs. The methods used in these are still to be decided.

Activity 1 was delivered via the following:

- Sponsoring and producing two DACUM workshops in January/February 2002. One workshop focused on identifying the role-related major areas of responsibility and tasks associated with primary-palliative care delivery, and the second focused on major areas of responsibility and tasks associated with providing local palliative care leadership in rural and remote clinical settings.

- Engaging in formative evaluation and action learning as a continuous improvement and feedback process during Major Activity implementation, including active and ongoing consultation with major stakeholder organizations associated with the provision of rural and remote health care delivery in Alberta, Saskatchewan, Manitoba, and NWT.


Activity 2: Resource mapping – Compile and develop a database and network of facilitators and clinical staff that can undertake CPD facilitation and clinical teaching responsibilities. Palliative care practitioners who can serve as clinical teachers, facilitators and coaches are at a premium and as an antecedent to coordinated CPD we need to know:

- Who has what interests?
- Who has what clinical skills?
- Who has what certifications in areas relevant to palliative care?
- Where they are located?
- What is their availability?
- What disciplines and insights can they contribute to palliative care CPD?
- What are existing palliative care educational and CPD resources?
- Who has developed them?
- On what basis can they be used, further developed or modified?

\(^{13}\) A list of the objects contained on the Pallium RRHII Project Package CD-Rom are listed as project deliverables in Appendix D.
Activity 2 was delivered via the following:

- Commissioning, circulating and assessing the results of a palliative care CPD Resource Identification document that participants attending the Project Launch symposium were asked to complete, as well as to and circulate among colleagues. Responses were compiled and used to identify other people (i.e., interests, clinical skills, teaching skills, certifications in palliative care, location, availability to coach/facilitate/teach, backgrounds/insights) and learning resources.

- Obtaining and reviewing existing palliative care teaching learning resources with the dual focus of resource mapping (Activity 2) and learning object development planning (Activity 5).

- Developing a web-accessible database as a Canadian Clearinghouse of Palliative Care Teaching-Learning Resources and hiring a summer intern, in part, to populate the database. The long-term home of the clearinghouse database, as well as the ongoing maintenance will be determined later in 2003 pending the outcome of the Pallium Project application under the National Initiatives envelope of the Primary Health Care Transition Fund (PHCTF).

- A collaborative program development workshop was held in September 2002, bringing some 25 palliative care professionals together to complete detail peer-review and pilot testing of a draft curriculum for the Clinical Introduction to Palliative and End-of-Life Care for Primary Care workshop (see Major Activity 5). This group also formed the first cohort and network of colleagues prepared to deliver specialized palliative care CPD designed specifically for the needs of rural/remote HCPs in community settings.

Objective 3: To establish, nurture and coordinate a professional community of local multidisciplinary palliative care HCP leaders using information and communications technologies (ICTs) as the medium for communication, dialogue, and dissemination about state-of-the-art CPD and developments, especially in primary health palliative care.

Activity 3: Design and implement a Pallium Internet portal site – The Pallium Internet web-portal will be a virtual, “one window location” into the palliative care educational resources available through Canadian health providers. The Pallium web-portal will evolve to become a major Canadian web-portal for HCPs who have an interest in quickly accessing accurate and timely information about quality palliative care CPD resources and opportunities, particularly those in rural areas.

The Pallium web portal will be an entry point to:

- An online resource centre (e.g., selected outputs from Activity 2)
- Online distance learning spaces (i.e., virtual classrooms),
- Virtual conference centre(s) (i.e., issue and theme based web-conferences),
- A publications library and resource centre, and
- A frequently asked questions (FAQ) centre.

Activity 3 was delivered via the following:

- Establishing the pallium.ca web-domain and a “learning lab” based approach to experimenting with web-based learning centre at www.pallium.ca. Respecting the directions of stakeholders about using taxpayer-derived funding for a HCP CPD project at a time when there continues to be a growing demand for public education materials. Therefore, the project development team designed a special section of the pallium.ca online web presence as an Information About Palliative Care for the Canadian Public area at http://www.pallium.ca/canadianpublic/info.asp

- Commissioning the design for, and supporting the implementation of, a Rural Palliative Network (RPN), with special emphasis on the implementation of an interactive: 1) Primary-care Pain & Symptom Management Forum, and a 2) Rural Palliative Care Service & Program Development Forum.

- Collaborating with the ACB Tom Baker Cancer Centre/University of Calgary, Centre for Distance Learning in Palliative & Supportive Care to establish a suite of online distance learning spaces using the Blackboard computer mediated conferencing (CMC) application.
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- Assessing, aligning, and collaborating at the design and governance-level with the formation/early development of the Canadian Virtual Hospice (CVH) project.

- Sponsoring development of special training for a cohort of palliative care specialists, and primary-care physicians and registered nurses with an interest in palliative care, to facilitate online course and conference moderation. A course, entitled Broadening Horizons, was delivered by a subject-matter expert in the Masters in Workplace Learning program at the University of Calgary, Faculty of Continuing Education. It was organized and administered by the Centre for Distance Learning in Palliative and Supportive Care. This cohort is a pool of resources available to facilitate web-enabled, distance learning courses on an “as needed” basis.

- Growing a stakeholder e-mail network 10 fold over the life of the project, from some 30 initial key stakeholders, to a professional community of more than 300 rural/remote/urban clinicians, academics and educators actively involved in building western and northern Canada’s palliative care capacity.

- Commissioning an educational technology consulting firm, InforTask Incorporated and the Institute for Professional Development at the University of Alberta, to complete a study to establish the current state and “readiness” for jurisdiction-based tele-health system operators to use their respective infrastructure to support greater adoption of videoconferencing and other alternative delivery means to deliver instruction to rural and remote HCPs.

- Actively investigating the willingness, interest and commitment of jurisdiction-based tele-health operators to enter into collaborative arrangements for the provision of video-conference based, “tele-rounds” education in palliative care.

- Collaborating with the recently disbanded Regional Palliative Care Program of the Lakeland Regional Health Authority in Alberta, to enable a province-wide “tele-rounds” session. This session was on key considerations in providing care to aboriginal clients in rural and remote health care settings (this is a linked activity that also intersects with Activity 5 deliverables), as a demonstration of the feasibility of scaling tele-rounds on a province-wide basis.

Activity 4: Pilot the use of videoconferencing and online conferencing (CMC) for “virtual rounds” and supporting educational activities – Undertake a series of pilot projects to assess the range of professional, technological, and organizational issues involved with using videoconferencing and online conferencing to provide tertiary-level palliative care consultant support and rounds to rural/remote primary HCPs.

Activity 4 was delivered via the following:

- Commissioning the design for, and supporting the implementation of, a Rural Palliative Network (RPN), with special emphasis on the implementation of an interactive Online Journal Club (OJC) model. This activity included developing a detailed design document and securing appropriate ethics review approval from the University of Calgary, Faculty of Medicine, to complete an educational research and evaluation study of the Online Journal Club (OJC) pilot.

Objective 4: To develop a repository of modularized online educational resources for primary health HCPs to address the specific issues involved with offering primary care palliative care services in a rural and remote primary care environments.

Activity 5: Modular multi-disciplinary course development in:

- Communicating with the terminally ill
- Palliative care as a compassionate alternative to euthanasia
- Grief and bereavement (as a population health issue)
- Cancer pain management (in the community)
- Symptom management
- Psychological distress
Activity 5 was delivered via the following:

- Commissioning Dr. Mare Mazuryk, MD, FRCPS (a specialist oncologist with fellowship training, interest and experience in palliative care), in collaboration with the Alberta Cancer Board, Palliative Care Research Initiative (PCRI) to design a modularized *Clinical Introduction to Palliative and End-of-Life Care in Primary-care Practice* courseware package. This package was designed with the full input and vetting of palliative care authority sources and opinion leaders from western Canada during a collaborative program development and facilitator training session in September 2002.

The *Clinical Introduction* has been specially designed with a special sensibility and sensitivity to the needs of primary-care professionals working within a rural and remote context. Modules developed in Version 2002-01 of the courseware are:

- Module 1 – Self-Awareness
- Module 2 – What Dying Patients and Their Families Want
- Module 3 – End-of-Life Decision Making
- Module 4 – Basics of Cancer Pain Management
- Module 5 – Communication Part 1 (Breaking Bad News; Code Status; Advanced Planning)
- Module 6 – Communication Part 2 (Responding to Difficult Questions)
- Module 7 – Communication Part 3 (Engaging Family as Stakeholders)
- Module 8 – Nausea and Vomiting/Malignant Bowel Obstruction
- Module 9 – Delirium and Palliative Sedation
- Module 10 – Dyspnea and Cough
- Module 11 – Psychological Distress/Depression, Anxiety and Grief and Bereavement.

An extensive Facilitator Manual, Participants Manual, supporting cases and learning objects (e.g., PowerPoint presentations) have been developed as part of this deliverable. The *Clinical Introduction* courseware was piloted in Dauphin, Manitoba in late September 2002, using an education outreach-based Regional Weekend Course (RWC) small-group, retreat-based format. This RWC format enabled 20 family physicians, registered nurses and pharmacists from the Parkland Regional Health Authority in Manitoba to participate in palliative care training in their community to demonstrate the courseware. Modules from the *Clinical Introduction* were also tested during a territorial palliative care conference Pallium produced with the Government of the Northwest Territories in February 2003, and then again, for an industry-sponsored Regional Weekend Course for the Sunrise Health Region based in Yorkton, Saskatchewan, in early March 2003.

The field-based testing resulted in a Version 2.0 of the *Clinical Introduction* courseware being developed. The Version 2.0 adjusts some of the content intensity and links said content, to support greater elaboration in the form on one-day intensive seminars that are anticipated to be offered in collaboration with other provincial/territorial jurisdiction-based partners in the future.

The Version 2.0 of the *Clinical Introduction* courseware also reduces the total number of modules developed in Version 2002-02. It does this by integrating several of the physical symptom management issues related to the gastrointestinal tract (G.I. tract) into a focused, singular module. It also moves more towards the orientation of the local care team's role in end-stage cancer care management, as one of gatekeeping, oversight, and generalists working collaboratively with each other and with the consultation of specialists.

The *Clinical Introduction* courseware is available throughout Canada for use by Pallium Project trained facilitators/faculty. There are quality assurance measures in place, made available through a partnership with the University of Calgary’s, Faculty of Medicine, Office of Continuing Medical Education and Professional Development (CME & PD). The University of Calgary, Office of CME & PD works in collaboration with local providers of the *Clinical Introduction* course, to ensure those wishing to take the course for MAINPRO-C accreditation are assured of proper quality control checks and compliance requirements associated with the provision of College of Family Physicians of Canada (CFPC) accredited courses.
• Commissioning an aboriginal relations authority-source to develop a Course Planning Manual & Courseware for Providing Hospice Palliative Care with Aboriginal Clients in Rural and Remote Settings. This is a 70 page course planning manual with associated courseware intended for use in designing customized short courses and retreats with rural and remote primary-care HCPs. The resource has been specifically designed for those primary-care professionals working within rural/remote settings, and who have as part of their professional practice, provision of service to aboriginal people.

The approach taken in designing the resource is sensitive to, and sensible about, the dynamics of the historical and social context for many aboriginal people. The resource is built on a foundation that promotes understanding, respect and accommodation as a pathway to building constructive care relationships with aboriginal people and their families, when they are facing life-threatening and life-limiting illness. The course planning resource is intended for constructing reflective, experiential learning in a small-group (up to 20 learners) environments. It promotes the use of individual reflection, small and large group exercises and exchanges, talking circles, video, brief presentations and case studies.

The course planning manual and supporting courseware is based on four main modules, and each module has several major sections:

Module 1 – Cross-cultural relationship building
  Section 1 – Cross-cultural experience assessment
  Section 2 – Responsiveness to cultural values, beliefs, traditions and practices
  Section 3 – Relationships in rural/remote community environments.

Module 2 – Situating Care for Aboriginal Clients in Context
  Section 1 – Historical Background as the relationship context
  Section 2 – Current health and social services delivery context

Module 3 – Establishing Care Relationships in a Climate of Diversity
  Section 1 – Dynamics of Diversity Within – Dual Realities/Dual Strategies
  Section 2 – Relationships in the Institutional Environment

Module 4 – Building and Keeping Care Relationships with Aboriginal Clients
  Section 1 – Managing the connections and preventing problems
  Section 2 – Understanding and responding to difficult dynamics and problems

• Engaging in the Ian Anderson program-sponsored Pediatric Palliative Care Decision-making module – Dr. Gerri Frager and Yarrow McConnell (leading Canadian authority sources in pediatric palliative care located at Dalhousie University) undertook the lead as subject-matter experts on this module.

This was a process sponsored by the Ian Anderson Continuing Education Program in End-of-Life Care at the University of Toronto. The Pallium Project abandoned its own early efforts to design/build a Pediatric Palliative Care module (this need figured prominently in the rural and remote needs assessment activities) and opted to participate in the Ian Anderson Program process.

The Pallium Project made its project consultant available to the Decision-making in Pediatric Palliative Care module Advisory Committee. Pallium RRHII Activity 5 resources were used in researching the peer-reviewed literature evidence-base that was used in, in part, in early fact-finding and design. These resources were transferred to the Ian Anderson Program for consideration in module development.

Discussions between the Pallium Project and the Ian Anderson Program that took place in March 2002 had centered on a partnership opportunity to further develop the content of the pediatric palliative care for flexible, electronic delivery. As of March 2003, however, the development process for the module was only at Draft 2 (not for circulation) stage, and the timing of the window of opportunity for collaboration described herein, within the scope of the RRHII project, closed.
Objective 5: To develop an effective model for providing health professional CPD at a distance by integrating traditional and state-of-the-art adult learning methods and emerging learning technologies.

Activity 6: Formative and summative evaluation – Documentation and analysis of ongoing formative evaluation activities are central to identifying the effective adult learning methods and new models of effective distributed learning (i.e., blends of face-to-face retreats, online computer mediated learning, and bedside clinical teaching).

Throughout the RRHII project, there were ongoing activities to support continuous improvement and feedback. The project structure supported the development of an Action Learning culture among major stakeholders. This is described in more detail in the Innovation section of this project report.

Activity 6 was delivered via the following:

- Establishing a Project Advisory Council (PAC), comprised of a representative group of stakeholders. Terms of reference were established early in the project, reflecting PAC membership from each jurisdiction and each major discipline group involved in the provision of rural and remote palliative care. The Alberta Cancer Board, as Project Sponsor, was represented through an ex officio appointment. The PAC met approximately three to four times per year over the life of the RRHII project. Part of the PAC’s role involved frank, honest and practical feedback as one of the formative evaluation strategies. The PAC members also formed part of the key informant group, many of whom opted to participate in the summative participatory evaluation.

- Completing Evaluation Research studies with ethical due diligence and approval from the University of Calgary's, Faculty of Medicine Ethics Review Committee. Ethical approval was granted to Dr. José Pereira as principal investigator on several evaluation studies. These studies included evaluation research related to the implementation of the RPN Online Journal Club, the RPN moderated discussion forums, and participant participation of the Clinical Introduction RWC detailed evaluation in Dauphin, Manitoba.

- Engaging a participatory evaluation process, consistent with the expectations of Health Canada, and conducted by an independent evaluation researcher. In this capacity a summative research process was undertaken and the results of said process form the Presentation of Stakeholder Evaluator Information section of this report.

Activity 7: Integration of experience with CPD literature – This activity will place the lessons learned from the project in the context of the known experience that is informed from the peer-reviewed published literature in continuing professional development, professional learning and change, and continuing medical education.

Activity 7 was delivered via the following:

- Developing and submitting: a) a Letter of Intent, developed collaboratively with the input of major stakeholders, that was submitted to Health Canada in August 2002, and b) the detailed consultation document that was used in the transition plan for a 3 year project application, both for the Primary Health Care Transition Fund (PHCTF).

- Developing the Framework Approach for Palliative Care CPD, which is presented, in part, as a later section of this project report.

Activity 8: Model development and dissemination – This activity will result in new model development and dissemination that will highlight the successes and barriers related to the innovation process of using an integrated approach to palliative care CPD.

Activity 8 was delivered via the following:

- Publishing, on a periodic basis, a Pallium Project Update electronic text-based newsletter delivered via email to some 350 project stakeholders throughout Canada.

- Publishing of audio and text files relating to the project and associated model development in the About Pallium section of www.pallium.ca.

- Developing and submitting several oral presentation, poster presentation, and paper proposals, resulting in the following juried and/or invited presentations delivered prior to March 31, 2003:


Delivering a keynote presentation to the Saskatchewan Palliative Care Association’s, 2002 Annual General Meeting and Education Day in Regina (June 2002).

Presenting a poster presentation at the Calgary Health Region’s, Palliative Care Open House and grand opening of the region’s Tertiary Palliative Care Unit (September 2001).

