Collaborative Palliative Care in Rural Communities

Final Report

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Executive Summary

Project Title: Collaborative Palliative Care in Rural Communities

Organisation: Tasmanian Specialist Palliative Care Service, Department of Health and Human Services

Organisationally, the Tasmanian Specialist Palliative Care Service (Service) sits within the Primary Health Sub-division of the Community, Population and Rural Health Division within the Department of Health and Human Services. The Service operates a 24-hour specialist in-patient unit in Hobart and three community interdisciplinary teams in each of the states three major regions – Hobart, Launceston and Burnie. Interdisciplinary teams currently comprise of palliative care medical specialists, specialist nurses, social workers and pastoral care. The Service has clinical nurse consultants undertaking liaison and consultancy roles in the States four teaching hospitals.

Background

The Collaborative Care in Rural Communities project submission was developed partly in response to: 1) the increasing demands being placed on the specialist palliative care service; 2) the need to strengthen relationships between the specialist palliative care service and primary care providers; and 3) the identification of the need to provide additional support to rural communities through the provision of palliative care education and the development of shared clinical tools. There was an identified need for the palliative care specialist service to define and develop collaborative relationships with primary care providers together with providing information, education and advice in relation to the development of multidisciplinary teams in palliative care.

The Caring Communities Project was seen as an opportunity to develop the resources to: a) define and develop the networks and relationships with primary care providers in the regions; and b) provide resources to support primary care palliative care practice. The Collaborative Care in Rural Communities project aimed to improve referral and communication systems, provide needs based professional development and education, and, undertake collaborative development of clinical assessment tools and guidelines.

Project Objectives

The objectives formulated were to:

- develop a collaborative approach between specialist and primary care providers in the delivery of palliative care services in rural communities;
- provide relevant and accessible strategies that were supportive of primary care providers in rural areas;
- develop an ongoing partnership of activity monitoring and trend analysis that would assist client focussed care and service planning; and
- develop a mentoring capacity within the specialist service that would strengthen collaborative networks and enable support and advice beyond the life of the project.

Methodology/Description

Phase 1 – Project Activation

A project coordinator was appointed and a multidisciplinary steering committee convened. A project plan was developed and endorsed by the steering committee.

Phase 2 - Consultation

This phase of the project involved providing information sessions about the project and its aims to stakeholders throughout the State. Following the initial information sessions focus groups were convened to ascertain stakeholder needs and opinions in relation to meeting the project objectives and development of the project outputs. Stakeholders involved in the consultations included specialist palliative care clinicians, general practitioners, community health nurses, rural hospital clinicians and allied health clinicians.

Phase 2 - Development

In this phase of the project tools to support primary care palliative care practice were developed. A clinical tools working group was convened to develop the tools.

Tools were trialled within the specialist community teams following review by the Clinical Management Committee. Outcomes of the trials were reviewed by the working group and refinements made.

A project team was convened to develop a service delivery model. Following consultation and review by key stakeholders a four tiered service delivery model for specialist and primary care providers of palliative care was developed.

A client registration form was developed to enable a comprehensive data set to be collected for each client.

Phase 4 – Implementation and development of network roles

Implementation of the clinical tools commenced in February 2006. A trial of the clinical assessment toolkit within the primary sector is to commence in May 2006.

The implementation of the service delivery model commenced in April 2006. Education sessions for primary care providers in each of the regions were provided by the Service to explain the model and the key elements of integrated palliative care networks. A Guide to Collaborative Palliative Care Practice is currently being finalised and should be available in June 2006. This will be distributed to approximately 800 primary care providers across the State. The Service's website is being redeveloped to include the additional resources.

The client registration form was implemented and the client information data base revised.

Phase 4 - Evaluation

Evaluation of the project included seeking feedback from the specialist palliative care team and primary care providers at the commencement, throughout the project and at the completion of the project. The evaluation of the project was primarily based on qualitative information from interviews, focus groups, questionnaires and audit of documentation and direct feedback through attendance at meetings. Further evaluation of the Guide to Collaborative Practice is planned for September 2006.

Results

Objective 1 required a collaborative approach between specialist and primary care providers in the delivery of palliative care services in rural communities to be developed. The palliative care

service delivery model provides a framework for collaborative specialist and primary palliative care practice. The service delivery model explains the level of involvement of the specialist and primary care providers in meeting the identified needs of palliative care clients. The model outlines the roles and responsibilities expected of both specialist and primary care providers in delivery of care. The aim of the model is to strengthen and enhance existing partnerships in creating an interdisciplinary framework for the delivery of coordinated and timely services for the client.

Objective 2 entailed developing strategies and resources to support primary care practice in rural areas. Tools and protocols have been developed and education provided to primary care providers. Further work needs to occur in disseminating tools to all areas across the State and providing education.

Objective 3 required that ongoing activity monitoring and trend analysis occur to assist client focussed care and service planning. A new client registration form has been developed. This form enables a consistent data set to be routinely collected across the three regions. The client information data base has been up-dated to include the additional data items. Data pertaining to the model of service delivery is now collected and will be regularly reported on. The more comprehensive data set will improve activity monitoring.

