Rural Palliative Care
Resource Kit

GENERAL PRACTICE
north west

Breaking Down Barriers

The role of the Palliative Care Medical Specialist in developing a palliative care knowledge and skill network

Author

Anita Dow
Project Officer
Rural Palliative Care Program
GP North West Tasmania

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Introduction

The North West Rural Palliative Care Project (NWRPCP) was one of eight projects implemented under the auspices of the rural palliative care program (RPCP). The NWRPCP commenced in 2004 on the North West Coast of Tasmania as a result of an innovative three-way partnership between General Practice North West (GPNW), the Department of Health and Human Services - Palliative Care and University of Tasmania's Rural Clinical School (RCS).

The aim of the project was to improve access to quality, coordinated palliative care for the people of the North West region. This included:

- exploring the potential for the formation of general practitioner led coordinated primary palliative care sites
- promoting general practitioners (GPs) working in groups and involved 24-hour care
- regular team meetings
- collaborative practice and effective communication
- mentoring with the resident palliative care medical specialist (PCMS).

This paper addresses:

- processes for implementing pilot sites
- participant experiences
- the implementation of multidisciplinary team (MDT) meetings and education programs
- challenges incurred and positive outcomes achieved
- the role of the PCMS
- identifying a PCMS and ensuring the role is sustainable
- benefits to the community related to access to a PCMS
- barriers to effective service delivery
- experiences from other national projects.

It is acknowledged that not all regions have access to a PCMS and that in most instances quality palliative care is competently provided in communities supported by knowledgeable health professionals. This was the case in the North West Tasmania for many years prior to the introduction of the PCMS role in 2002.

Background

As with many rural communities, the majority of palliative care delivery in North West Tasmania is by GPs based in small, dispersed towns.

A GP population, consisting of approximately 100 part-time and full-time practitioners, and other primary care providers, predominantly based in the larger centres, provide primary health care services to the region. The specialist palliative care service (SPCS), comprising medical, nursing and social work professionals, services the entire region and is centrally located. There is a regional hospital with two campuses and three small district hospitals.

Literature review

An extensive literature review was conducted as a critical component of the project. Palliative Care Australia's (2003) guidelines to assist planners, funders and service providers to plan for palliative care services adopted World Health Organization recommendations (Stjernsward, Colleau & Ventafridda 1996) and emphasised the interdisciplinary nature of palliative care. As Hudson (2003) said:

> *The way forward is to establish partnerships between government, service providers, general practitioners and researchers to collaboratively explore appropriate evidence-based best practice approaches to home based palliative care. (p. 37)*

These guidelines were put together by a national independent expert group of experienced palliative care clinicians as a resource for busy health practitioners involved in the care of palliative patients.

In palliative care, patient outcomes improve when GPs and specialist palliative care teams communicate well and work together collaboratively (Woods 2001; Mitchell 2002; Shipman et al. 2002), but impaired communication and conflicting views of the roles and responsibilities of the service providers involved in the care have been identified as key barriers to patient outcomes (Mitchell, Reymond & McGrath 2004).

Analysis of current palliative care provision highlights that on average, GPs on the North West Coast see 8-12 palliative patients per annum (Focus Group 2004, GP communication), in comparison to the national average of 5-6 patients (Mitchell 2002). Additionally a needs analysis conducted by GPNW in 1999/2000 determined that GPs desired enhanced skills and expertise in providing care for people who are dying and their families. Similarly, the specialist palliative care service acknowledges that, to be sustainable, their activities must be supported by skilled GPs.

Traditional forms of education delivery, such as the didactic and non-multidisciplinary method historically employed by GPNW, have been shown to be less effective in changing clinical behaviour than interactive, case-based and individualised learning (Mitchell 2002; Reymond, Charles, Israel, Read & Treston 2005), particularly when this is based on a well conducted needs assessment (Norman, Shannon & Marrin 2004). Additionally, the literature supports the provision of multidisciplinary learning opportunities as a means of encouraging teamwork and recognition and clarification of roles and responsibilities and their importance in collaborative approaches to care provision (Kelley, Habjan & Aegard 2004).

Getting started

Setting up a GP-led Pilot Site

1. The Project Officer and PCMS visited all GPs on the North West Coast to introduce the project and the concept of working together as a multidisciplinary team.

2. As a capacity building activity and good will gesture all primary providers received complimentary copies of the Palliative Care Therapeutic Guidelines text. This text was used as a reference and tool in all education presentations.

3. Expressions of interests were invited and interested health professionals were required to acknowledge the following selection criteria:
    - an eagerness to be a key GP leader who is a resource and provider of support to other GPs and members of the multidisciplinary team
    - an interest in developing additional knowledge and specific skills in primary palliative care provision
    - a willingness to work and meet as a member of a multidisciplinary team
    - an interest in working with the PCMS, medical and nursing students.