Producing/disseminating large, laminated posters, suitable for presentation in teaching hospitals and other visible public spaces. For instance, stakeholders from Saskatoon have prominently displayed their Pallium posters at the entrance to the tertiary palliative-care unit at St. Paul’s Hospital for all staff, families and visitors to peruse.

Commissioning a high-quality Media Relations Kit that was customized for each province in the RRHII-project catchment. The catalyst for this media kit was Canadian Hospice Palliative Care Week, May 6 to 12, 2002. The catalyst for developing this resource was a concern that existing media relations materials available through the Canadian Hospice Palliative Care Association (CHPCA) and the “Living Lessons” project did not adequately address some of the key messages and issues related to palliative care in a rural and remote context. The Media Relations Kit contained a generic News Release for each province and a Backgrounder that was released to 240 rural weekly newspapers through their provincial associations in the three prairie provinces and the Northwest Territories.

Creating linkages between the Regional Weekend Course and local rural media. Content from the Media Relations Kit was re-purposed and used in partnership with local regional health authority communication department staff for those times during the RRHII funding for the project when Pallium was involved in education outreach in Manitoba, Saskatchewan and NWT. The concept was to sensitize local citizens to the constructive actions, enabled by Health Canada, that are being taken to help improve the provision of local palliative care. There was local media coverage in all three instances, and extensive local coverage in several rural newspapers in the instance of the Sunrise Health Region’s, Regional Weekend Course in early March 2003.
DETAILED REVIEW OF KEY INNOVATIONS

**System-Linked, Capacity-building Orientation**

The Pallium RRHII-project was designed to link hospice palliative care CPD to the needs of an emerging health care environment. Throughout professional practice there is increasing pressure to change, to adapt, and to respond to new demands driven by citizen-consumer expectations, technology, and social transformation (e.g., aging of North America). There is much more focus paid to the quality of performance in professional practice and accountability for outcomes. Professional regulators are more interested in models of professional regulation that assure continued competence. The challenge for designers and providers of CPD is to transform interventions in ways that are consistent with the continual demands for health delivery system improvement and renewal.

A key design innovation of the Pallium RRHII-project is that it has always been oriented to linking with health delivery system improvement and change goals, and focused on using CPD to build system capacity. In this sense, Pallium has been designed to make CPD strategic, supportive, and facilitative in achieving larger health system goals. Program development has always done in a way that demonstrates clear and logical links between accountability, responsiveness, and performance.

The project development team was pre-occupied with effectiveness and understanding the situational (herein described as context or contextual) factors that influence the ability of rural/remote HCPs to deliver safe, effective, ethical and care appropriate in their respective workplace/professional practice. This approach is a very clear departure from much health-sciences CPD, which typically uses the Education Model, and where little thought is given to design that assists in system-linked, capacity-building and change management goals.

For instance, the design of the Regional Weekend Course (Activity 5) focuses on bringing colleagues from the same region together to work through content in the context of their respective health region and work situation. In the evaluation results received to-date, many participants report this is the first time they have met with, and learned with, colleagues from their own region on this topic.

They report reduced feelings of isolation and a sense that they are not alone locally in striving to provide better care, often in the face of the same local obstacles. This attention to system-linking was also incorporated into the design of the Online Journal Club (Activity 3). Rather than having an academic colleague pick peer-reviewed journal articles for the OJC session, learner’s rank ordered choices from a long list of current articles to review that were relevant to their contemporary local practice.

System-linked, capacity-building CPD is also sensitive to and sensible about HCP learning and change being supported in various settings. Interventions can, and were, targeted to the workplace, home, community and institutional settings, and a mix thereof. CPD interventions ranged from highly-structured planned educational experiences with specific goals (e.g., Clinical Introduction course), to less formal ones that more effectively captured and legitimized the professional knowledge of practitioners derived through reflective practice in rural/remote work settings (e.g., OJC, Rural Palliative Network) and “wise action” that arises from informal and incidental learning.

At some levels, Pallium can serve as an emerging model for the blending of interventions that support a broad array of HHR CPD, especially when the goals are to link learning and change of HCP with system change and renewal goals.

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Community of Practice (CoP)\textsuperscript{15}

CoPs are predicated on the idea that learning does not come solely from educational interventions, and that learning, especially workplace and professional practice learning, is experiential and fundamentally social. That is, learning is derived from experience and practice based on our interactions with others/our world. It is linked to professional practice, involves the shared construction/negotiation of meaning, and occurs on its own terms. The most pressing enabling in moving towards a capacity-building orientation for knowledge, skill and attitude development is the design of social infrastructures that foster workplace and professional learning and contribute to better patient care. A CoP is an emerging model of nurturing and sustaining professional community that enables system-linked, capacity-building CPD.

Throughout the project a professional Community of Practice (CoP) emerged that engaged stakeholders from many sectors, many levels of care, and many disciplines. For instance, education process specialists were actively engaging with health service delivery specialists. Rural registered nurses and palliative care coordinators were working side-by-side with their specialist colleagues from secondary-rural, tertiary, academic health science centres. Colleagues from rural health authorities actively sought out the counsel and insights of opinion leaders. Vigorous debate occurred about whether there was a “best practice” for various medical management processes, or whether there might be several “better practices,” based on contextual factors such as pharmaceutical availability in rural and remote areas; knowledge, skill and licensure (e.g., Methadone license); availability of home care coverage, etc.

The CoP is a critical innovation in the implementation of the RRHII-related project, because it creates the conceptual and relational infrastructure that enables workplace and professional learning that is most responsive and sensitive to context vis-à-vis improving quality of patient outcomes.


Implementation of DACUM Occupational Analysis

The DACUM (Developing a Curriculum) approach is a systematic, analytic and descriptive process of gathering, documenting and analyzing content-valid information about actions that people in a particular role or job take in performing the tasks incumbent in that role. It is both explanatory and predictive as a needs assessment protocol. It lends itself well to the goal of designing education and CPD that is clearly linked to better patient care and quality and compassionate care outcomes.

The DACUM approach to needs assessment and program development has become widely known in industrial sectors in Canada and the United States over the last 30 years, as an effective means to involve front-line staff and leaders in the design of learning. It is based on the assumption that the people who actually perform a role or oversee it being done are the people who can best describe the role functions. Working with Dr. Anne Wilson, an acknowledged Canadian authority with extensive domestic and international experience conducting DACUM analyses, a DACUM process was slightly modified (to focus on roles rather than specific jobs). Through this modified DACUM process, the Pallium Project’s DACUM working groups identified Major Areas of Responsibility and Major Tasks for: 1) health care professionals providing primary-level palliative and end-of-life care; and 2) palliative care leaders in rural and remote practice settings.

The DACUM process results in a validated “DACUM chart” that lists several Major Area of Responsibility as column items, with associated Major Tasks as a row or “band” associated with the respective Major Areas of Responsibility. The DACUM chart serves as a comprehensive “road map” for detailed task analysis and planning various teaching-learning and associated resource development interventions. The DACUM concept can be difficult to understand, therefore, a metaphor is helpful for the purposes of explanation. If the package of courseware and associated learning resources were a “house” then the DACUM chart would be the well-constructed, “solid foundation,” that holds it firmly in place. The DACUM chart can also be used for other HHR purposes, including job design, competency mapping for recruitment, and gap analysis for knowledge and skills development of palliative care health services delivery programs.
First Rural Online Journal Club (OJC) in Canada
To the best of the knowledge of the project team, Pallium pioneered the first Canadian-based, rural Online Journal Club (OJC). The OJC pilot involved 12 rural/remote family physicians, registered nurses and a pharmacist (from Alberta, Saskatchewan and Manitoba), committing to studying two peer-reviewed journal articles/month (6 in total), and actively discussing/debating the content, research methods, and implications within a small group format.

The OJC was enabled through a password protected web-based, computer mediated conferencing (CMC) system. The pilot was designed to encourage OJC participants to engage a range of current literature relevant to their needs. Participants rank-ordered choices of journal articles based on a long-list vetted by an academic resource and OJC rural practitioner/moderator. They sought to improve their skills as users of peer-reviewed clinical literature to make choices about clinical practice, while building professional community through the exploration and interpretation of individual and shared experience in specific clinical situations. For instance, many explored their management of patients requiring hydration based on an article review. Others explored their experience and approach to managing end-state dementia in another. Articles were always relevant to current practice and sought “meaning making,” relative to what was the most appropriate approach to specific practice issues, based on key decision choice factors.

The OJC takes the concept of traditional hospital-based “journal rounds” and makes it broadly accessible to isolated colleagues. The intent is to help busy primary-care professionals stay connected about new developments in the peer-reviewed clinical literature. It helps create awareness of, and access to, new peer-reviewed literature, and it helps keep people at the forefront of current issues in the profession.

The OJC was designed to encourage rural HCPs to engage in more evidence-based practice, particularly since full journal subscriptions are prohibitively expensive for most rural HCPs. The Pallium OJC concept increases interaction among rural/remote, secondary and academic HCPs, by deliberately linking rural and remote colleagues with an academic health sciences faculty member as part of the process. The OJC provides a flexible vehicle for continuous learning based on self-directed learning principles.

It makes collegial learning opportunities accessible outside the context of face-to-face classroom and/or web-based instruction. It enables colleagues to build professional community and individual confidence by sharing information, interpreting it through the various experience-based “lenses” of the participants, and challenges participants to demonstrate professional judgement in context. The OJC also promotes a learning culture of using “best-evidence” in clinical practice and creates a culture of evidence-based palliative care, while increasing practitioner skill and comfort level with reviewing/analyzing the literature.

Rural Palliative Network (RPN)
The RPN is a self-sustaining online professional community that uses a web-based, fire-wall protected computer mediated conferencing (CMC) platform (i.e., Blackboard) to enable professional networking, about palliative care, among regulated health care professionals in North America. The RPN has several online forums to which regulated health care professionals can subscribe as a means of professional networking over time and space. The first two of these forums launched in 2003 are: 1) a pain and symptom management forum, and 2) a rural palliative care service and program development forum.

The RPN has several quality assurance checks integrated within its design. These are to ensure a responsible approach to professional online community building. These include the RPN operator assuming responsibility for engaging in due diligence to assure those interacting with colleagues are indeed bona fide HCPs. For instance, the registration process involves an administrator verifying an applicant’s current status as a regulated health care professional. This is done by requiring the administrator to verify via telephone, with the Registrar of the respective regulatory college to which the RPN applicant is licensed/registered, that the RPN applicant is currently a regulated professional in good standing with the respective regulatory college.

The RPN nurtures a professional supportive network and Community of Practice. It serves to enhance interactions and communication between rural health professionals and academic health science centres, with the aim of enhancing patient care and disseminating better practices to rural and remote locales.
First Canadian Palliative Care Teaching-Learning Resource Database

As part of Activity 2, Pallium undertook to design a web-accessible database to inventory its extensive knowledge of palliative care teaching-learning resources. To our knowledge, this is the first Canadian palliative care database of its type that is publicly-accessible to any stakeholder with web-access.

Clinical Introduction to Palliative Care Courseware & Regional Weekend Course Format

As a major deliverable associated with Activity 5, Pallium developed an 11 module *Clinical Introduction to Palliative Care in Primary-Care* courseware. It has received MAINPRO-C continuing education accreditation from the College of Family Physicians of Canada (CFPC). The final course design resulted in an inter-disciplinary learning experience focused on the clinical needs of family physicians, registered nurses and pharmacists at the community-level.

The RWC focuses on clinical management of cancer care in the community (local hospital, office-based practice, or in the home). It leads from HCP self-reflection, communications issues, and a physical pain and symptom management starting point. It uses this awareness, relational, and practical-orientation to address key issues in the management of the whole person experiencing life-limiting disease in the community (in this instance focusing on cancer care, but the concept is transferrable).

The RWC format is designed on the idea that it is valuable for people to learn in teams, in ways that are aligned with collaboration in practice. As more collaborative models of care emerge, the RWC format facilitates learning about the concerns of each respective discipline in providing patient care.

The RWC delivery model and delivery formats are also innovative. The course has been designed to be self-sustaining through third-party financial sponsorship, and is packaged and presented locally as a government-industry-local partnership. Health Canada, through the RRHII, has paid for objective, needs-based courseware development and piloting. It has also contributed to the initial training some 25 peer practitioner-facilitators, who have been actively involved in shaping the final direction and form of the courseware and are broadly acknowledged as “Pallium faculty.”

Third-party sponsorship for a RWC is based on need, as negotiated between local regional health authorities and prospective sponsors (e.g., pharmaceutical company unrestricted education grant; local service-club investment, etc.). Third-party sponsorship pays direct costs of delivery, including faculty honoraria/travel costs, on-site participant meals and manuals. Local partners, usually health authority HCPs, collaborate on securing local venues for a RWC course, recruit local health authority staff and community physicians/pharmacists, “troubleshoot” locally, and provide liaison with local media to promote public awareness about the knowledge and skills component of quality, compassionate hospice palliative care. Health authorities also pay staff replacement/salaries as applicable.

The RWC format is also innovative for it brings a subject-matter expert team of practitioner-facilitator faculty of at least one physician and a registered nurse, to a local community to conduct an intensive two-day course (Friday PM, Saturday, Sunday AM). This strategy increases access to palliative care education. It enables learners (small group learning of approximately 20-25) from the same regional health authority to come together, in a retreat-based setting, to learn and explore palliative care knowledge and skills development together, shaped by the specific local/regional context in which they deliver care.

The *Clinical Introduction* course can also be delivered as a series of four-hour intensive sessions. It has been adopted by the University of Calgary, for delivery scheduled in 2004 as a series of one Thursday evening per month, and directed towards physicians in office practice in the Calgary Health Region. In this instance, it is designed to support change management of a new “rurban” consolidated regional health authority. That is, effective April 2003 in Alberta, both Edmonton and Calgary had the geographic catchment of their respective health authorities more than double, with a commensurate increase in population of only about 10% (similar circumstances also occurred for Regina and Saskatoon in 2002). Engaging community-based physicians in office practice through the *Clinical Introduction* course is seen as a constructive way of linking integrated palliative care service-delivery programs, with new community-based colleagues using a flexible education outreach strategy.
Values and Relational-based Aboriginal Palliative Care Teaching-Learning

Early the project, it became clear a major unmet need for rural/remote palliative care CPD was the unique nature of dying and death in rural/remote aboriginal communities and the interface with non-Aboriginal HCPs, often in institutional settings. Concomitantly, there is a need to respect and work within the paradigm of multiple-jurisdiction devolution of health service delivery to the local-level associated with aboriginal self-governance. This need was further reinforced during and immediately following a National Action Planning Workshop on End-of-Life Care, organized by Health Canada in March 2002.

The Project engaged Gaye Hanson of Hanson & Associates, a respected aboriginal registered nurse, former Deputy Minister of Health for the Yukon Government, and principal of an aboriginal management consulting services firm, to provide counsel, process and subject-matter expertise. Ms. Hanson’s firm provided the conceptual and “cultural sensibility” leadership for an initiative, funded under Activity 5, that led to the beta-version of courseware entitled Providing Hospice Palliative Care with Aboriginal Clients in Rural and Remote Settings.

As a courseware development exercise, and as an aboriginal engagement strategy, this deliverable is quite innovative. First, it deliberately avoided a typical “design trap” of leading from curriculum design grounded in an anthropological orientation. Rather, the courseware was led from a values- and relational-based approach. That is, the design team started with the assumption that a course needed to be practical and focus on building and keeping functional care relationships with aboriginal clients. It had to address the realities of non-aboriginal primary-care professionals working in rural and remote settings, including providing service to aboriginal people, as well as a frank discussion of the historical and social context that impacts many care relationships.

The overarching goal of the courseware design is to focus on building and maintaining functional care relationships with aboriginal people by being sensitive to, and sensible about, the dynamics of the historical and social context for many aboriginal people. Before the courseware was designed, considerable background research and stakeholder consultation occurred. A consultation document was developed in 2002 entitled: Prospective curriculum development directions: Aboriginal palliative and end-of-life care education and professional development. This consultation document was broadly distributed throughout Canada for comment and additional input prior to commencement of courseware development.

The courseware is designed for delivery in a “multi-provider” format and uses experiential and participatory methods. It is designed to actively engage learners in reflection about their own values and beliefs vis-à-vis aboriginal people. It is designed to help find common ground for providing quality, compassionate palliative care with aboriginal clients. It incorporates the construct of “dual realities – dual strategies” to acknowledge and respect the co-existence of traditional, subsistence-oriented reality and the industry-oriented reality of aboriginal lifestyles in contemporary Canadian society.