Objective 4 involved developing a mentoring capacity within the specialist service to strengthen collaborative networks and enable support and advice beyond the life of the project. This was piloted in the North West region. In this region the specialist service facilitate monthly clinical meetings with primary care providers. These meetings are held in conjunction with the North West General Practice palliative care project. This model is to be implemented in the North and the South by the Area Managers.

Discussion

The principal aim of the project was to define and develop collaborative relationships between specialist and primary care providers in rural communities and provide additional resources to support clinical practice in these areas. As a result of the project's activities the specialist palliative care service has developed and enhanced its processes for providing advice, support and education. Furthermore the development of the palliative care service delivery model clearly articulates roles and responsibilities and how the specialist and primary care providers work together to provide palliative care to clients.

The collaborative strategy was piloted in the North West of the State in partnership with the North West Division of General Practice palliative care project. The North West General Practice project's principal aim was to develop and improve primary health palliative care services supported by the GP workforce across the region. As such the complimentary nature of the two projects brought about improved access to quality, coordinated palliative care services for the North West region's population and the development of a regional palliative care network.

To a lesser extent this has also been achieved in the other two regions of Tasmania the South and the North, through the development of the palliative care service delivery model, establishing networks and the development of resources. Further work is progressing in these two regions to implement the palliative care networks including clinical network processes such as case conferencing, shared care plans and clinical meetings. This work will be continued through the Review Implementation Project[1]. The Collaborative Care in Rural Communities

[1] The Review Implementation Project is a three year project commenced in 2005 to address the recommendations from a Review of the Tasmanian Specialist Palliative Care service undertaken in 2004.

project was recognised within the Review Report as being a key driver for the implementation of Review recommendations due to shared objectives. The Review recommended the development of a collaborative model of service delivery by which palliative clients would have access to the level of care commensurate with their need; this would be provided by an integrated network of both primary and specialist health care providers. Tools to facilitate seamless delivery of care would include network-wide clinical protocols, care plans, referral pathways, multidisciplinary training and professional development in palliative care.

As a consequence of the Review's findings and recommendations there was a need to align the Caring Communties Collaborative Practice project and the Review Implementation project. In addition to the Collaborative Practice project the Specialist Palliative Care Service also became invloved in two other projects in 2004 – the Australian Governemnt Program of Experience in the Palliative Approach (PEPA) and the Australian Division of General Practice (ADGP) Rural Palliative Care GP Project in North West Tasmania. Ongoing collaboration with the project personnel of these projects was sought, thus enabling a consistent approach to the implementation of key activities of all projects and preventing duplication of effort, resources and misalignment of objectices.

There were a number of issues that arose in undertaking the project these related to: a) project coordination and management b) the scope of the project;; and c) the impact of the subsequent external review of the palliative care service (Palliative Care Review), PEPA project and North West, General Practice project.

In terms of project management the original project submission allocation of resources was found to be insufficient for a state-wide project. The considerable scope of the state-wide project and the inadequate project management resources required changes to made to the way in which the project was progressed.

To address the scoping issue the collaborative network partnership processes were initially piloted in the North West region. The need for dedicated project management resources was addressed through a subsequent variation to the project Schedule. However the employment of a project officer was delayed. By the time the project officer was recruited in January 2005 there had been considerable slippage in the project timeframes and therefore delays in achieving the project outputs. This necessitated a revision of the project plan. This attempted to address the delays in achieving the outputs and also to align the project with the recommendations from the Review of the palliative care service.

As discussed above the subsequent external Palliative Care Review, PEPA and North West General Practice projects required the project plan to be reviewed to ensure that there wasn't duplication of effort and that the objectives of the projects were aligned. The impact of the Review, PEPA and the GP project activities were that they complimented and enhanced collaborative practice.

Since the project commenced in 2003 the proportion of clients accessing the community palliative care service throughout the State has shown a consistent and sustained increase. This increase can be partly[2] attributed to an increased awareness about the role of the specialist Service as a consequence of the project. Primary care providers are referring more clients to the Service.

[2] Other projects undertaken concurrently by the Service also raised awareness of the role and function of the specialist palliative care service e.g. the Program of Experience in the Palliative Approach (PEPA) and the Review Implementation project.

Another measure of the Service's activity which has changed significantly since the commencement of the project is related to clients and primary care providers contacting the Service out-of-hours. Since 2004 when the project commenced the number of out-of-hours contacts from primary health care providers has increased. This marked shift in out-of-hours contacts by primary care providers can be attributed to the changes promoted by the Service in terms of providing a resource out-of-hours for primary care providers and also greater awareness about the role of the service in supporting primary care providers caring for palliative care clients.

Conclusion

The Collaborative Palliative Care in Rural Communities project in Tasmania has addressed the need to: 1) define and develop collaborative relationships between the specialist palliative care service and primary care providers; and 2) provide resources to support primary care practice in rural communities. The resources developed together with the information and relationships that have been established as an outcome of the extensive networking and consultation have resulted in many benefits. Palliative care clients irrespective of where they live in Tasmania are now able to consistently access quality palliative care provided by a network of specialist and primary care providers.