4. Interested primary care providers participated in focus groups to identify a model of care provision and education delivery specific to their needs.

    NB. Focus groups were co-facilitated and funded by the Caring Communities Project being managed by the Tasmanian Palliative Care Service.

5. A flexible education program was developed and delivered via a two-tiered model.

    Tier 1: Large regional education events open to all primary providers

    Tier 2: Pilot site educational activities: involving key GP leader, the specialist palliative care team, community and practice nurses and medical students.

    NB: Continuing Professional Development (CPD) points were allocated through the Royal Australian College of General Practitioners, Continuing Professional Development Program's modules including "small group learning".

6. Pilot sites were progressively implemented and developed around a number of identified key general practices.
    - Pilot site 1 involved GPs from three practices in three different towns
    - Pilot Site 2 involved the only two practices in a single town
    - Pilot Site 3 involved one practice from one town.

    It is interesting to note at Pilot Site 1 GPs had not previously worked together and at Pilot Site 2 the GPs worked together in many different forums and had good relationships. However both sites experienced different challenges.

7. A palliative care community awareness raising campaign commenced at pilot sites including displays in community buildings, GP practices and hospitals. Surveys were conducted at participating GP practices with patients in the waiting room.

8. Monthly breakfast meetings were held over twelve months in a non-clinical environment. Meetings were held at a central and neutral venues between 7.30 am - 8.30 am. Local cafes and hotels were utilised and a modest breakfast was provided.

   Discussion centred on the presentation of a case study by a GP with the Palliative Care Medical Specialist providing mentoring and education. Continuing professional development points were allocated to GPs through the RACGP small group learning module. Participants identified topics of interest and different key note speakers which were integrated in a program of events for the year.

   Pilot Site 3 was the only site to elect evening meetings. These were held at the participating practice between 6.30 pm - 7.30 pm and light refreshments were served.

9. Meetings were evaluated at 6 and 12-month intervals.

Please see the additional tools section for examples mentioned.

Participant experiences

An example of pilot site interaction and multidisciplinary team meetings

Case : The team
Before the project, much communication about individual clients' needs occurred by telephone, letter or fax between individual providers and the GP. Service providers involved in the care, such as community nursing or allied health, were not always aware of each other's involvement. Sometimes little communication occurred and there might be duplication of services.

As a result of the project's multidisciplinary meetings, the care team (comprised of GPs, practice nurses, community nurses, allied health and the Palliative Care team's medical, nursing and social work representatives) come together in a confidential forum. They discuss and explore issues around individual patients and their families and how the disease process is affecting them. The meetings 'put faces to names' and communication is direct, coordinated and efficient.

A care coordinator drives the process, discussing what can be provided and by whom. Duplication is avoided. Over time, the meetings generate a sense of trust which promotes the sharing of personal insights and concerns. They become a forum for education and learning in a safe and professional environment. Health professionals begin to talk the same palliative care language to describe the patient's and care-giver's situations at different times through the trajectory of the illness.

The benefits of the team approach are clearly demonstrated in the case of one patient with complex multiple issues — complex pain, other symptom management needs such as nausea, and psycho-social support needs. The discussion that occurred around the case assisted those involved to understand the disease trajectory, what might occur next, and how to be prepared for potential symptoms like bowel obstruction or spinal cord compression, or for requests for sedation or possible talk of suicide and euthanasia which often emerge from fear.

As a result of the multidisciplinary meetings and associated education, the GP understood more about the required medication and other possible interventions and was able to feel more open and confident about the medical management of the patient. The nurses felt informed, consulted and more supported. The specialist team was confident that the primary care providers had the level of support needed to enable them to manage the patient with minimal input. The patient benefited because it was clear that care providers were working together with the patient's best interests in mind.

Challenges and outcomes

1. Historically impaired relationships between palliative care providers namely GPs and the specialist palliative care service based on the perception that the palliative care service take over patient care.

   Perseverance, integration of different aspects of palliative care i.e. palliative chemotherapy and radiation therapy not traditionally associated with palliative care by GPs, empowerment of GPs to own the sessions and be responsible for presenting cases and acknowledging the past by constructively identifying new ways to work together. An example of this is the attendance of the palliative care service at regular multidisciplinary meetings at a local GP practice previously involving only GPs and community nurses.

2. In the instance of leave, illness or competing commitments reliance on the PCMS as *the sole provider of education became a problem.*

   Planning meetings between the Project Officer and PCMS were held regularly and dates added to diaries as early as possible. Additional key note speakers were identified by participants and included in the educational program to cover planned absences. Good communication was paramount.