It incorporates several design elements that help “demystify” and clarify many common behaviours that appear outside the norm (i.e., their “norm”) to the uninformed, non-aboriginal caregiver. It seeks to instill in learners the spirit to create care environments based on non-defensive questioning and “learning in the context of care” by remaining in a position of curiosity and not judgement, when working with aboriginal patients and families. In effect, the courseware is designed to promote “cultural competence” through an exploration of one’s values, experience, and ethical interest in providing high-quality, compassionate palliative care to all Canadians.

Early versions of the courseware were pilot tested through a provincial video-conference “tele-rounds” throughout Alberta in November 2002, and an early version of the courseware was integrated into the delivery of a territorial palliative care conference in Yellowknife in February 2003.

16 For more information on the concept of “dual realities – dual strategies” the reader is directed to Bill Hanson’s site at http://www.geocities.com/Athena/Acropolis/7082/dualrealities.html (Access Date March 2003).
Project Design – Engagement and Action Learning

Throughout the early evolution of the Pallium Project, the work enabled by the RRHII was guided by the principle of “engagement.” This concept of engagement was implemented throughout the project based on the foundational work of the Kellogg Commission on the Future of State and Land-Grant Universities throughout the late 1990s. It is a philosophy and a process that enables research-intensive universities to become productively and sympathetically involved in the problems and issues of their communities. It has the following characteristics:

- Two-way, mutual problem solving and solving between academic specialists and community-based practitioners (this is a distinct conceptual break from traditional “outreach” and one-way “knowledge transfer” models).

- The resources of the university (people, knowledge, expertise) can be, or already are, readily organized to serve local, regional and national needs.

- There are deliberate efforts to organize and integrate research, teaching and service, into an integrated scholarship model, so that scholars are acknowledged and rewarded for becoming engaged in the emerging knowledge needs of their communities.

The early success stories associated with the foundational work of the Pallium Project is directly attributable to the use of engagement principles in working collaboratively with other institutions, and especially with rural and remote HCPs. Many rural HCP stakeholders were cautious at the outset about the ability of large tertiary-care staff being able to work in a respectful, two-way collaboration.

Over the course of the project, an environment was created where frank dialogue and engaged debate could happen. This exchange would often focus on why “best evidence-based practice” from the perspective of authority-source, academic colleagues was not necessarily the most appropriate, nor effective practice at the community-level, as informed by the field-based experimentation, learning and effectiveness demonstrated by rural colleagues. Over the course of this project, rural HCPs developed and maintained status as full and equal partners in directing and informing the project generally, as well as tempering the specific final form of deliverables so that they could be realistically and practically implemented in rural/remote practice settings.

Although not initially intended as a designed process orientation, the project very quickly took on aspects of an Action Learning orientation. Action Learning is predicated on the idea that ordinary people, working together, are capable of solving their own problems. Action Learning is based on the following principles and tasks:

- Learning is an outcome of addressing real problems.
- Stakeholders learn when they are faced with a difficult issue that they do not know how to address.
- Under said circumstances, stakeholders sort through their past experiences for relevant concepts, to put concepts together in new ways, and to seek out new information and insights that bear upon the issue.
- Throughout the project process, stakeholders address a “real” problem (i.e., a genuine investment in the outcome leading to change or improvement of the status quo).
- Stakeholders engage, over an extended period of months, in problem identification, solution generation, and implementation.
- Learning is derived from: actively working to make sense of a situation; implementing a solution stakeholders have constructed; experiencing the results of the action; rethinking the situation based on the results; and acting again (the learning in action occurs when stakeholders reflect on their action, not just their planning).

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- Stakeholders are volunteers to the process.
- Professional work and learning are coupled and inseparable.
- Learning occurs over time.
- Learning requires “fresh eyes” (i.e., it is enhanced by perspective and reflecting on the importance of context).

Many of the processes and the products associated with the RRHII project had never been tried before. If they had, they were often either relatively new to the health services delivery sector in Canada (e.g., DACUM), or they required a complete rethinking about how to package and deliver learning resources (e.g., Online Journal Club, Rural Palliative Network, Regional Weekend Course). This new way of thinking about CPD was always sensitive to, and sensible about, the context of rural/remote health care service provision.

Much of the work required active stakeholder experimentation, feedback, and engagement in the design, and was evolutionary (some project deliverables have gone through several “versions” and continue to evolve as more is learned from experimentation and refinement). In short, Action Learning has been a powerful process innovation for continuous improvement, responsiveness, and formative evaluation. It has enabled timely, appropriate and accountable project deliverables based on the needs and context of rural/remote HCPs.
PRESENTATION OF EVALUATIVE INFORMATION

This section describes the process used for summative participatory evaluation research that was conducted with key stakeholders. Other evaluative information linked to specific activities is contained in PowerPoint presentations (e.g., Online Journal Club juried presentation at International Congress on Care of the Terminally-ill) on the accompanying Pallium RRHII-Project Package CD-Rom. Other evaluative information gathered during the project process is being processed and analyzed in the context of a publication agenda for several peer-reviewed, collegial journals. Those readers wishing to be made aware (by email) of when published reprints of Pallium-related peer-reviewed journal articles become available should contact the Project Leader, Dr. José Pereira to be placed on a mailing list.

As previously noted in the Major Activity accounting (Activity 6) of the prior section, Dorian Frère of D. Frère and Associates Ltd., was engaged to conduct semi-structured key stakeholder interviews, as a major component of a participatory summative evaluation process. A list of key stakeholders was provided to the interviewer by the Project. Identified stakeholders included the Project Advisory Council (PAC), stakeholders directly involved in project activity development, founding partner representatives, Provincial Palliative Care Associations board presidents/Chief executives, and key members of the palliative care communities within the project boundaries. A total of sixteen key informants participated as interviewees.

The interview questions were developed to inform three of five fundamental evaluation questions guiding the project’s summative evaluation reporting. These are consistent with the Project’s accountability to Health Canada. These are also based on the Participatory Evaluation framework that accompanied the Contribution Agreement contract in February 2001. These key evaluation questions were:

1. Did we do what we said we would do?
2. What did we learn about what worked and what didn’t work?
3. What difference did it make that we did this work?
4. What could be done differently?
5. How do we plan to use evaluation findings for continuous learning?

We have attempted to clearly discharge our duty relative to Question 1 in the previous section of the Report (Major Activity accounting), as well as with the regular Quarterly Reports and quarterly cash flow reporting process. Questions 2 through 5 will be addressed through the presentation of the evaluation researcher’s findings in this section and our analysis and reporting in the final sections of this report.

The following set of open-ended questions were developed in a negotiated process between the Project Leader, the Project Consultant and External Interviewer, and were used to guide semi-structured telephone interviews with key informant interviewees:

1. What three words would you use to describe the Pallium Project?
2. Tell me if you believe the Pallium Project has contributed to improving palliative care education and training? If yes, then describe how. If no, then elaborate on why.
3. What are three major achievements to-date of the Pallium Project?
4. What difference do you think it has made that the Pallium Project occurred?
5. What, if anything, do you think might have been done differently with the project to-date?
6. What ideas do you have about future directions for the Pallium Project?
7. What ideas do you have about specific future activities for the Pallium Project?

Describing the Project

A substantial number of stakeholders described the educational aspects of the Pallium project with the terms learning, education, knowledge. The Pallium Project is also described by many of the respondents using terms referring to elements that the project provides to caregivers such as support, awareness, Best Practice, helpful, capacity building, coordination, and Palliative Care. Stakeholders also used terms referring to the team nature of the project such as,

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19 All text presented in the rest of this section of the report (Presentation of Evaluative Information) comes directly as published in the Evaluation Researcher’s Summary Report and has not been edited or altered in the preparation of the Project Report.
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collaborative, mix of experiences, inclusive, interdisciplinary, partnership with rural caregivers, and community.

Many identified quality statements using the words excellent, good, expertise, and successful. Reference was made to the rural nature of the project, using the terms rural and prairies. The project was also described from a holistic perspective as comprehensive, organized, complex and innovative, while other descriptive words used by stakeholders reflect the process itself as slow, evolving and growing. The project was also described through its value to the community, as practical, timely, appropriate, and responsive to need.

Discussants, as illustrated above, describe the project using a variety of terms and phrases, reflective of the range of the project itself from their perspective. Four key descriptive elements that were identified and when ordered using frequency ratings are:

- education/learning, team, provision of services, and quality.

Pallium’s Contribution to Improving Palliative Care Education and Training

Stakeholders overwhelmingly responded affirmatively that the Pallium Project has contributed to improving palliative care education and training. For the few respondents who did not, their statements qualified that they expect that the project will, or is starting to contribute, however, from their perspective, the project activities are just now having an effect.

Respondents registered strongly that the network created by the project was a key factor in improving palliative care education and training. They stated that connecting experts from educational setting such as universities and urban centres was important, but also important was the connection between rural practitioners. Frequently respondents used the terms “team”, “connected” and “network” when they explained the improvement. The opportunity to access information and share knowledge and experiences with others regarding palliative care was the most frequently referenced theme emerging from the stakeholder respondents.

Also mentioned with relative frequency was the mobility of the project’s education sessions, the ability to provide educational opportunities to rural professionals in their setting. Key phrases used by the interviewees were “taking education to care providers”, “bringing education to rural professionals”, and “delivering the course to where people are.” This was reported by stakeholders as one of the more innovative features of the project contributing to its effectiveness.

Less frequently used descriptions referred to the inclusive and multi-disciplinary nature of the project. These respondents refer to the involvement at many levels in the development of the project. Also identified during the interviews, and linked to the inclusive nature of Pallium as described by stakeholders, was the rural involvement in the development of the project educational materials, and the consideration of rural realities in their design and content.

Single statements describing how the Pallium Project has contributed to improving palliative education and training include:

- the on-line journal club,
- the people involved being able to stimulate action,
- the development of a framework that contributes to the system overall,
- the success of the project as referred to in professional circles,
- improved care for palliative patients,
- increased visibility of palliative care with the use of a standardized educational program which provides credibility,
- its responsiveness to local needs, and
- its impact on developing increased local capacity.

Although these emerged as single statements, they reflect some key observations related to the contribution of the Pallium project.

Major Achievements

Stakeholders were asked to list three major achievements of the Pallium Project to date. From the responses, three themes became evident:

1. the development of educational materials,
2. increased awareness of palliative care, and
3. the collective ownership of the process.

In reference to the development of educational materials contributors stated that the process of designing the content of the program was a key
success factor. The DACUM process was referred to as comprehensive and successful in refining the educational material to meet the needs of the learner. Educational material that had not previously been available to learners was created through the Pallium Project.

Stakeholders were very enthusiastic when referring to the increased awareness and visibility of palliative care that was achieved by the project. The education program having obtained MAINPRO C accreditation status was identified as evidence of the credibility of Pallium. Overall, respondents state that this project has elevated the profile and discipline of palliative care.

With equal frequency, the stakeholders that were interviewed referred to the achievement of a collaborative process resulting in sense of collective ownership. They expressed that this was difficult but important to achieve. In order for the Pallium Project to be true to its intent, they posit, stakeholders had to feel included in the process. Interview statements such as, “Everyone was a part owner”, “No exclusivity” reflect that in the opinion of the respondents, this occurred. The Pallium Project reached beyond a medical focus to achieve a multi-disciplinary profile as reported by key informants.

With less frequency, but also identified as a major achievement by stakeholders, was the Pallium Project focus and reach to rural/remote palliative care community members. This was described as unique to the project. As well, several stakeholders identified the development of a network as an achievement. The network was described as the Western Region of Canada, academic centres and rural areas working together, all people “doing” palliative care, colleagues, and specialists.

Individual stakeholders mention the on-line journal club, creating a momentum around palliative care as an emerging field of practice, the opportunity to move the project beyond concept to operationalization, the Pallium web page, the DACUM process, and the use of technology as achievements of the Pallium Project.

A respondent statement that might best summarize the collection of stakeholder responses was: “That we did this was an achievement.”

The Difference that the Project has Made
Key stakeholder responses emphasize three main effects of the Pallium Project. They are:

1. increased awareness of palliative care particular to rural areas,
2. the achievement of local learning for rural palliative caregivers, and
3. the development of partnerships and collaborations.

These themes represent the vast majority of responses elicited from the stakeholder group. Many stakeholders offered simple statements that reflected these thematic streams. Examples are: “Palliative care is now on the radar screen.” “We have accessible education for palliative care.” “There’s somebody to go to for advice, support and assistance.”

Respondents also identified the comprehensive nature of the education modules beyond a medical focus as a unique difference attributed to the Pallium Project. As well, some stakeholders refer to increased knowledge about palliative care and the development of a standardized program as key differences that the Pallium Project is responsible for. The project, interviewees state, has resulted in increased access to people and information, as well as provided an opportunity for “inter-disciplinary learning.”

Single respondents offer several more differences that the Pallium Project has made from their perspective. One contributor identified the inclusion of the aboriginal community in palliative care through the project. Also mentioned was the innovative community building through technology evidenced by the creation of a virtual palliative care network. Equality through collaborative planning was another key difference according to one respondent. The Western Prairie Provinces along with the NWT were able to come together to identify strengths and weaknesses toward equalizing their capacities to address palliative care in their rural communities. Finally, the operationalization of an abstract conceptual model of multi-disciplinary rural based professional development was identified as yet another key difference that the Pallium Project made.

Clearly the key stakeholders that were interviewed felt strongly that the Pallium Project activities have made a difference on the landscape of palliative care. They
commented on several key areas as well as offered explicit examples. As with previous response data, analysis of these responses extended beyond frequency ratings and key thematic groupings to consider with equal import, the key insights and examples provided by the respondents.

**Suggestions for Doing Things Differently**

The project was applauded for its process with the majority of respondents stating that they had no suggestions regarding “doing things differently”. The respondents who offered ideas were very specific. Their suggestions are to:

- Provide educational materials on site two weeks in advance of the delivery of the [RWC] program in order to ensure adequate time for review and preparation by the facilitators.
- Involve people connected to the Pallium Project in each province in the delivery of the [RWC] educational program in that province. This would provide a visible local connection and would establish ongoing support links provincially.
- Include the “notes” section in the PowerPoint slides so that presenters have the material to refer to as they facilitate the [RWC] program.
- Formalize the recognition of the professional role in the development phase for the project so that the professionals involved have dedicated, compensated, and clinical coverage assured during their time away from practice. This would result in a more concentrated effort in the initial development phase of the project over a shorter period of time as opposed to developing a project in addition to other professional obligations. The intended result is an expedited process.
- Formalize the support and mentorship mechanism so that it is not an “add on” responsibility.
- Ensure equitable compensation for all team members involved in providing [RWC] education programs to rural sites, particularly between disciplines, to achieve a true multi-disciplinary team with equally valued members.
- Increase the speed of curriculum development. Although difficult, a faster development process (DACUM) would have resulted in more buy-in at an earlier stage therefore more people would have been involved at an earlier stage of the project.

Stakeholders that were interviewed can be considered as the project continues to evolve.

Some discussants offered examples of project strategies that they considered to be very effective. They include; input from a variety of people, the DACUM process that created the potential to transfer the curriculum model beyond the current boundaries of the project, the collaborative development process that was driven by needs, and finally, the hiring of a coordinator with a high level of expertise and skill, who is associated with IPD and who provided “excellent” overall management to the complex project.

**Future Directions**

The future of the Pallium Project as described by respondents suggests continuation of the processes that have been established. The majority of stakeholders that were interviewed stated that the established elements of Pallium provide a foundation from which to expand. They used words such as “continue”, “build”, “expand”, “further develop” and “maintain”, illustrating their recognition and validation of the value of the Pallium Project’s achievements to-date.

Stakeholders refer to a momentum that has been created by the project: “It is unfolding in its intended direction.” They assert that this momentum should not be lost and must be continued. As well, informants state that they consider expansion of the project both to other provinces and internationally as a fundamental future direction in order to build on and to share the knowledge and experience gained through the project to-date. A key element of continuance referred to by many stakeholders was the multi-disciplinary team-based nature of the project. As Pallium moves into the future, these elements must remain, with respondents cautioning against transitioning to a physician or RN focus.

In addition, the Pallium Project in its future, as stated by one respondent, can support the process of informal learning in the workplace through its continued development and support of Communities of Practice. This can be enhanced in the future through building on web-based technologies in order to integrate interaction, moving from a “content only” space. This, as posited by key informants, would create a contextual environment for the palliative care.
community, and would nurture dialogue between front-line practitioners, specialist in larger centres, and academicians.

*The development of a public information component* was also identified as a future direction for the Pallium Project. The result of this, suggested stakeholders, would be:
- Increased awareness of end-of-life care, issues, and options.
- Support for rural programs.
- Demonstrated recognition of the difference between rural and urban needs, not only the infrastructure but also in relation to culture.

Of interest, one respondent suggested the importance of maintaining a “Canadian flavour” in the future of the Pallium Project.

