An educational strategy to increase the palliative care capacity of primary health care providers working in rural and remote areas of Australia

Final Report

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Fund holder (auspice body): Royal Australian College of General Practitioners (GPEA)
Name of service conducting the project: Brisbane South Palliative Care Collaborative

Part C - Executive Summary

1. Background

Project Title: An educational strategy to increase palliative care capacity of primary health care providers working in rural and remote areas of Queensland.
Time period: 1st April, 2003 – 1st March, 2006
Lead Organisation: Brisbane South Palliative Care Collaborative
Project manager: Ms Fiona Israel

Setting: The primary aim of this project was to increase the palliative care capacity of primary health care providers working in rural Queensland with the implementation of an educational intervention. The project was initially focused on four rural and remote areas, namely the districts including Charleville, Mt Isa, Normanton and Roma. Due to a budget residue, the project was extended to include an urban setting within Brisbane, the QE11 Hospital Health Service District. The intervention was based on travelling workshops or one-on-one academic detailing sessions delivered at rural venues by a team of palliative care specialists from Brisbane South Palliative Care Service and Mt Olivet Hospice working in collaboration with local stakeholders. Participants determined the content of the intervention according to their perceived local palliative requirements and resources. Workshops were accredited for continuing professional development (CPD) points for attending medical officers. Quantitative and qualitative evaluation showed the intervention to be cost-effective with remarkable medical officer reach and to have significantly improved participants' palliative care knowledge and skills. Importantly it also generated on-going clinical networking between rural generalists and urban specialists.
***Background*:** The Commonwealth National Palliative Care Strategy consensus document recognises that, in general, people prefer to die with the support of family and friends within their local community be this in their own home or an in-patient unit. However, because the distribution of palliative care resources in Australia is concentrated within metropolitan centres, palliative patients from rural and remote areas are often unable to die in the environment of their choice [5]. For instance it is often problematic for the Brisbane South Palliative Care Service to discharge patients from Brisbane tertiary referral hospitals back to their rural homes due to lack of palliative care expertise or resources. The challenge to government, as well as specialist and primary health care providers, is to identify efficient and effective strategies for the recurrent upskilling of local primary health care team members who provide palliative care.

Implementation of such strategies needs to be tailored to the requirements of each local area and sustainability encouraged through guaranteed recurrent funding and establishment of clinical network linkages between local and distant palliative care service providers [18].

2. Project Objectives

The primary objective of this project was to develop, implement and evaluate an interactive educational strategy aimed at increasing palliative capacity of primary health care providers working in rural and remote communities. A secondary objective was to evaluate the efficacy of the strategy within an urban environment.

3. Methodology/Description

Methodology was based on the development and implementation of travelling workshops and one-on-one interventions delivered to targeted local rural venues by palliative care specialists from the Brisbane South Palliative Care Services and Mt Olivet Hospice working in collaboration with local primary health care providers and other palliative stakeholders. Educational teams included a minimum of a medical officer, a clinical nurse consultant and an allied health professional. Participants included medical officers, nurses, allied health professionals, Aboriginal and Torres Strait Islander health workers, volunteers, counsellors, pastoral care workers and other therapists working across community, hospital and residential aged care facilities. They were targeted by Divisions of General Practice and other government and non-government health networks and were contacted by the project manager to organise convenient intervention dates and times. Participants determined the subject matter of the interventions according to perceived local requirements. In addition, a mentoring program was instituted that allowed two rural community nurses to spend a week as supernumerary staff members within Mt Olivet Palliative Service.

Due to a budget residual, the project was extended to an urban site, the QE11 Hospital Health Service District, and five workshops were delivered in that area.

The project was evaluated internally. It was assumed that for this intervention to be considered successful it needed to be cost-effective with adequate professional reach and to have positive educational and clinical outcomes.

Numbers of participants attending interventions were obtained from attendance sheets, cost per participant estimated by dividing total grant monies by the number of participants. Reach was calculated as a percentage of the total number of primary medical practitioners across the targeted rural districts who attended an intervention. Reach was only defined for medical officers because it was too difficult to establish fulltime equivalents of other workers across a range of private and public workplaces.

Educational and clinical outcomes were evaluated by quantitative and qualitative analysis of the achievement of intervention learning objectives and measures of changes in participants' confidence consequent to intervention attendance. Using 4 or 5 point scales participants' rated knowledge, skills and management confidence for a range of palliative topics. These ratings were compared pre-intervention, post-intervention and at four months follow-up using paired t-tests for medical officer responses and independent samples t-tests for others. The follow up questionnaire was an attempt to assess the maintenance of the benefits of the intervention. Participants were asked whether they had treated any palliative patients in the four months since the workshop and, if so, had their attendance influenced management.

4. Results

A total of 243 participants attended one of 25 interventions at an average cost of $500/participant. Rural medical officer reach was extensive - 76% of the full-time equivalent primary medical practitioner workforce attended an intervention.

Evaluation of medical officer educational and clinical outcomes revealed significant improvements in confidence regarding palliative care knowledge and skill levels as well as the management of common palliative symptoms. Four month follow-up return from rural medical officers was poor and small

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Part D – Main Message

What we did

- Developed, implemented and evaluated an educational strategy to increase the palliative capacity of primary health care providers working in rural and remote areas of Queensland.
- Delivered that intervention to 243 participants across rural and urban settings.

What has been learned?

- The developed strategy is cost effective, at a cost of about $500 per participant.
- The strategy has good professional reach, most rural medical officers attended an intervention if it was tailored to their needs.
- Evaluation showed that intervention attendance results in significant improvements in confidence regarding palliative care knowledge and skill levels as well as the management of common palliative symptoms
- Organization of distant education events is time intensive and knowledge of the relationships between local providers is required to ensure success.

What is useful to other projects/communities?

- Given adequate funding, this project could be run in other rural and remote areas as well as urban areas.
- Rural and remote generalist clinicians appreciate being able to network with urban specialists on a face to face basis
- After attending the educational intervention rates of communication between healthcare providers increased.

What have been the benefits of disseminating information about this project?

- Disseminating information about the project has allowed the sourcing of other one off monies to continue to deliver outreach palliative care upskilling

What needs to happen in order to sustain the key achievements of this project?

- To sustain the achievements of this project, the provision of recurrent funding for the purpose of providing outreach education needs to be established as part of core funding for level 2 and 3 specialist palliative care service providers, particularly for the services whose catchment areas include tertiary referral hospitals. Level 2 and 3 specialist palliative care service providers have a duty of care to provide outreach education but are rarely, if ever, funded to do so.

What resources did we develop and are they available to others?

- The resource developed by this project is the model of the "travelling palliative care workshop" incorporating one-on-one academic detailing sessions for medical officers. This model is freely available and should be easily adapted to other service and geographical environments.