3. Low GP attendance towards the end of the project.

   Promotion and marketing, making it attractive and displaying credibility are the keys to success. GPs have any number of education events available to attend in a week and this project attempted to provide a unique multidisciplinary experience. The Project Officer continued to promote the project throughout the three years of the project, always trying to reach new audiences.

The important role of the PCMS in the NWRPCP

The project relied heavily on the expertise and experiences of the resident PCMS. This role was critical to the implementation of the education program conducted and instrumental in participants realising the benefits associated with the project.

"Experiences related to the implementation of the pilot site model of education and training are both negative and positive. 80% of what we did in the meetings was useful, 20% we would do differently next time. The key to these meetings was developing respect and providing advice without seeming intrusive. The breakfast meetings raised the level of interest in enthusiasm for and awareness of contemporary palliative care unlike any initiative before, the difficulty of this heightened awareness was balancing the needs of different providers. The Specialist Palliative Care Service learnt a lot about General Practice and community nursing, who in turn learnt a lot about the Specialist Palliative Care Services".

Taken from an interview with the PCMS 7th of March 2007.

Advice related to establishing a successful PCMS education and clinical support program in your region.

In North West Tasmania PCMS' are employed by the Department of Health and Human Services within the Palliative Care Service. All PCMS' in Tasmania have conjoint positions made possible through a partnership between the Department of Health and Human Service and the University of Tasmania local Rural Clinical School. In addition to this conjoint role the position in the North West is also supported to provide outreach support in palliative care under the Australian Government Department of Health and Ageing initiative Medical Specialist Outreach Assistance program (MSOAP).

A particular achievement of the project has been the strong collaborative working relationship between the PCMS, GPNW and the RCS on developing and implementing the Rural Palliative Care Program Project. Particular benefits included support for general practitioners and enhanced collaborative approaches to service delivery.

Similar partnerships and collaborative relationships could be explored elsewhere where there is interest in developing and strengthening the palliative approach in local areas.
Please contact the Tasmanian Palliative Care Service on (03) 6224 2515 if you require further information.

PCMS Key points

- Under the conjoint funding agreement the PCMS is responsible for providing undergraduate education and training to fifth and sixth year medical students and post graduate education and training at the local and regional hospital campuses. The role also includes the provision of clinical support and professional development to the local Specialist Palliative Care Service.
- The PCMS does not have admission rights at the regional hospital and there is no hospice in the region. This model encourages collaborative practice between specialists at the hospital. The PCMS is on call after hours.
- Ensure the PCMS has adequate administrative support and access to transport, a phone (mobile) and IT appliances.
- Link the PCMS to a community specialist palliative care nursing service.
- To ensure a position is sustainable consider creating opportunities for primary providers to develop specialist knowledge and skills rather than the PCMS simply taking over patient care. Broaden providers' perception of palliative care and knowledge of contemporary palliative care practice.

In the absence of a PCMS role in your region

- Ensure educational opportunities with general practice through partnerships/agreements with Divisions of General Practice.
- Develop hospital linkages through link nurse programs or a liaison position
- Enlist the expertise of a local GP champion to assist in the provision of a multidisciplinary education program.

- Coordinate and host clinical multidisciplinary meetings.

Benefits

Fortunately the funding structure and responsibilities of the North West PCMS position allowed the flexibility for the appointment of a full-time resident position. The PCMS commenced practicing in 2002. Below are a number of the reported benefits to the North West community through the introduction of this role:

- enhanced contemporary palliative care knowledge and skills amongst primary palliative care providers through improved access to education, clinical guidance and support
- enhanced service delivery by the regional palliative care services, increased autonomy and access to medical expertise, support and mentoring for nursing and social work staff
- access to support and education for hospital staff and undergraduate medical and nursing students
- enhanced relationships with GPs through education, support and mentoring
- enhanced medical services available to patients
- enhanced community awareness of palliative care
- enhanced primary provider capacity to independently provide contemporary palliative care in rural and remote areas whilst being supported by the PCMS.

Other benefits included:

- improved communication and team approach to service delivery
- no duplication of services
- shared insights and concerns promote professional learning
- discussion of cases improves service providers' understanding of trajectory of diseases and of how to respond most effectively to patients' and care givers' needs
- GPs and nurses reported feeling more confident and more supported
- patients reporting the benefits from more cohesive treatment and service

The North West Palliative Care Medical Specialist and fellow GPs at a breakfast meeting in 2005.

Barriers

The issues outlined below have been identified as key barriers to effective service delivery and working relationships between palliative care providers on the North West Coast (Walker, Dow & Behrens. 2006):

- low numbers of GP referrals to the specialist palliative care service
- the historical reluctance of GPs to learn in a multidisciplinary environment
- geographical disposition

- the independent nature of rural and remote GPs
- impaired communication and conflicting views of the roles and responsibilities of service providers.