**Future Activities**
Key stakeholders suggested specific future activities for the Pallium Project during the interviews. As one respondent suggests, the project leaders may consider ordering the activities in a logical sequence along the project’s “operational process continuum.” The suggested activities below are not presented in any presumed process order, but rather are listed as single statements as offered by the respondents, and ordered according to frequency ratings.

- Continual development, revision, and update of materials and trainers
- Formalize the consulting process and follow-up support mechanisms
- Create education modules for both small and large groups
- Initiate discussions with Professional Associations toward the recognition of competencies through Palliative Care Certification – specialist recognition
- Obtain financial support to continue and expand operations
- Expand work with First Nations
- Provide services in the local language of choice and within cultural variations
- Initiate discussions with educational institutions for healthcare providers to integrate palliative care knowledge gained by the Pallium Project into the curriculum
- Develop an orientation package of palliative care information to integrate into the healthcare orientation for all caregivers
- Develop educational and reference materials that can be used at the bedside – posters, pocket-sized references
- Investigate the integration of Pediatric palliative care into Pallium
- Transfer the knowledge gained in Pallium to their related health issues such as bereavement and chronic pain management
- Operationalize the on-line course
- Expand the education/training material to include other professionals who are involved with palliative care patients – formal informal caregivers, therapists, etc.
- Refine the Telehealth link
- Contribute to Canadian Virtual Hospice
- Evaluate the effect on palliative care practice

**End Thoughts**
A continued echoing throughout the interviews were statements related to the:

- comprehensive approach of the project,
- the inclusiveness of the process, and
- the creation of a network of people.

The key stakeholders, in response to several inquiry domains, refer to these elements with a high degree of frequency. This may evidence through the perceptions and insights of the project stakeholders, that they consider these key elements to be core foundational concepts of the Pallium Project.

Several respondents offered additional comments to the interviewer reflecting their enthusiasm and support of the project. Regarding the leadership of the project, comments include:

- “Jose [Pereira]’s high profile and affiliation gave the project local credibility.”
- “I am super-impressed with the work that has been produced by the two leaders of this process, Jose [Pereira] and Michael [Aherne].”
- “Under the leadership of Jose [Pereira] and the coordination of Michael [Aherne], we have done awesome things with few resources.”
- “Excellent people, good leadership.”
The Pallium Project – Rural and Remote Health Innovations Initiative (RRHII)

- "Jose [Pereira]'s commitment was contagious. It has been a great experience to work with Jose [Pereira] and Michael [Aherne]."

General comments:

- "In a short time, we’ve come a long way."
- "We have developed a model framework to operationalize the project, the model is inherently flexible and transferable."
- "Finally, someone has seen the need to address rural Canada. Our people can go to the city, but it is so nice to see that people recognize the importance of what we do here."
- "We have started a process rolling that’s going to make a difference."
- "I am impressed with the level of professionalism and dedication of people working with the project. They have a vision."
- "Knowledge is the foundation for the provision of palliative care. I see Pallium as the centre for excellence for palliative care education and training for care providers."
- "I feel good about being part of this project."
INTERPRETATION AND ANALYSIS

In this section, we reflect on the foundation building of the Pallium Project, as enabled by the RRHII funding, and provide analysis on several key themes that have emerged and that have been reinforced over the course of the project development-to-date.

System Readiness – Leadership and Culture

Quality End-of-Life Care: The Right of Every Canadian declared that quality end-of-life care “must become and entrenched core value of Canada’s health system,” with each person entitled to die in relative comfort, as free as possible from the physical, emotional, psychosocial, and spiritual distress.

The reality is that within the health delivery system as a whole, there is considerable work to do to realize this aspiration. In February 2003, the First Minister’s Accord on Health Care Renewal process resulted in a commitment to a $16 Billion “Reform Fund” over a five-year period, with clear signals that stated priority areas include enhanced and new services for those experiencing life-threatening and life-limiting illness.

The phrase “buy change” has been used at the ministerial level to describe part of the rationale for a separate health transfer as part of the overall new $34.4 Billion commitment. The three pillars of the separate health transfer (i.e., primary health care, home care, catastrophic drug coverage) all intersect at some levels with palliative care, and in particular, end-of-life care. Moreover, within the home care envelope, the First Minister’s Accord seeks to provide first dollar coverage for a core set of fully portable home care services in three areas, including end-of-life care.

The reality, however, is that the respective health delivery systems within Canada continue to be generally very poorly prepared, both in senior leadership orientation (executive and governance), delivery system organization, and cultures to engage the growing demand for integrated palliative care services, including end-of-life care and bereavement support. Notwithstanding pockets of excellence in some provinces, particularly within the larger urban centres, there is virtually no meaningful integrated palliative care programming per se, and very few current resources committed to palliative care service and program development.

In Manitoba, regional health authorities have core funded a palliative care coordinator position since 1999 per provincial government directive and tied funding. Regional palliative care coordinators meet in retreat-style working groups bi-monthly, to work on service and program development priorities. The regional coordinators have also taken some positive steps towards harmonization and standardization of data collection and surveillance processes, and engaged in standards-based training for support workers throughout the province.

Saskatchewan also has designated palliative care coordinators for their respective regional health authorities, but these roles in rural RHAs are typically an “add on” responsibility to other community health/home care responsibilities, and come with few if any, dedicated resources to assist in palliative care service and program development.

In Alberta, the provincial situation actually regressed during the course of this project. Alberta is the only province in the Project catchment that does not have designated palliative care program coordinators/managers for each of its respective regional health authorities. Moreover, effective April 1, 2003, the provinces 19 health authorities (17 RHA, the Alberta Cancer Board, Mental Health Board) have been consolidated into 9 regional health authorities and the Alberta Cancer Board, with significant setbacks for system readiness of rural integrated palliative care service provision.

During health authority consolidation, one of Canada’s “light house” rural integrated palliative care programs in Lakeland Regional Health Authority (LRHA)20, was actually disbanded by senior management with reasons cited in local media outlets by the region’s CEO as the region’s management “wished every citizen in the expanded region to have access to the same level of service.” In reality, this senior manager’s vision for palliative care was that everyone in the new region was entitled to a similar

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20 LRHA’s Regional Palliative Care Program was created in 1997 as one of Alberta’s 27 Government of Canada-funded Primary Health Projects through the Health Transition Fund. The reader can view the evaluation report of this unique program at http://www.health.gov.ab.ca/system/key/phc/projects/Lakeland/PalliativeCareIndependent.PDF (access date March 2003).
level of reduced or eliminated integrated palliative care service. In Edmonton and Calgary, the respective geographic areas of responsibility doubled while the population catchment increased by approximately 10%, reflecting a new “rurban” (i.e., rural/urban) mix, with no respective increases in palliative care program delivery funding reported as of March 31, 2003.

What we have learned during this project is that many senior management teams and health authority governance directors tend to internalize and treat palliative care as a “second class” service. Many health authority executives indicate that caring for those with life-threatening and life-limiting illness is a priority. Yet intent does not clearly translate into action. This is a continuing and pervasive challenge for health reform in Canada.

The exact reasons for this remain unclear and this is a potential area for further examination in health services and/or policy research. In reality, we can only hypothesize, based on informed opinion and experience. At one level, many health authority decision-makers ultimately are driven by economic determinism. Palliative care advocates have generally been poorly equipped and prepared to demonstrate the net-cost reduction and system utilization gains possible from well-designed hospice palliative care.

At another level, clinical decision-making and service provision is highly influenced within service delivery organizations by the biomedical, curative-orientation demonstrated by many clinical leaders who influence the process. In other words, active/curative treatment dominates the culture and “wins” the lion’s share of the resources!

Moreover, as a modern western society, many Canadians (as system consumers) demand state-of-the-art curative regimes and interventions that often promote “death deferral.” That is, until they or a loved one are in the throws of a life-limiting illness that is accompanied by intractable pain and excruciating physical, psychological, spiritual and emotional distress. Active, curative treatment and quality, compassionate palliative care are not mutually-exclusive, yet most delivery system cultures, planning and reward systems continue to treat them as if they are.

Clearly, there is much work to left to do to sensitize regional health authority senior management and governing/trustee representatives of the compassionate, cost-effective role of integrated palliative care in a duly constructed care continuum that truly supports “cradle to grave” care. We anticipate reluctantly empowered citizens, acting as advocates for their aging parents and loved ones, will increasingly drive the service and program development agenda of palliative care for many health authorities.

Furthermore, hospice palliative care in Canada throughout its 30 year incubation, has very much been funded through individual philanthropy and community investment. It is quite likely that this early predominant reliance on community investment has some influence in how palliative care is treated in mainstream service decisions and funding. Community investment will remain an essential component to meet the requirements for holistic care, but should no longer be seen as an expected primary source of service and program development funding.

We further anticipate a “tipping point” that will drive system readiness for hospice palliative care up on respective health authority agendas will be the consumer demand that will invariably follow a critical mass of Canadian’s accessing the recently announced Compassionate Leave benefit through the Employment Insurance program. It is inconceivable that Canadians will stand for continued poor or non-existent hospice palliative care service (generally provincial/territorial jurisdiction) in rural/remote parts of Canada, when they have access to a government-sponsored, paid-leave benefit to care for a loved one with a life-threatening or life-limiting illness.

We also anticipate that, without focused intervention for organizational development and culture change, hospice palliative care service and program development will continue to occur within an organizational culture where hospice palliative care competes with other curative-oriented services. In effect, the risk exists that the paradigm of comparing “apples” and “oranges” in service decision making will continue, rather than conceiving hospice palliative care as a logical link in a well-constructed, active and continuing care service continuum.

The Canadian Hospice Palliative Care Association (CHPCA) as process sponsor, and many dedicated
individuals (most practicing palliative care professionals and academics) have invested the last decade on achieving national consensus on norms of practice and principles for hospice palliative care. The CHPCA document entitled *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice* was released in 2002.

The Model reinforces a pathway to the development of palliative care service and program development in Canada based on a dual track, conceived as a “Square of Care” and a “Square of Organization” as its two building blocks. The CHPCA Model perhaps provides the best hope Canada has as a federated nation-state, for moving towards harmonized, integrated, and equitable hospice palliative care for ALL Canadians.

**From Education to Capacity-Building**

The RRHII funding was approved for a CPD innovation project for rural HCPs, and that is what has been delivered. It is important to discuss, however, that the leadership approach the project used was fundamentally a “capacity building” orientation and not an education orientation.

Too often system readiness and other organizational problems are mis-diagnosed and ill-constructed as gaps in education or training. That is, management assumes “if we only do more training the problem will be solved.” The reality confirmed early on, is that if the project focused solely on education/training of HCPs as its orientation to CPD, and ignored larger system readiness issues, it would ultimately be training rural/remote HCPs to deliver service that their respective health authorities would not be positioned to support. The relational risk in such well-meaning ventures is that newly empowered rural/remote HCPs become frustrated quickly in not being supported, with a corresponding impact on morale and professional ethics, contributing to increased disillusionment, burnout and staff/physician retention.

The project development team and the PAC conceive CPD as a strategic health system resource. This has had a profound effect for how needs assessment and program/resource development has been approached. It starts with understanding that there are clear and logical links between accountability, responsiveness, and role performance, that are linked to the context of the workplace. That is, rural HCPs can only implement the knowledge, skills and attitudes necessary to impact quality of patient care if they understand how to constructively engage and overcome barriers in the local environment (i.e., context of care).

In some instances, this is a very practical community development exercise. For instance, it can take the form of something as simple as bringing a local community pharmacist into the care team and ensuring that certain medications are on hand and available, and making arrangements for “after hours access” to both physicians and community pharmacists when caring for a patient with life-limiting illness in a community setting.

Other times, it is more involved. It might mean working as an advocate to engage senior management and local community leaders to address local unmet needs in new ways (e.g., 24 hour RN home care access in the obvious last days/hours of life). In other words, the approach that has been taken to rural/remote hospice palliative care development is to engage HCPs as health professionals AND local leaders.

A capacity-building orientation is also very important in low-patient volume environments. The adage that “practice makes perfect” is an essential tenant of clinical practice and typically a cornerstone for providing competent professional interventions. The reality is that many HCPs in rural/remote Canada will care for relatively few patients with life-threatening and life-limiting illness on an annual basis. When they do, however, it is important their patients receive quality, competent, safe and ethical care, and have access to the tools/resource people to support said care on a just-in-time basis.

Increasingly, this is a licensure/registration duty and obligation for the individual HCP and a quality assurance and accreditation accountability of the respective regional health authority. Therefore, greater emphasis must be placed on developing knowledge resources that support self-directed, just-in-time learning. Stakeholders in northern Canada actually refer to this form of workplace learning as “crisis learning.” That is, they experience a new problem in the course of their professional practice and react in crisis to find the information and consultative resources necessary to deal with a patient’s symptoms or presenting conditions, on a just-in-time basis. These
are clearly “signals” that future design of CPD to support quality patient care must advance beyond current “education-only” (see below) models, and respect the changing role of the primary-care professionals as a “knowledge manager.”

For most contemporary planners and decision makers considering possible responses to a knowledge, skill or organizational development gap, the concepts of education and learning are synonymous. The reality is that they are not! This conceptual challenge is further complicated in clinical and academic health science settings, where the culture, language, and reward systems support and perpetuate the concept of education as equal to learning.

The reality is that learning can and does occur in the absence of educational interventions. Academic cultures are resistant to this, for many reasons related to philosophy about the sources/epistemological base of legitimate professional knowledge. That is, many academics and academic leaders tend to resist (often as a hidden, underlying attitude/assumption) the reality that practitioners too are valued sources of legitimate professional knowledge. Addressing these historic cultural barriers is a critical success factor in creating the respectful, mutually-beneficial exchange that many stakeholder cite as an important in designing effective rural/remote CPD.

Moreover, most contemporary academics and professionals do not understand that the dominant paradigm for approaching learning is Ralph Tyler’s Education Model21 (also referred to as the curriculum or programming model). Consequently, decision makers traditionally respond to a new “need” through an educative/instructive experience, such as a program, course, or seminar. In contrast to Tyler’s Education Model, the reality is that HCPs learn to solve problems in a variety of ways, only one of which is participation in formal instruction. They also tend not to understand the Education Model perpetuates an approach that effectively reinforces a one-way transfer of knowledge and skills. This is a fundamental challenge when working with rural/remote HCPs, because the context of care is almost universally very different than those at large referral teaching hospitals and academic health science centres (but no less important if you are the patient for whom care is being provided).

The other main performance-based ways professionals learn in addition to instruction are through experience (i.e., adequate patient volumes, reflective practice) and inquiry (i.e., encountering a new problem in practice and formulating a response to address it), often by seeking information and consultation.

A capacity-building approach is not mutually exclusive from the Education Model. It extends the Education Model to address demands of a dynamic and changing workplace (i.e., care delivery context); respects the paramount importance of service delivery context in being able to offer effective, safe and ethical professional service; and integrates supports for other modes of learning that transcend the instruction-based, Education Model paradigm.

During the implementation of the RRHII-process, this move to implement a Capacity Building approach was realized in several ways. It was demonstrated through:

- The language used to guide the implementation of the project (much which was new to stakeholders);
- An approach to planning and implementing content-valid needs assessment that was closely aligned with the actual role requirements of practice (e.g., DACUM needs assessments); and
- The development and circulation of learning resources that provided reminders and support (e.g., fact sheets, handbooks) on a just-in-time basis.

From Instruction to Knowledge Management and "Just-in-Time" Workplace Learning
Consistent with the analysis in the previous section, it is reasonable to assume that part of the innovation demonstrated through this project is conceptual. That is, compelling stakeholders to revisit their mental models to recognize the need to move beyond single-strategy methods such as instruction (Education Model paradigm). The need to support a range of knowledge and skill development needs that are timely, accountable, based on best-available evidence (i.e., efficacy), and that are appropriate to context (i.e., they are available and can work in specific rural/remote settings). That is, that focus on the knowledge and skills needed to provide hospice

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palliative care (i.e., workplace) as part of a larger
primary-care practice characterized by multiple and
competing demands (i.e., rural/remote HCP as
generalists with considerable depth in many areas).

The convergence of rapidly evolving technologies in
information and communication, learning, and
knowledge management is driving and enabling a
transformation in CPD that helps address workplace
learning more effectively. For instance, professionally-staffed health
call centres (e.g., Health Link type operations) and desktop/handheld (e.g.,
PDAs) computing devices hold considerable promise
for ensuring that rural/remote HCPs have access to the
right information at the right time in the right form, to
guide their patient care planning and decision making.
Interestingly, several excellent resources currently
exist, and with some enhancement and wider
availability, are ideal for supporting rural/remote
HCPs and other primary-care professionals who
provide quality hospice palliative care in low patient-
volume environments. These include:

- Palliative Care Handbook (Alberta Cancer Board)
  (Capital Health Authority [Edmonton], Regional Palliative Care Program)
- Pocket Booklet: Medical Care of the Dying (3rd Ed). (Victoria Hospice Society)
- A Caregivers Guide: A Handbook About End of Life Care (Palliative Care Association of
  Alberta/Order of St. Lazarus of Jerusalem
- The Pain Manual: Principles and Issues in Cancer Pain Management (Purdue Pharma)

Moreover, it is increasingly more important for
rural/remote HCPs to know where to quickly find
information and be able to implement interventions
under the guidance of knowledgeable specialist
colleagues, more so than it necessarily is for them to
be sufficiently competent in all areas at all times.
Well-designed, just-in-time, workplace learning
supports also demand ready access to specialist
colleagues in secondary and tertiary-level hospice
palliative care practice who are sensitive to, and
sensible about, the context/reality of rural/remote
practice.

The emerging reality for many rural/remote HCPs is
that increasingly their competence will be assessed, in
part, by the demonstration of their knowledge
management skills in clinical practice, as
demonstrated by implementing “collaborative
practice” and by the quality of patient care received.

There are, as well, other considerable professional and
organization culture barriers to overcome. There is
considerable evidence from the field to suggest that
physicians and other HCPs are not particularly adept at
demonstrating “responsible ignorance.” That is,
admitting they do not know something that if
responsibly addressed on a just-in-time basis, could
otherwise help the patient. Dr. Frank Ferris noted at the
Project Launch, the importance of recognizing what
EPEC has called the “they don’t know that they don’t
know” challenge. In many other instances, however,
this has been behavior-linked and described as a fear of
losing authority status in the hospital or community.

The reality is, however, that media such as the web
and books, and the proliferation of health information
available on radio (e.g., House Calls with Dr. Art
Hister) and television stations make specialist
knowledge available to consumers and colleagues. For
instance, for those in western Canada who receive
ACCESS or Canadian Learning Television (CLT) via
satellite/cable, they can view the same program
content as registered nurses enrolled in Grant
MacEwan College’s, post-graduate palliative care
certificate program. Citizens can also run a quick
“Google” search on the web, and find the same
information that clinicians have access to. Much of
this information is freely available through sites such as
Living Lessons, Ian Anderson Program, EPEC,
EPERC, ELNEC, Pallium.ca, palliative.info (and a
host of other hospice palliative care special project
and academic health science centres) web-sites.

Underpinning the availability of this new information,
is an emerging generation of citizen-consumers who
have comparatively higher education and literacy rates
than that their parent’s generation, and who tend to
approach the provision of specialist services with
much caution and scrutiny, often wearing their
consumer “buyer beware” hat and skill set.

This “democratization” of specialist clinical and care
information often compels reluctantly empowered
consumers and colleagues to challenge physician and
care team member inaction and decision choices. It
often strains relationships and perpetuates further
defensive responses on the part of HCPs. One of the most profound barriers to remove in hospice palliative care CPD/service provision is the professional/organizational cultural impediment that “disables” physicians and other members of the care team from admitting that they do not know how to deal with a patient concern— at this moment! Moreover, they need to be empowered as “knowledge managers,” with skills to know who, how, and where to go to get appropriate information and consultative support on a just-in-time basis, and integrate said knowledge into a safe, ethical and effective response.

Increasingly, it is reasonable to expect that it will be the emerging role of specialist tertiary health science centre colleagues to synthesize current information and make it available in forms that are useful to the busy professional (e.g., EPERC’s Fast Facts & Concepts). Moreover, there is much to be done to improve the functional collaborative linkages between primary-care HCPs (especially rural/remote) and specialist palliative care colleagues.

This shift to a knowledge management orientation is reflected in the evolving design of Pallium’s Clinical Introduction course. The intent is not to make palliative care specialists out of rural/remote HCP generalists. The intent is to empower rural/remote HCPs through case-based learning and reference materials, so they might understand and identify common situations, symptoms, and circumstances, and develop strategies and sources of information where they can go once said need occurs in practice. The reality previously noted is that hospice palliative care is a relatively low-volume practice area for most rural/remote HCPs, yet it is important that rural/remote HCPs are aware and know how to access information and consultation when the need arises.

**Health Education Culture as a Systemic Barrier**

A growing expectation of HCPs, by both regulators and the public, is the ability to continuously learn (including unlearning and relearning) in response to new evidence that illustrates the effectiveness of particular therapies or interventions. There are several realities that make this particularly difficult for many HCPs relative to hospice palliative care.

Most current practicing HCPs were never exposed to hospice palliative care philosophies or content in their pre-professional education. As Dr. Frank Ferris, (EPEC principal investigator and leading North American palliative care authority source) noted at the Project Launch symposium in April 2001,22 how can we realistically hold HCPs to account for being competent for something that they were never exposed to in the first place? In other words, there is practically no theoretical and conceptual base in most health sciences education programs in the area of hospice palliative care upon which to build a career-long, evidence-based foundation for continuous learning.

It should be noted here that the matter of pre-professional service preparation in hospice palliative care is being addressed in Canada. It is happening through organizations such as the Canadian Society of Palliative Care Physicians, the national Working Group on Education for Formal Caregivers (Canadian Strategy on Palliative and End-of-Life Care), through individual family- and palliative-medicine residency programs, and through pockets of dialogue among colleagues in registered nursing and other professions, however there still remains much to be done.

The nature of the work to be done includes nurturing academic and organizational cultures that respect, and are in alignment with, the move to the active management and new utilization of evidence about the efficacy of particular hospice palliative care management approaches and interventions. There is much work to be done, but this should ultimately result in better decision making and patient care.

Moreover, culture change efforts also need to focus on the requirement for all HCPs to continuously learn, and to also possess the self-awareness and skills to unlearn and relearn. One of the pervasive challenges of this project has been to engage the rural physician community in ways that help them unlearn much of the “hidden curriculum” effects of medical school socialization. This includes balancing a pre-occupation with healing and curing at the expense of integrating a responsible approach to active treatment of disease with enlightened approaches to hospice palliative care. It also involves a revisiting of physician attitudes vis-à-vis changing expectations for their respective roles in the organization and delivery of collaborative care. This reflection certainly mirrors...

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22 A time-edited version of Dr. Ferris’ presentation is available in Windows-media audio file format on the RRHII Project Companion CD-Rom.
much of the discussion that has been focused on primary-care reform, particularly with respect to transforming community-based practice for more timely, appropriate and seamless care.

Academic culture change also includes working with registered nurses and nursing professional schools in a respectful way to address many of the professional socialization issues associated with “caring.” Another ongoing challenge throughout this project has been to “debulk” myths that hospice palliative care is “soft stuff” and the attitudes displayed by many registered nurses that “I must be giving good palliative care, because I am trained as an RN and we are trained to care and advocate for the patient.” The reality is that modern hospice palliative care has considerable rigor, science, and method. It involves many patient management and other clinical interventions in which the registered nurse is a full and active collaborator in consultation with family physicians and other members of the care team. There is a considerable “hard” side to contemporary hospice palliative care.

Systemic changes for hospice palliative care are long-overdue in Canadian health sciences education. The one relatively universal area that every HCP will encounter during their career is engaging in a patient-care situation that involves the proper planning, management and treatment of those with life-threatening or life-limiting illness. And yet, almost no Canadian health sciences education incorporates the introduction to hospice palliative care as a core part of its pre-service curriculum. In the words of one project stakeholder (and reflective of views heard throughout the Project), it would be “much easier” to deal with this gap when students are still in school than to try and change their behaviour once they have been in practice all these years.”

In this respect, the CPD orientation of the Pallium Project really represents a relatively small, symptomatic response to the challenge of a much larger health education culture and systemic problem. Until such time that hospice palliative care is thoughtfully and meaningfully integrated into health sciences education at the pre-service level, the ability to affect meaningful change and improved patient care at the health system delivery level will remain predictably poor.

Adoption of Innovation

During the course of this project, Dr. Neil Hagen, Director of the Division of Palliative Medicine at the University of Calgary, reminded Canadian palliative care stakeholders during a challenge session at the National Action Planning Workshop on End-of-Life Care, that we need to be realistic about what innovation is, what is achievable, and how can we encourage adoption. Dr. Hagen led from Evert Roger’s 23 innovation diffusion model, and posed the following questions that have been taken quite seriously in Pallium RRHII-project implementation:

When considering an activity or intervention, the following questions are paramount:
1. Can it work?
2. Does it work?
3. Will it make a difference?

Moreover, we have used two additional questions throughout our ongoing formative evaluation and continuous improvement efforts. These are:

1. Does a client system have the receptor capacity to receive and implement the change required/innovation?
2. If the client does not have the current capacity, what has to be addressed first on the pathway to the desired change?

Moreover, we considered other criteria around community innovation readiness, such as:
- Technical/technology availability
- Market/community acceptability
- Policy supportability

When reflecting and analyzing on the Pallium Project to-date in this context, it is clear that the stakeholders can claim relative to the resources and objectives, that several innovative responses to current rural/remote HCP CPD in hospice palliative care were developed. Several of these are bona fide Canadian “firsts”, and some are “firsts” on a global scale. The reality is, however, much of real work required to ensure sustained innovation in uptake for integrated hospice palliative care remains to be done. Responses that move beyond a clinically-oriented, knowledge and skills

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development agenda are required if Canadians living in rural/remote locales are to experience meaningful change in the nature, quality and availability of hospice palliative care. System readiness must be a cornerstone consideration in diffusion of a sustainable hospice palliative care innovation.

To use the CHPCA Model, the work of the Pallium RRHII-funded project has started to address many of the “Square of Care” development needs. There is much work left to do, however, to ensure wider adoption of innovation as part of hospice palliative care integration and development in Canada’s respective health systems.24

Much of these issues are currently being addressed at the national-level, through the Canadian Strategy on Palliative and End-of-Life Care. Within the purview of Pallium’s prospective contribution to future development of Canada’s hospice palliative care capacity, however, much remains to be done in the area of CPD and targeted capacity building interventions on the “Square of Organization” side, to enable sustained and meaningful adoption of innovation in HCP knowledge and skills development.

Therefore, any future capacity building agenda for Pallium ought to give due consideration to both the system readiness (i.e., organization and system factors necessary to implement effective change), as well as the development needs of caregivers/teams. Moreover, consideration ought to be given in better understanding and appropriately responding to the interface between HCPs and volunteers, as well as informal (e.g., family) caregivers in the development and sustainability of vibrant, responsive primary-care oriented, hospice palliative care solutions.

National Solutions in Inter-jurisdictional and Inter-sectoral Collaboration
This project also highlighted several relevant issues and insights about planning and implementing national solutions in a project delivery context that is characterized by multiple jurisdictions (provincial/territorial/aboriginal) and sectors (e.g., government, education, health service delivery, non-governmental associations). The constitutional division of powers within Canada’s federated nation-state model, create considerable complexity, extensive relationships, and unique interdependence that impact at all levels of project development. This phenomenon creates considerable transaction-related costs for project development and relationship management.

Few, if any, national health-related projects can meet all the needs of every jurisdiction all the time. There is a particular sensibility and sensitivity that must be applied to making effective efforts to understand the specific organization, state of development, and current issues within each respective jurisdiction. And to their respective credit, some jurisdictions have much better developed hospice palliative care infrastructures than others, as has been alluded to earlier in this report. Therefore, it is prudent, if not always necessarily perceived as equitable, to apply the principle of “unmet need” when working with stakeholders in individual jurisdictions. That is, some jurisdictions will be further developed and others will lack essential enabling infrastructure to support rural/remote CPD and related capacity-building (e.g., provincial/territorial learning centre; access to tele-health resources; access to available specialist consultative resources, etc).

Future investments are likely to have the most impact when they help to equalize jurisdictions based on a national approach, such as common goal pursuit of integrated hospice palliative care based on the CHPCA Model. Moreover, structural barriers and the rather insular nature of jurisdiction-based systems results in a poor transfer of best practices from one jurisdiction to the next, many that often have potential broader application, as well as the potential for significant impact on patient care if adopted and “localized” in other jurisdictions.

Clearly, national solutions are most effective when they:

- Bring jurisdictions together to work on common goals and objectives,
- Address common issues, challenges, opportunities and needs that would otherwise result in inefficient duplication, and
- Enable synergies that ensure collaborative results through local champions who can interpret the suitability/adaptability of a national solution to a jurisdictional and local context, and champion adoption of innovation locally.

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24 For project implementation purposes, it is essential to conceptualize Canada as having at least 16 major health systems (provinces/territories; aboriginal governance, military, RCMP).
Future evolution of the Pallium Project might best be undertaken in ways that continue to respect the distinctive nature, organization, and state-of-development of health systems in the respective jurisdictions in which it operates. While perhaps a self-evident statement, it cannot be understated how important this insight and principle is to implementing national, project-based solutions that are linked at varied levels with health delivery systems. This is particularly so when there is a high-level of local personal, emotional and organizational investment in the status quo and current, local infrastructure.

It should also be noted that the dynamics of inter-jurisdictional and inter-sectoral collaboration, and the inherent interdependency it characterizes, poses considerable relational and operational risk. For instance, it takes many “actors” in a jurisdiction to bring a collaborative initiative to fruition, but it only takes a single “actor” with access to key inputs, “means of production,” or “gateways” to derail the process. On at least a few occasions throughout the project, a failure to be able to rely on collaborators at the local-level demonstrated the relational and operational risk exposure inherent in inter-jurisdictional and inter-sectoral national projects.

Moreover, when local collaborators are “gatekeepers” to essential jurisdictional infrastructure necessary for service and program development, the result is that an entire jurisdiction can be denied access to rural/remote CPD and related capacity building resources that are otherwise available in other cooperating jurisdictions. There is no easy answer to overcoming this potential risk, but it is an essential dynamic that ought to be considered and accommodated for in strategic decision making/operational contingency planning.

Rather than slip into a trap of becoming “all things to all people,” Pallium is best positioned to broker a set of core, standards-based Canadian knowledge development and learning resources applicable across all jurisdictions. It is also well-positioned to become a focus and locus for stakeholders from academic health sciences, adult learning, and health services delivery, seeking a collaborative Canadian response in the form a “centre of excellence” approach to hospice palliative care knowledge, skills, and organizational development. Finally, Pallium has the potential to create meaningful and sustaining change at the jurisdiction-level, by providing facilitative leadership in helping establish local infrastructure (e.g., provincial learning centres) and augmenting existing infrastructure where there is a current unmet need.

**Meaningful Partnerships**

Much has been learned about partnership and collaboration in the scope of the Pallium RRHII-funded activities. The partnership concept is predicated on the idea and belief that organizational performance can be significantly improved through joint, mutually dependent action. Partnership, however, is a word that can suggest much and result in little. Conversely, powerful collaboration can emerge in which the word partnership is never used by the principals to the collaboration. Both scenarios have played out in the RRHII-funded project activities.

As the major stakeholders consider their continued and active role in Pallium Project development, more care, attention, and dialogue ought to be invested in exploring the concept of contribution to a shared cause, and to partnerships, specifically. The lesson that has been reinforced during the RRHII-funded activities is that partnerships linked to Project strategy require energy, leadership, time and investment to develop, nurture and sustain. Moreover, in a national project with inter-jurisdictional and inter-sectoral scope, there is a systemically-derived multiplication of relationships and prospective stakeholders who deserve and demand due consideration as prospective partners. Simply put, effectively managing relationships and navigating partnerships is essential, but time and labour intensive and often difficult to achieve, particularly within the implementation and reward framework of a Major Activity-based and funded project.

To address future matters related to relationship management and partnerships, the principals to the Pallium Project have conceived a prospective partnership model based on two distinct, but not mutually-exclusive types. One is a *Relational Partnership* and the other is *Functional Partnership*.

A *Relational Partnership* acknowledges the growing importance of “relational capital” as a form of “intellectual capital” in seeing things get done. It

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25 For a more detailed discussion on the emerging conceptual discourse about Intellectual Capital, the reader is directed to the foundational work of Dr. Nick Bontis from McMaster University.
respects the intangible value and power of networks and relationships for achieving results. The characteristics of a Relational Partnership include, but are not limited to, written and organizationally-endorsed agreement, to:

- Work strategically and productively towards pursuit of a common-goal.
- Identify a designated point-of-contact and liaison.
- Formalize relations between the two organizations.
- Commit and act on a formalized exchange and dissemination of information and sharing of pertinent intelligence through each other’s networks.
- Produce pertinent information for sharing within each other’s networks.

A Functional Partnership may, and very likely would, contain all the elements of a Relational Partnership. It would, however, move that relationship to a functional-level and focus on an agreement to formally partner on something else substantive. Possible scenarios for a Functional Partnership would also be based on a written and organizationally-endorsed agreement, and might focus on:

- Sharing (operationalized on a preferred licensing basis) a resource for further development.
- Providing in-kind staff time to complete a project task (e.g., assistance in program design, development, delivery).
- Providing expertise & technical assistance in the development and validation of a resource (e.g., peer review).
- Providing access to a unique resource required to further the goals of the Project (e.g., existing distribution system for resources).
- Providing money (e.g., programs that parallel Glaxo’s Employee Donation Program).