To address these issues, the NWRPCP commenced in 2004, and the partnership approach, between GPNW, the DHHS through Palliative Care and the RCS, was implemented.

The program's goals were to:

- improve palliative care provider relationships
- enhance GP palliative care knowledge and skills
- provide mentoring and enhance educational opportunities for GPs
- encourage GPs to participate in multidisciplinary education
- strengthen relationships with the RCS and to work with the RCS to collect and evaluate local data, which would build local knowledge and provide an evidence-base for future projects.

Experiences from other national projects

1. "**The Medical Specialist Outreach Assistance Program (MSOAP),** funded by the Australian Government Department of Health and Ageing has been integral to the success of the RPCP in the North West Tasmania project. The palliative care medical specialist (PCMS) offers clinical consultation to patients, healthcare worker education, and is a "drawcard" to encourage greater attendance at multidisciplinary palliative care team meetings. The specialist has undertaken a commitment to be available from his base hospital to take calls from local GPs with specific clinical concerns. The impact of these activities has been to enhance the capacity of the primary health model to deliver the PCA standards for providing quality palliative care" (participant in South East NSW RPCP).

Two issues for consideration:

1. Initially the specialist was able to attend intermittently due to workforce pressures in other areas.
    - It is vital to get commitment that (at least) monthly visits can be maintained.
    - The coordinating of referred patients for review and education events is rendered futile if the specialist has to cancel at the 11th hour.
    - This also undermines the integrity of the objective of gaining healthcare "buy in" for the RPCP.

2. Processes need to be established to ensure invoicing of MSOAP specialist are undertaken regularly to ensure funds are received by the body managing the MSOAP grant.

2. Palliative Care Specialist for the South Burnett

Palliative Care Specialist, Associate Prof Liz Reymond, Brisbane South Palliative Care Collaborative (BSPCC*)* was engaged for a fly-in fly-out visit to the South Burnett region from April to September 2006 to:

- provide local level education
- support and appropriate advice for service providers involved with palliative care.

Dr Reymond also:

- attended Case Conferences, patient reviews (at GP request)
- provided individual or small group education with GPs
- conducted case reviews with Private Hospital Nursing staff and with Indigenous Nursing staff
- attended a workshop identifying gaps in local Indigenous community palliative care management
  - this was originally proposed as an extension of MSOAP funding but was not identified as priority by the GPs when discussed at local Chapter Meetings.

    This initiative proved so successful in both the NSW RPCP sites it was decided by the Governance Committee to fund a 6 month pilot from the RPCP budget.

Dr Reymond had previously provided education and evaluated areas of need for GPs in 2004. A natural progression was to then engage Dr Reymond to provide education linked with identified needs. (*This report can be found in Additional Tools*) This strategy also encompassed the development of an education plan which included:

- lunchtime small group education for GPs in practice tearoom
- Kingaroy Hospital Allied Health education sessions attended by Social Worker, Physiotherapist, Speech Pathologist, Dietician and Community Nurses
- RACF education on a Palliative Approach at four RACF attended by AAINs, ENs, CNC and NUM
- Lecture for Hospital RNs – Opioid Conversions
- Presentation for GPs – *Smorgasbord, Palliation in Aged Care*
- Presentation Pharmacists – Update on Palliative Drugs.

The overall feedback from the many stakeholder groups was overwhelmingly positive. The comment by Dr Reymond, on the benefit of these visits for stakeholders in the region, from her perspective, effectively summarises the positive outcomes of this support.

"My first point is that I think that the area is providing an excellent integrated, multidisciplinary service that allows for good patient and carer outcomes. In terms of needs, in recent visits I have noticed that:

- staff are hungry for education and genuinely appreciative of anything offered - they are motivated to learn and to interact
- in many ways my sessions are providing professional supervision where staff can involve themselves in reflective practice for difficult patients. I think it's important that something similar to this continues, particularly with an independent professional, as it decreases stress and burnout. Palliative care is not an easy area to work in because of the constant ethical challenges that staff face, usually on a one-to-one basis and having an independent professional validate their experience and reinforce their skills improves their performance
- the sessions are empowering staff and increasing their practice confidence
- although there has been little involvement of GPs to date (consulting with Palliative Specialist) I think that they will come on board in future, particularly as they get new palliative patients and the non-medical staff feedback to them the advantages of the case conferences even if the GPs don't come on board, if the non-medical staff improve their practice capacity and confidence this has to generate improved patient and carer outcomes - and this is the bottom line."

RPAC Coordinator (SQRDGP)

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For additional information please contact Elvie Hales, the Executive Officer at General Practice North West on (03) 64321440