Moreover, the project development team of the Pallium Project suggests that proper attention be given to, and resources invested in, both processes and roles required to effectively manage relationships and develop both types of partnerships described herein. This includes baseline project infrastructure investments in regular and well thought out communication with stakeholders as an essential engagement strategy.

It should be noted that extensive professional service time, expertise, organizationally-incurred staff/travel expense, as well as other forms of organizational infrastructure and support have been contributed to the project, well in excess of the $250,000 in the Contribution Agreement. Future contributions would be formalized through partnership arrangements, assuring that stakeholder organization leaders are aware of, and acknowledged for, the extensive local investments being made to the collaborative goal of advancing hospice palliative care capacity building.

**Tackling the Digital Divide**

The medium of the World Wide Web and Internet connectivity generally, open up previously unheard of opportunities for collaboration, professional community building, and resource sharing. The reality is, however, that much of the web is dominated by English-language content and related infrastructure. The Digital Divide has become a moniker for the concept that there are many individual, social, economic, technical and linguistic barriers to digital inclusiveness. Digital inclusiveness is the extent to which citizen-consumers embrace, and have the interest, willingness, capacity and ability to embrace, the “Information Highway” and Internet in daily life.

Digital inclusiveness concerns played out linguistically and technically throughout the implementation of the RRHII-funded project.

With respect to linguistic inclusiveness, Pallium.ca was designed, in large part, as a hospice palliative care “portal” and as a support for practicing rural/remote HCPs within a national project context. While initially launched using a “learning lab” paradigm, the Project did, and continues to experience, challenges in making operational a truly-equitable Official Languages compliant web-presence.

Much of this challenge relates to the structural organization of the web, and in particular, the general lack of comparable third-party content for French-language development. The Project has several stakeholders who consider themselves French as a first-language Canadians. The Project has also invested in project and relational infrastructure to assure reasonable access to Pallium-related content in both Official Languages.
Further to discussion with Health Canada officials, Pallium maintained its Version 1.0 web-site at pallium.ca and has taken no new action to develop (or redevelop) a Version 2.0 of the web-site until such time that the project development team can more effectively address the “digital divide” issues raised by using a “portal” concept to link to existing resources (i.e., consistent with the Project’s “reduce duplication” objective).

The Project has also undertaken translation of its current Version 1.0 web-site original content, but has not been able to satisfactorily address linking French-language introductions for “navigating into” third-party, English language content over which it has no ownership or editorial control.

The Project’s experience-to-date with digital inclusiveness mirrors the experience reported by the Commissioner of Official Languages, Dyane Adam, in March 2002. Ms. Adam reported that there is considerable risk of “two solitudes” developing on the web, with concern that evolution of the web and Canadian information highway policy is contributing to the isolation of French-Canadians and in a growing digital divide.

Future development in the area of Official Languages content might be better undertaken nationally, within the purview of collaboration with the Canadian Virtual Hospice. Specific actions taken may include seeking permission and licensing rights to translate and present high-quality, third-party owned English content into other languages. Clearly there remains a need for an Official Languages policy dialogue and commensurate “action plan” for addressing many of the Digital Divide issues.

The concept of the Digital Divide also presents generally for rural/remote HCPs that rely on patients and families to play a more active and responsible role in self-care and treatment decisions predicated on the construct and underlying principles of “informed consent.”

Future efforts might include innovations that move away from a predominantly text-based approach to information dissemination and rely on a more balanced approach that integrates better and more effective use of streaming audio and video in low band-width environments as complementary means of communicating valuable information. This would help many visually-impaired (e.g., age-related) citizens, as well as those Canadians with relatively lower literacy levels. And once digital audio and video content is produced and stored at source, it can be easily re-purposed in a variety of media, including audio CDs for home/vehicle and VHS/DVD for home viewing.

At a second-level, the digital divide manifests itself from various technical dimensions and these were experienced to various degrees throughout this project. There is considerable disparity between urban and rural/remote technical Internet infrastructure. This impacts the degree and nature of interventions that can be used for web-based CPD outreach and engagement. There is also considerable disparity in Internet infrastructure within individual jurisdictions, that impacts the application of national project solutions to individual jurisdictions. In many cases, low-bandwidth and service of questionable reliability creates a considerable irritant in encouraging adoption of the Internet as a CPD resource. Moreover, there is also considerable disparity in the numbers and compatibility related to video-conference infrastructure in various jurisdictions, which currently impacts the ability to effectively use this medium as a consistent and reliable CPD vehicle.

The Project also heard recurring reports from the field that data about adoption of web-based desktop computing technologies in the physician community is not necessarily generalizable to other disciplines. It was noted that relatively few rural hospitals and community-health centres have Internet (i.e., web) connected desktop computing stations that can be easily dedicated to care research planning, information seeking, and to facilitate web-based learning.

A theme that also came out very clearly through the project is that it is unrealistic to expect and assume the rural registered nursing community will be able to easily engage in computer-based, workplace-related...
learning from home. The message is clear and repeated many times. Rural registered nurses often are conflicted by their multiple roles as health professional, farming partner, parents, caregivers to their/spouse’s parents, and community leaders, leaving little time for workplace learning outside the confines of the health care workplace. Moreover, there were extensive anecdotal reports that where Internet connectivity and a desktop computer is available in the home, the rural RN often places last on the priority list for usage after farm business and child use of the home computer is factored in.

This discussion clearly illustrates that it is responsible and prudent to question many of the assumptions policy makers, program planners and decision makers are making with respect to the accessibility of Internet-enabled, desktop computing technology and other factors that influence digital inclusiveness and adoption of digital innovation for HHR. Early in 2002, the project development team had hoped to collaborate with scholars specializing in learning and knowledge management technologies to conduct exploratory research into many of these important questions.

Preliminary work had been completed for an application to a Research in Learning Technologies (RLT) program at the Office of Learning Technologies (OLT), Human Resources Development Canada. The Project’s digital inclusiveness research and development agenda lost momentum, however, following information from OLT that the RLT had been indefinitely “shelved” due to financial re-profiling in the Government of Canada, as part of the “security agenda” in the wake of the September 11, 2001 events and subsequent government planning/financial responses.

The project development team encourages the reader to consider the unique structural and technological barriers when planning interventions to support rural/remote innovation, particularly in health service delivery sectors. This is particularly so of those solutions that rely on Internet-based technologies as the primary or sole means for service and program delivery.

This learning about digital inclusiveness has very much influenced the development of Pallium-related service and program development, and is central to understanding the “blended model” of traditional and technology-enabled CPD the Project advocates when designing responses and collaborating with rural/remote colleagues.
EMERGING FRAMEWORK - ACCOUNTABLE & RESPONSIVE PALLIATIVE CARE SYSTEM-LINKED DEVELOPMENT

In reflecting on the evolution of Pallium as a catalyst for enabling better access and availability to “context appropriate” CPD, it is clear the Project is evolving into a focal point and locus for helping enable Canadian hospice palliative care knowledge, skills, and organizational development.

With adequate resources, leadership and staffing, Pallium has the potential to make a focused and sustained contribution to Canada’s hospice palliative care system development.

Much of what has made Pallium’s early activities possible to date has been the commitment of individuals and teams within universities, teaching hospitals, health delivery systems, and non-government associations, throughout its jurisdictional catchment. Moreover, there is the opportunity to build on early pan-Canadian interest in Pallium, and provide leadership to other regions who are interested in modeling Pallium, in part or in whole, to build their own regional capacity (e.g., British Columbia, Yukon, Atlantic Canada provinces).

Much of Pallium’s early evolution demonstrates aspects of a traditional “education consortia” model. From a slightly different perspective, it is also reasonable to suggest Pallium serves as an early model of a strategic health system development resource. Moreover, when layering these models with the role that emerging information and communications technologies (ICTs) played in the RRHII-project’s development, Pallium also demonstrates aspects of the new early models of the emerging network organization that supports continuous, career-related learning.27 Considering these various “mental models” and organizational constructs collectively, it is clear that Pallium ultimately reflects a hybrid model of an emerging Community of Practice, comprised of clinician academics, clinician practitioners, educators, policy, and non-governmental leaders, who are actively engaged in building Canada’s palliative care capacity.

Features of a network organization that seem to apply to Pallium’s evolution at the completion of the RRHII-funding include:

- Complementary strengths – Pallium complements that which already exists and “amplifies” individual/team contributions to CPD on a broader, inter-jurisdictional and inter-sectoral basis.

- Relationally-based communications, rather than transaction or rigid procedures. In fact, Pallium’s chief intellectual property is its network and relational “goodwill.” Pallium can only achieve results through others and its legitimate “power” to act is derived solely from collaboration and “moral suasion” linked to building the kind of hospice palliative care capacity that decision makers desire and that Canadians demand.

- A medium degree of flexibility, particularly related to the degree and amount of change that it can solely impact within any single jurisdiction. To reiterate, Pallium’s authority to effect change is derived solely from its “relational capital” and moral suasion.

- An open-ended climate, where stakeholders can enter and exit, depending on the degree they see, and are seen to be, accruing benefits. Collaboration within the context of Pallium activities must be, and be seen to be, accruing benefits that exceed the costs of participation.

- A relatively high degree of interdependence. Pallium to-date has largely relied on its respective network members resources (e.g., time, expertise, commitment), to achieve what it has with relatively few resources. Moreover, this high degree of initiative interdependence makes it relatively easy for uncooperative stakeholders and gatekeepers to “block” specific developments and diffusion of innovation at the jurisdictional-level.

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The emergence of the Internet and inexpensive telecommunications (e.g., teleconference) has made the emergence of the network organization model
more economic and feasible. It also makes the network more transparent. As time and Major Activity resources permitted, the Project was able to inexpensively and easily share developments through the Update newsletter.

Pallium is emerging as a network organization that uses a mixed model to support CPD & workplace learning for care providers in hospice palliative care. As Woodstra & Adria (2003) note, “it is toward the ideal of a committed, decentralized, and dynamic community of scholars and students that the network distance education organization is progressing (p. 540).” This description is very much in alignment with the early developmental status of Pallium, and is perhaps, the single best third-party description of what the Pallium Project represents.

The mix of courseware and learning resources that Pallium has enabled reinforces the importance of small-group, retreat-oriented, in-person learning. This approach works on the dual goals of developing current knowledge and skills, and also focuses on affecting change. It complements interventions that enable people to engage and learn in the place and time of their choice via electronic means.

In June 2002, the Project Advisory Committee (PAC) for the Pallium convened to discuss the future of Pallium and transition from the early work enabled via the RRHII-funding. At that meeting, the PAC determined much of the early work in which Pallium had engaged was more broadly applicable to, and of help within, emerging directions for primary-care reform in Canada.

The PAC endorsed a project direction based on the following vision statement for the interim-future development of the Pallium Project:

Every Canadian formal and informal care provider will have access to needs-based, reliable information and learning support resources, to enable quality palliative care, including end-of-life care and bereavement support, in a way that respects the most effective and affordable place of care, and that maximizes the potential contributions of Canada's health care continuum.

In early 2003, the following design principles were proposed to support the development of Pallium:

- Building, aligning and integrating good work being done by others throughout the nation.
- Pursuing a “Needs-based approach” as defined by the actual requirements of practice (e.g., DACUM).
- Building the capacity of the system to respond to emerging demand (i.e., system readiness).
- Facilitating workplace learning (i.e., experience-based, just-in-time, evidence-supported).
- Facilitating context-based (situational) learning (i.e., getting the job done with what you have).
- Recognizing three levels of need (i.e., individual care giver, team/organization, system).
- Building solutions from evidence-based practice and practice-based evidence.
- Organizing to interface through provincial/territorial and regional clusters/approaches as a unit of delivery and building (i.e., outreach programming).
- Encouraging and leading curricular standards development (e.g., linked to CHPCA Norms of Practice, CNA nursing specialty, etc.) with learning objects “adaptable” to local needs.
- Supporting and encouraging a culture of “critically reflective practice” and transform towards quality end-of-life care as an “entrenched core value” of Canada’s health care systems.
- Valuing and promoting a holistic approach (i.e., multiple domains of issues causing suffering and decrease in quality of life), but leading from pain and symptom management as the “hook” for current care givers.
- Promoting innovation in service and program development by activity involving senior decision-makers in learning and development, particularly within the “Square of Organization” for the CHPCA Model.

Pallium’s stakeholder are also advised to continue to develop the project is a direction that respects the emerging context for hospice palliative care in Canada, and one that incorporates a range of responses that support CPD for enhanced competence and performance. To that end, we have explored using the University of Alberta, Institute for Professional Development’s Framework for an Integrated Approach to CPD as a “mental map” as a starting point for future development.
Application of Integrated Continuing Professional Learning and Development Framework Applied to Canadian Hospice Palliative Care

- Public expectations about EoL care
- Aging population/difficult deaths
- Changing expectations about how care is delivered (multi-provider)
- Maturing views about managing pain and other symptoms
- Composition of health workforce

- Innovation for sustainable care
- Front-end investments in developing flexible-learning infrastructures
- Continued pressure to innovate in finding sustainable models for palliative & EoL care

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Adapted courtesy of the
Institute for Professional Development
University of Alberta (www.ipd.ualberta.ca)
SUGGESTED DIRECTIONS

We offer the following suggested directions for consideration by Health Canada and the project stakeholders. The intent is to inform and provide facilitative leadership in the continued evolution of Pallium, as a strategic health human resource and system capacity building support in developing Canada’s hospice palliative care capacity:

Suggested Direction 1 – A National Approach. Adoption of the Canadian Hospice Palliative Care Association (CHPCA)’s Model to Guide Hospice Palliative Care as the foundation for continuing professional and organizational development activities. A national approach should address the “Square of Care” and the “Square of Organization” in a thoughtful and integrated way.

Suggested Direction 2 – Links to Primary-care Reform. Leverage the opportunities presented by the emphasis placed on primary-health care reform, particularly at the Government of Canada-level, as a pathway for facilitating the development of a more coherent and consistent response to hospice palliative care development in Canada.

Suggested Direction 3 – Targeted Health Human Resource (HHR) Investment in Rural Canada. Continue to invest financial and relational resources in rural/remote HCP professional development generally, using aspects of the Pallium framework, to support the renewal and continued growth of HCPs. And, using processes and approaches demonstrated via Pallium’s RRHII project, engage academic health science centres and referral teaching hospitals as full-partners, to assure Canadians equitable access to evidence-based health services, that are delivered in an effective, safe and ethical manner.

Suggested Direction 4 – Focused Engagement of Canadian Health Education Leaders. It is predictable that many of the systemic challenges facing the continued evolution of hospice palliative care will not be effectively addressed without the understanding, commitment and full cooperation of senior academic and administrative leaders in Canada’s health education programs. Measures ought to be considered that actively engage health education leaders to address the systemic challenges related to culture (e.g., professional socialization) and curriculum that currently exist.

Suggested Direction 5 – Inter-departmental Collaboration on the Digital Divide. Collaborate with Heritage Canada and the Office of the Commissioner of Official Languages of Canada, to invest in policy and program research and experimentation to reduce the disparity in access to health-related resources in both Official Languages. Moreover, collaborate with the Department of Indian Affairs and Northern Development (DIAND) on demonstration projects to make hospice palliative care information available in oral (via digital audio) and text (printer-friendly versions) in various languages of Canada’s first peoples.
CONCLUDING COMMENTS

The Pallium RRHIi-project enabled considerable foundation building work to occur that will continue to directly assist in improving the quality and quantity of hospice palliative care CPD resources for rural/remote HCPs in Canada. The Project also highlighted much of the work left, particularly in the areas of organizational development and system readiness. Much of this foundation building work is also in alignment with emerging directions of broader pan-Canadian agendas linked to health system reform, especially primary-care reform.

The Pallium Project also created a relational structure and operating model that increased the quality and quantity of collaboration among diverse stakeholders who have an interest in improving hospice palliative care in rural/remote Canada. Without Pallium it is predictable that these talented palliative care leaders would have otherwise been limited to jurisdiction-based initiatives. Specifically, Pallium enabled colleagues to work across jurisdictions and sectors (e.g., academic, health services delivery, government, non-governmental organizations) in a way that seeded a process and structure for strengthening the capacity of the respective systems to improve patient care. Individual leadership and participation provided new collaborative opportunities and enabled collective, pan-Canadian CPD system-linked strengthening, that would otherwise have been most difficult to achieve.

Pallium represents one model for how the Government of Canada can seed change, by using the partnering and enabling approach seen with growing frequency in its facilitative leadership and programming directions. At the same time, Pallium represents a model for how the Government of Canada can work within jurisdictions on issues of paramount importance to all Canadians, in ways that respect constitutional division of responsibilities, and the many unique challenges of working effectively within a diverse federated nation-state.

As this summative Project Report illustrates, the Pallium RRHIi-project achieved intended outcomes consistent with the goals articulated by the RRHI program envelope. It created specific innovations consistent with that which was committed in the original proposal. It also, however, demonstrated a model approach for building system capacity, leading from CPD, which can be modeled for other areas of primary-care practice. These include, but are not limited to: healthy aging in rural/remote communities, healthy childhood development, mitigating high-risk behavior, obstetrics, community oncology, and other chronic disease management (including diabetes, heart, kidney disease).

The reality is that the pathway to primary-health reform is paved with good intentions, but it is predictable that it will only occur with targeted interventions oriented to transformation and bringing broad cross-sections of disparate providers and sectors together in new ways to address unprecedented problems.

In February 2000, Dr. Harvey Chochinov (now the nation's first Canada Research Chair in Palliative Care) noted in testimony before the Senate Subcommittee to Update "OfLife and Death, that … "in end-of-life care we do not have a vocal constituency. The dead are no longer hear to speak, the dying often cannot speak and the bereaved are to often overcome by their loss to speak."

While Pallium represents a glimmer of hope of the way we might work together to build and provide service for those who are at a most vulnerable time in their life's journey, its work has only begun. Much is left to do to impact the system/organizational culture and system development changes required to assure all Canadians, irrespective of place of residence or socioeconomic status, are afforded the opportunity to face to life-threatening illness and death, with dignity, in relative peace and comfort, free from needless pain and suffering.

We express our collective thanks, as a professional community, to Health Canada for enabling us to journey into the unknown, on what can only be described as an "innovation expedition." This Project Report concludes with a clear signal to Pallium's major catalytic funder that we are indeed better off and more prepared to tackle the emerging challenge of rural/remote hospice palliative care better than we were some 2 years ago, both on a regional-basis, and on a pan-Canadian basis. It is clear the Pallium professional community would not have come this far and this fast without the catalytic investment made possible by the Rural and Remote Health Innovations Initiative.
APPENDIX A
RRHII PROJECT ADVISORY COUNCIL
TERMS OF REFERENCE AND COMPOSITION

Introduction

These terms of reference outline the approach, responsibilities, composition, service and term of service for a Project Advisory Council (PAC) that will provide advise and direction the project leader in the execution of the Contribution Agreement and supporting activities for the Pallium Project.

General Approach & Rationale

The proposed structure for Pallium Project governance is that of a Project Advisory Council (PAC). The role of the PAC is to provide counsel and constituent representation to the Project Leader. The stakeholders (also referred to as founding partner organizations of the Pallium Project) are accountable through the Project Leader for the planning, execution and evaluation of the project, consistent with their commitments in the August 30, 2000 proposal that was accepted by the funder, Health Canada.

The Contribution Agreement with Health Canada governs the Pallium Project for the term February 15, 2001 – August 2002. The Contribution Agreement binds the project to what we will do, but is flexible on how we do it. To this end, an appropriate governance approach is the Policy Governance approach based on the work of John Carver. In this model of governance the purpose of the governing body is, on behalf of some ownership, to see to it that the project achieves what it should and avoids what is unacceptable. A synopsis on the Policy Governance approach is available from the Project Consultant.

Area of Responsibility

- Sets the PAC’s work plan and agenda for the term of service and for each meeting
- Provides consultation and direction to the Project Leader in macro-level project planning, execution monitoring, and evaluation.
- Establishes the results, recipients, and acceptable costs (governed by Contribution Agreement) of those results that justify the project’s existence.
- Examines monitoring data and determines whether the Project Leader has used a reasonable interpretation of project/funder-stated criteria.
- Determine PAC’s training and development needs
- Becomes knowledgeable and proficient in policy governance
PAC Composition

Ex Officio

Project Leader
Representative, Office of Rural Health, Health Canada (Funder)
Alberta Cancer Board (Sponsor/Hosting Authority Liaison)

Appointed

Jurisdictional Representation (1 each)
   Alberta
   Saskatchewan
   Manitoba
   Northwest Territories

Health Professions Representation (1 each from rural/outreach)
   Medicine
   Registered Nursing
   Pharmacy
   Other health professions

Professional Development/Education Representation (2 each)

Secretariat role

The Pallium Project consultant serves as secretariat to the PAC

At the discretion of the Project Leader and subject to availability of qualified advisors, a representative may serve dual representation roles (i.e., jurisdictional AND health professions representative).

Service Utilization

It is anticipated there will be 6 PAC meetings during the duration of this project, aligning with the quarterly reporting requirements of the Funder.

Remuneration

Members of PAC serve as volunteer board members sponsored by their stakeholder organizations. Service to PAC is reflected and acknowledged as an in-kind contribution to the project for the purposes of the Contribution Agreement. The Pallium Project reimburses reasonable travel, accommodation, and sundry expenses pursuant to the funding guidelines issued by the Major Funder.

Term of Service

The term of service is anticipated to be until August 2002.
Pallium Project Advisory Council (PAC) Composition

**Project Leader** (Ex officio)

**Dr. Jose Pereira**  
Alberta Cancer Foundation  
Professorship in Palliative Medicine;  
Associate Professor, Division of Palliative Medicine, University of Calgary;  
Medical Leader, Tertiary Palliative Care Unit, Calgary Health Region;  
Co-chair, National Working Group on Education for Formal Caregivers, Canadian Strategy on Palliative & End-of-Life Care

**Health Canada** (Ex officio)  
**Ms. Rukshanda Ahmad**  
Policy Analyst  
Office of Rural Health  
Health Canada

**Alberta Cancer Board** (Ex officio)  
**Ms. Marie-Joseé Paquin**  
Coordinator  
Palliative Care Network Initiative (PCNI)  
From March 2002

**Ms. Nancy Summers**  
Coordinator  
Palliative Care Network Initiative (PCNI)  
Until August 2001

**Rural Medicine**  
**Dr. Rob Wedel**  
Family Physician, Taber, Alberta;  
Medical Director, Regional Palliative Care, Chinook Health Region;  
Vice-president & Board Chair, College of Family Physicians of Canada

**Manitoba Jurisdiction**  
**Dr. Paul Daeninck**  
Assistant Professor & Program Director, Palliative Care Residency Program, Palliative Care sub-Program, University of Manitoba;  
Medical Leader, Oncology Administration, CancerCare Manitoba;  
Chair, Residency Program Directors, Canadian Society of Palliative Care Physicians

**Saskatchewan Jurisdiction**  
**Dr. Srin Chary**  
Medical Leader, Palliative Care  
Saskatoon Health Region  
Regional Palliative Care Program

**Rural Nursing**  
**Ms. Dennie Hycha**  
Program Director  
Regional Palliative Care Program  
David Thompson Health Region;  
Canadian Nurses Association (CNA), Hospice Palliative Care Nursing Specialty Working Group;  
Co-chair, National Working Group on Best Practices & Quality Care, Canadian Strategy on Palliative & End-of-Life Care

**Northwest Territories Jurisdiction**  
**Dr. John Morse**  
Medical Leader, Stanton Regional Health District;  
Internist, Stanton Regional Hospital

**Other Health Professions**  
**Ms. Terri Schindel**  
Director, Pharmacy Outreach Education  
Faculty of Pharmacy & Pharmaceutical Sciences, University of Alberta

**Professional Development/Education**  
**Ms. Nancy Guebert**  
Unit Manager, Tertiary Palliative Care Unit  
Calgary Health Region  
Until June 2002

**Alberta Jurisdiction**  
Vacant

**Rural Pharmacy**  
Vacant

**Professional Development/Education**  
Vacant
APPENDIX B

RRHII PROJECT AND BUSINESS PLAN OVERVIEW

PALLIUM PROJECT DIRECTIONS & PROCESS MAP

PROJECT STRUCTURE
- Establish Project & Outcomes (Core Results)
  - Governance
    - Project Advisory Council and Project Leader
  - Stakeholder Communication
  - Network/Relationship Development
  - Project/Fund Development & Report

PROJECT FUNCTIONAL TASKS
- Needs Assessment
  - Individual/team education/professional development
  - Health system leadership awareness & change tools
  - Public education & tools for informed care choices
- Coordination Collaboration Communication
  - Multiple methods
    - Perceived (provider-driven) & Real needs (service-driven)
    - Current people COP resources
    - Current learning COP products
    - Aboriginal/Cultural diversity
    - Barriers@rural secondary level
- Evaluation/Lessons Learned

Special Skills/Leader
- Identify local champions
- Standards-based training
- Online, web-based support network

Primary Level Practice
- Basic palliative care course
- Rural outreach education & supports
- Online, web course

pallium.ca
- Web-based clearinghouse
- Portal to quality palliative care resources & tools
- Online palliative care curriculum repository
- Online Independent & group learning opportunities
- Online forums, rounds, symposiums, knowledge exchange opportunities

Rural/Remote Outreach
- Information products for local media awareness
- Tools for local Town Hall Meetings/Outreach
- Linkages at the Canadian Health Network (CHR)
- Electronic and print media public education outreach

System Readiness
- Engage provincial governments, regional health authorities/boards
- Executive/policy-level briefings and site visits
- Standardized presentation materials for local leaders
- Measurable outcomes/indicators/results
- Palliative program development institute

Model Development
- Strategies for sustainable rural professional development with limited education resources
- Effective strategies for engagement
- Integrated Professional Development incorporating appropriate traditional & new learning technologies
- Strategies to facilitate responsive/effective professional learning and change in the health workplace
- Issues identification for future accreditation/standards development
- Lessons learned for future palliative care professional development

Prospective Indicators & Impact Measures
- Comparative analysis between proposed/actual project goals
- Access to COP-rural/remote
- Responsiveness to patients overall terminal care needs
- Kinkspareen- 4 Levels of Learning evaluative model

Version – February 2002 Update
### PALLIUM PROJECT – BUSINESS PLAN OVERVIEW

#### MISSION

**PALLIUM exists to significantly improve access to education and training resources in palliative care for Canadian health care professionals and the Canadian public.**

#### CORE PURPOSES

1. A Canadian clearinghouse, knowledge exchange and Community of Practice for efficiently disseminating palliative care knowledge, skills and resources.
2. Coordinate, and facilitate the integration of, palliative care continuing professional development (CPD).
3. Collaborate among palliative care stakeholders on the adoption/adaptation of existing; and the creation of new, palliative care learning resources.
4. Facilitate strong, collaborative links with practitioners, policy makers, and scholars in palliative care research, public policy, clinical practice and educational/professional development.

#### CORE GOALS

1. Map the local needs, issues and priorities related to rural and remote primary palliative care CPD and establish a framework approach for collaborative action.
2. Establish, nurture and coordinate a professional community of local multidisciplinary leaders/educators using ICTs as the medium for communication, dialogue and dissemination about state-of-the-art, evidence-based practice.
3. Develop a repository of online CPD resources for primary health care professionals to address palliative care in a primary care context.
4. Develop an effective model for CPD at a distance through integrating traditional and emerging adult learning methods and emerging technologies.

#### KEY STRATEGIES

- Stakeholder consultation symposium
- Survey to assess CPD needs.
- Develop/disseminate a database of CPD resource people.
- Compile an inventory of existing palliative care learning products.
- Design/Implement a PALLIUM Internet portal at www.pallium.ca
- Create an e-learning application to support a Community of Practice (CoP).
- Develop a communications strategy to create awareness for pallium.ca.
- Pilot distance learning tele-health demonstrations to showcase use of appropriate technologies for CPD.
- Create collaboratives that help HCPs learn to use ICTs for distance learning and knowledge management.
- Integrate pallium.ca with other major regional rural online tools.
- Evaluate feasibility of adopting/adapting existing learning resources for Canadian primary-care palliative care CPD.
- Establish pallium.ca as a leading portal/entrance point to quality third-party palliative care CPD.
- Facilitate modular, multi-disciplinary resource and course development.
- Fast-tracking/network development to expert resources in telehealth, e-learning and CPD.
- Evaluate current learning resources.
- Establish a stand-alone online health and CPD.
- Broker, facilitate or find new catalytic learning opportunities that address barriers to rural/remote CPD.
- Facilitate accreditation processes for CPD.
- Develop a descriptive, practical model for integrating traditional and state-of-the-art adult learning and emerging learning technologies to impact constructive change and facilitate patient responses in professional practice/service transformation.
## APPENDIX C
### RRHII PROJECT LAUNCH SYMPOSIUM
#### DESCRIPTIVE INFORMATION

**PALLIUM Project Launch & Needs Assessment Symposium**
**Detailed Working Agenda – April 27, 2001**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Resource People</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800–0830</td>
<td><strong>Commencement and Introduction</strong></td>
<td>□ Dr. Albert Einsiedel, Jr., Professor &amp; Executive Director</td>
</tr>
<tr>
<td></td>
<td>Moderator – Morning Session</td>
<td>Institute for Professional Development, University of Alberta</td>
</tr>
<tr>
<td>Clara Christie Theatre (CCT)</td>
<td>Message from Government of Canada (PALLIUM project major funder)</td>
<td>□ Ms. Judith Dowler, Manager, Office of Rural Health, Health Canada</td>
</tr>
<tr>
<td></td>
<td>Overview of PALLIUM initiative – PowerPoint presentation</td>
<td>□ Dr. Jose Pereira/Mr. Michael Aherne, PALLIUM Secretariat</td>
</tr>
<tr>
<td>0830-0930</td>
<td><strong>Regional Perspectives/Experiences – Alberta, Saskatchewan, Manitoba, and Northwest Terr.</strong></td>
<td>□ Ms. Nancy Summers, Alberta Cancer Board, RPCI</td>
</tr>
<tr>
<td></td>
<td>10 MINUTE PRESENTATION + PANEL DISCUSSION</td>
<td>□ Mr. David Kay, Rural Physician Action Plan-Alberta</td>
</tr>
<tr>
<td></td>
<td>□ What is the current state of preparedness vis-à-vis rural and remote health care professionals (i.e., knowledge, skill and awareness/attitudes towards palliative care)?</td>
<td>□ Dr. Srin Chary, Regional Palliative Care Program, Saskatoon Health District/ University of Saskatchewan AND</td>
</tr>
<tr>
<td></td>
<td>□ What current programs or mechanisms exist to build capacity (i.e., knowledge, skills, attitudes) about palliative care in the rural and remote health care work force?</td>
<td>□ Dr. Lawrence Klein, Regional Palliative Care Services, Regina Health District (Confirmed) + input from colleagues</td>
</tr>
<tr>
<td></td>
<td>□ How are they being evaluated?</td>
<td>□ Dr. Mike Harlos, Palliative Care Program, Winnipeg Regional Health Authority + input from colleagues</td>
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<tr>
<td></td>
<td>□ What are the early lessons learned?</td>
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<tr>
<td></td>
<td>□ What programs or initiatives are under development or are being considered/proposed?</td>
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<tr>
<td></td>
<td>□ What resources and skills exist to further develop palliative care capacity in the rural and remote health work force?</td>
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</tbody>
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*Project Report*
*Health Canada Project Reference #6788-15-2000/0390420*
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:45-1100</td>
<td><strong>Current State and Best Practice in Palliative Care Education &amp; CPD – A North American Overview</strong></td>
<td>- Dr. David Weismann, Medical College of Wisconsin, Project Co-Director, End-of-Life Physician Education Resource Center (EPERC), <a href="http://www.eperc.mcw.edu/">www.eperc.mcw.edu/</a>&lt;br&gt;- Dr. Frank Ferris, Palliative Care Standards/Outcome Measures, San Diego Hospice, and Principal, Education for Physicians on End-of-Life Care (EPEC), <a href="http://www.epec.net">www.epec.net</a>&lt;br&gt;- Dr. Pippa Hall, University of Ottawa Palliative Care Institute&lt;br&gt;- Dr. Deborah Dudgeon, Kingston, Ontario (Video Presentation)&lt;br&gt;- Dr. Larry Librach, University of Toronto, Ian Anderson Project (Video Presentation)</td>
</tr>
<tr>
<td>Rm G618 (Video Conf)</td>
<td>10-15 MINUTE PRESENTATION + PANEL DISCUSSION  &lt;br&gt;- What program(s), resources, materials have you developed?&lt;br&gt;- What was the catalyst and why was your program created?&lt;br&gt;- Who are the primary audiences that you serve?&lt;br&gt;- What is the format for delivery?&lt;br&gt;- How have you evaluated the impact?&lt;br&gt;- What are the lessons learned to-date?&lt;br&gt;- What are other pertinent palliative care education/CPD programs from your perspective (especially that might be adapted/adopted to rural and remote health care professionals)</td>
<td></td>
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<tr>
<td>1100-1215</td>
<td><strong>Education and Professional Development Strategies/Issues</strong>  &lt;br&gt;- Interdisciplinary, web-based pilot course in P.C.&lt;br&gt;- Nursing education&lt;br&gt;- Distance/distributed learning&lt;br&gt;- Telehealth strategies that support Education/CPD&lt;br&gt;- Educating for unique populations/needs</td>
<td>- Dr. Jose Pereira, Alberta Cancer Foundation Professor in Palliative Medicine, University of Calgary&lt;br&gt;- Ms. Miriam Hills, Cancer Education Program, Continuing Nursing Education, Continuing Medical Education and Professional Development, University of Saskatchewan&lt;br&gt;- Dr. Katy Campbell, Academic Technologies for Learning, University of Alberta (key insights on instructional design to support technology-enabled CPD &amp; distributed learning)&lt;br&gt;- Dr. Marilyne Hebert, Health Telematics Unit, Faculty of Medicine, University of Calgary (key insights on telematics to support technology-enabled CPD &amp; dist. learning)&lt;br&gt;- Ms. Louise Forest, Aboriginal Cancer Control Strategy, Alberta Cancer Board (key insights on what we need to know to design Palliative Care CPD from a first peoples’ perspective).</td>
</tr>
<tr>
<td>Time</td>
<td>Location</td>
<td>Session Title</td>
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| 1300-1330    | Clara Christa     | Rural Perspectives – Barriers &       | - Ms. Nancy Summers, Moderator
| (CCT)        | Theatre           | Opportunities                        | - Dr. Rob Wedel, Regional Palliative Care Program, Chinook Health Authority
|              |                   | PANEL DISCUSSION                      | - Dr. William Hnydyk, Regional Care, Lakeland Regional Health Authority
|              |                   |                                      | - Ms. Chantal Vallee, Lakeland Regional Health Authority                      |
|              |                   |                                      | - Dr. Ron Spice, Claresholm                                                   |
| 1330-1600    | Clara Christa     | Group Consultation – Needs & Priority Areas of Focus | - Ms. Sandy Winnick, Facilitator
| (CCT)        | Theatre           |                                      | Caritas Health Group, Edmonton                                              |

We will take the inputs from the stakeholder consultation portion of the needs assessment and process them through a descriptive and interpretive framework. In effect, “what they said” and “what we heard.” Results to be sent back to participants for additional elaboration and validation prior to being tabled as a deliverable of PALLIUM project activity 1.
## APPENDIX D
### INVENTORY OF PROJECT DELIVERABLES
CATALOGUED IN PALLIUM RRHII PROJECT PACKAGE CD-ROM

<table>
<thead>
<tr>
<th>OBJECT TITLE</th>
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<tr>
<td>Project Launch &amp; Needs Assessment Symposium Detailed Agenda</td>
<td>FinalAgenda_PALLIUMSymposium_04272001 In Act1-NeedsAssessment folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the detailed agenda for the April 27, 2001 Project Launch &amp; Needs Assessment Symposium conducted at the University of Calgary, Health Sciences Centre.</td>
</tr>
<tr>
<td>Lancet Journal review of the US EPEC Project</td>
<td>LancetReview(Ferris) In Act1-NeedsAssessment folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>Lancet peer-reviewed journal article on the US Education of Physicians on End-of-Life Care project furnished by Dr. Frank Ferris as participant materials for the April 27, 2001 Project Launch &amp; Needs Assessment Symposium</td>
</tr>
<tr>
<td>Modified DACUM process overview for Rural Palliative Care Leaders</td>
<td>ModifiedDACUM-ProcessOver-PaiCareLdr In Act1-NeedsAssessment folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>Describes the Occupational Analysis design for the Competency Identification needs assessment activity describing Major Areas of Responsibility and Major Tasks for Rural Palliative Care Leaders.</td>
</tr>
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<td>OBJECT TITLE</td>
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<tr>
<td>Modified DACUM process overview for Rural Palliative Care Leaders</td>
<td>ModifiedDACUM-ProcessOver-RuralPrimary</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>Describes the Occupational Analysis design for the Competency Identification needs assessment activity describing Major Areas of Responsibility and Major Tasks for Primary Palliative Care Professionals.</td>
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Project Report
Health Canada Project Reference #6788-15-2000/0390420
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<tr>
<td>Record of Inter-Institutional Meeting on Post-Graduate Interdisciplinary Palliative Care Education</td>
<td>PALLIUM-Jan11EoLCare-MeetRecordInTheAct1-NeedsAssessmentfolder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>Record of a meeting with Palliative Care and extension/continuing studies administrative representatives of the universities of Alberta, Calgary, Manitoba and Saskatchewan on January 11, 2002, to explore collaboration on a graduate-level, interdisciplinary hospice palliative care credential initiative.</td>
</tr>
<tr>
<td>DACUM Chart for Rural Palliative Care Leaders</td>
<td>PALLIUM-PallCareLeader-DACUM-032002InTheAct1-NeedsAssessmentfolder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>Validated occupational analysis results of the DACUM (Developing a Curriculum) Needs Assessment Workshop from February 2002 of Rural Palliative Care Leaders.</td>
</tr>
<tr>
<td>DACUM Chart for Primary Palliative Care Professionals</td>
<td>PALLIUM-PPCP-DACUM-032002InTheAct1-NeedsAssessmentfolder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>Validated occupational analysis results of the DACUM (Developing a Curriculum) Needs Assessment Workshop from January 2002 of Primary Palliative Care Professionals.</td>
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<tr>
<td>Mr. David Kaye’s April 27, 2001 presentation text</td>
<td>RRHII_AltaRPAP_Kay-04272001InTheAct1-NeedsAssessmentfolder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>Mr. David Kaye’s April 27, 2001 presentation text on the Alberta, Rural Physician Action Plan (RPAP) delivered at the Project Launch &amp; Needs Assessment Symposium</td>
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<tr>
<td>OBJECT TITLE</td>
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<td>U.S. Education for Physicians on End-of-Life Care Project Overview &amp; Results-to-date</td>
<td>RRHI_EPECOverviewDoc(Ferris)_04272001 in Act1-NeedsAssessment folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of information shared by Dr. Frank Ferris of the U.S. Education for Physicians on End-of-Life Care Project Overview &amp; Results-to-date, distributed to participants at the April 27, 2001 Project Launch &amp; Needs Assessment Symposium.</td>
</tr>
<tr>
<td>Pallium core web-site content French Language translation</td>
<td>PalliumE-FrenTrans in Act3-WebPortal&amp;RPN folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF file of French Language translation completed of core <a href="http://www.pallium.ca">www.pallium.ca</a> web-site content (note: This content has not been uploaded... refer to analysis on digital divide problems associated with ownership of third-party content cited in analysis section of RRHII Project Report).</td>
</tr>
<tr>
<td>Rural Palliative Network Information Brochure &amp; Registration Form</td>
<td>RPN_Info&amp;RegForm_032003 in Act3-WebPortal&amp;RPN folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of Rural Palliative Network (RPN) promotional information brochure and registration form.</td>
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</tbody>
</table>
**The Pallium Project – Rural and Remote Health Innovations Initiative (RRHII)**

<table>
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</thead>
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<tr>
<td>Rural Palliative Network (RPN) Prospectus and Design Document</td>
<td>RPN-Prospectus-02242002 In Act3-WebPortal&amp;RPN folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of February 2002 prospectus and design document that was used as the planning foundation for commissioning the Rural Palliative Network (RPN), including the online forums and the Online Journal Club pilot.</td>
</tr>
<tr>
<td>Current State and Infrastructure for E-learning in Palliative &amp; End-of-Life Care: Selected Canadian Jurisdictions</td>
<td>InfoTask&amp;IPD-PALLIUM-EleamRep-072002 In Act4-TelehealthPilots folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of study report on current state of e-learning infrastructure and processes in Alberta, Saskatchewan, Manitoba and NWT, as prepared by Robert Powell (InfoTask) and Michael Ahern (University of Alberta, Institute for Professional Development).</td>
</tr>
<tr>
<td>Providing Palliative Care to Aboriginal Families – Provincial Tele-rounds PowerPoint Presentation</td>
<td>Pallium_LRHATeleRoundPres_110802 In Act4-TelehealthPilots folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of PowerPoint presentation used by Gaye Hanson in delivering Providing Palliative Care to Aboriginal Families a Provincial Tele-rounds PowerPoint Presentation completed in partnership with Lakeland Regional Health Authority (LRHA), Regional Palliative Care Program on November 8, 2002.</td>
</tr>
<tr>
<td>When Two Cultures Collide – PowerPoint Presentation</td>
<td>Pallium_AbCourse_2culturescollide_03312003 In Act5-Aboriginal folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of a PowerPoint presentation used with the Providing Hospice Palliative Care with Aboriginal Clients in Rural and Remote Settings coursework</td>
</tr>
<tr>
<td>Providing Hospice Palliative Care with Aboriginal Clients in Rural and Remote Settings - PowerPoint Presentation</td>
<td>Pallium_AboriginalCourseware_03312003 In Act5-Aboriginal folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of a PowerPoint presentation used with the Providing Hospice Palliative Care with Aboriginal Clients in Rural and Remote Settings coursework</td>
</tr>
<tr>
<td>Template Letter for Regional Weekend Course (RWC)</td>
<td>Pallium_RWC_SampleLetter_V1 In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of a template letter for local palliative care coordinators to model in preparing a promotional/introductory letter to local health authority staff and community-based physicians introducing a local Regional Weekend Course (RWC).</td>
</tr>
</tbody>
</table>
# The Pallium Project – Rural and Remote Health Innovations Initiative (RRHII)

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<tr>
<td><strong>Clinical Introduction to Palliative and End-of-Life Care in Primary-Care – Facilitator Manual</strong></td>
<td>PALLIUM-FacilitatorManual-V2002-01 In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the first version of <em>Clinical Introduction to Palliative and End-of-Life Care in Primary-care</em> Facilitator Manual developed in partnership with colleagues in September 2002 and piloted in Dauphin, Manitoba in late September 2002 in Regional Weekend Course format. Note: This facilitator manual has been succeeded by two versions. Subsequent versions property of Dr. Jose Pereira.</td>
</tr>
<tr>
<td><strong>Clinical Introduction to Palliative and End-of-Life Care in Primary-Care – Participant Manual</strong></td>
<td>PALLIUM-ParticipantManual-EV2002-02 In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the first version of <em>Clinical Introduction to Palliative and End-of-Life Care in Primary-care</em> Participant Manual developed in partnership with colleagues in September 2002 and piloted in Dauphin, Manitoba in late September 2002 in Regional Weekend Course format. Note: This facilitator manual has been succeeded by two versions. Subsequent versions property of Dr. Jose Pereira.</td>
</tr>
<tr>
<td><strong>Regional Weekend Course (RWC) Detailed Outline</strong></td>
<td>Pallium-RWC-DetailedOutline-Fall2002 In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the detailed outline table for the Friday, Saturday, Sunday (Regional Weekend Course) version of <em>Clinical Introduction to Palliative and End-of-Life Care in Primary-care</em>.</td>
</tr>
<tr>
<td><strong>Confirmation letter from College of Family Physicians of Canada for Clinical Introduction course</strong></td>
<td>Pallium-RWC-MAINPROC-Conf In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the letter from the College of Family Physicians of Canada (CFPC) confirming that the <em>Clinical Introduction to Palliative and End-of-Life Care in Primary-care</em> has been approved for 14 MAINPRO-C credits.</td>
</tr>
<tr>
<td><strong>Clinical Introduction course Commitment to Change form</strong></td>
<td>RWC-CommitToChange-092002-V1 In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the Commitment to Change form used as part of the post-course evaluation work for the <em>Clinical Introduction</em> course (September 2002 pilot development), pursuant to CFPC MAINPRO-C requirements.</td>
</tr>
<tr>
<td><strong>Clinical Introduction course Course Evaluation questionnaire</strong></td>
<td>RWC-CourseEval-092002-V1 In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the Course Evaluation form used as part of the post-course evaluation work for the <em>Clinical Introduction</em> course (September 2002 pilot development).</td>
</tr>
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<td>Clinical Introduction course Pre-&amp;Post-course knowledge test</td>
<td>RWC-Pre&amp;Post-KnowTest-092002-V1 In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the Pre-&amp;Post-course knowledge test used as part of the learner-based needs assessment and evaluation work for the Clinical Introduction course, pursuant to CFPC MAINPRO-C requirements (September 2002 pilot development).</td>
</tr>
<tr>
<td>Clinical Introduction pre-course survey instrument</td>
<td>RWC-PreCourseSurvey-092002-V1 In Act5-ClinicalIntroduction folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the Course Pre-survey used as part of the learner-based needs assessment for the Clinical Introduction course, pursuant to CFPC MAINPRO-C requirements (September 2002 pilot development).</td>
</tr>
<tr>
<td>Participatory Evaluation Summary Report</td>
<td>Pallium_StakeHInterview_SumRepFinal In Act6-Evaluation folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the Participatory Evaluation summary report prepared by the independent evaluation researcher of D. Frère &amp; Associates Inc.</td>
</tr>
<tr>
<td>Contribution Agreement application to Health Canada, Primary Health Care Transition Fund (PHCTF), National Envelope</td>
<td>Pallium_PHCTF_AsSubmitted_041603 In Act7-ModelDevelopment folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the application and proposal document for a 3-year project to develop primary-palliative care and further integration of care through workplace learning. Submitted for the National Envelope of Health Canada's, Primary Health Care Transition Fund (PHCTF). Note: This electronic document does not contain the hardcopy letters of participation from prospective partners.</td>
</tr>
<tr>
<td>Pallium Project Poster</td>
<td>Pallium_ProjectPosterforUnits_09282001 In Act6-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the poster that was created for the academic and specialty care partners at universities of Alberta, Calgary, Saskatchewan and Manitoba to prominently display at their respective palliative care clinical teaching sites.</td>
</tr>
<tr>
<td>OBJECT TITLE</td>
<td>FILE NAME &amp; LOCATION</td>
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<tr>
<td>Speaking Notes for Saskatchewan Palliative Care Association</td>
<td>Pallium_SPCARegina_SpeakNotes_06072002 In Act8-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of draft speaking notes used as reference for a keynote presentation to the Saskatchewan Palliative Care Association (SPCA) Annual General Meeting &amp; Education Day, June 7, 2002, Regina.</td>
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<tr>
<td>Project Launch &amp; Needs Assessment Symposium Poster</td>
<td>Poster_Symposium_04272001 In Act8-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the poster created to support stakeholder communication at the Project Launch &amp; Needs Assessment Symposium at the University of Calgary, Health Sciences Centre, April 27, 2001.</td>
</tr>
<tr>
<td>Building rural and remote capacity through professional learning: Insights from the Canadian Pallium Project</td>
<td>PALLIUM-ManitobaPresentation-091902 In Act8-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the PowerPoint presentation used by M. Aherne at a concurrent session of Hospice &amp; Palliative Care Manitoba's, 12th Annual Provincial Hospice Palliative Care Conference, Winnipeg, September 19, 2002.</td>
</tr>
<tr>
<td>An online journal club for palliative care professionals: Early results from a Canadian demonstration</td>
<td>PALLIUM-Montreal-OJ CJuriedPres-100802 In Act8-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the PowerPoint presentation (Valleé, Wedel, Aherne, Pereira) presented during a concurrent session at the 14th International Congress on Care for the Terminally-Ill, Montreal, October 8, 2002.</td>
</tr>
<tr>
<td>Palliative care education in rural and remote areas of Canada: The Canadian Pallium Project</td>
<td>PALLIUM-MontrealPresentation-Final In Act8-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the PowerPoint presentation (Pereira, Aherne, Daeninck, Chary) presented during a concurrent session at the 14th International Congress on Care for the Terminally-Ill, Montreal, October 7, 2002.</td>
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<tr>
<td>Pallium: Why and how did it evolve?</td>
<td>Pereira_EdmConference_10012001 In Act8-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of the PowerPoint presentation (Pereira, Aherne) at the Edmonton Regional Palliative Care Program's annual Research &amp; Education Days, Edmonton, October 1, 2001.</td>
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<td>Pallium RRHII Business Plan overview slide</td>
<td>RRHII_ProjectBusinessPlan_092001 In Act8-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of one-page business plan overview slide used throughout the Project (September 2001 version)</td>
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<td>Pallium RRHII Project Overview slide</td>
<td>RRHII_ProjectOverviewSlide_022002 In Act8-Dissemination folder</td>
<td>Portable Document Format (PDF) use Adobe Acrobat Reader</td>
<td>PDF copy of one-page project overview slide used throughout the Project (February 2002 version).</td>
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<td>Media Kit – Alberta</td>
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FOR FURTHER INFORMATION, INQUIRIES, OR ADDITIONAL COPIES OF THIS REPORT

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