Rural Palliative Care Medical Purchasing Fund evaluation

Final project report for Palliative Care Victoria

A Victorian Government initiative

Victoria The Place To Be

Rural Palliative Care Medical Purchasing Fund evaluation

Final project report for Palliative Care Victoria

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Accessibility

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1 Executive summary

The Rural Palliative Care Medical Purchasing Fund (RPCMPF) was established in 2006–07 from the Hospital Futures budget allocation. New, recurrent funding of $600,000 was allocated between each of the five rural palliative care consortia to improve specialist palliative care medical services in rural Victoria. The RPCMPF aims to:

- provide rural regions with funding to purchase additional specialist medical palliative care in order to address gaps in access to specialist medical palliative care
- build capacity for rural regions to become self-sufficient in providing specialist medical palliative care.

Each of the five rural palliative care consortia has achieved the RPCMPF's aims of expanding specialist palliative care medical consulting arrangements and addressing gaps through training or upskilling general medical providers in their region. Each consortium has implemented the RPCMPF differently. The implementation models developed have built on the resources and capacity of each region and are adapted to local conditions and context. Table 1 provides a summary of some of the RPCMPF's key achievements.

In some regions, the RPCMPF was used to employ new palliative medicine specialists or extend the hours of specialists already employed within the region. In other regions partnerships with metropolitan or other rural services were established in order to purchase specialist palliative medicine services from outside the region.

All regions have been successful in engaging with some general practitioners to increase their palliative care skills either through postgraduate tertiary courses supported under the RPCMPF or through locally delivered education programs. Palliative medicine specialists funded under the RPCMPF have contributed to general practitioner and other clinical education in all regions.

Partnerships with divisions of general practice and collaborations with other palliative care initiatives and programs have enhanced the RPCMPF's outcomes in some areas.

The RPCMPF models are sustainable in most regions although the Hume region faces some sustainability risk factors with its current arrangements.

In implementing the RPCMPF, consortia faced a range of barriers and challenges that often required creative solutions to overcome. Challenges frequently involved dealing with workforce shortages, overcoming distance and time constraints faced by rural health care providers. Some of the solutions and initiatives developed and the lessons learned have applicability in other regions.

Equity continues to be an issue in delivering rural health services although the RPCMPF has contributed to redressing rural access and equity issues in providing palliative care services.

Overall, the data obtained through the mixed-method evaluation approach supports the finding that the RPCMPF has been successful in achieving its aims of increased delivery of quality palliative care services across rural Victoria.

The evaluation findings support continuation of the RPCMPF in all regions. A range of recommendations have been developed to enhance and support the RPCMPF's effectiveness in continuing to achieve its aims as it moves into the next phase. The recommendations are listed in section 12 of this document.

Table 1: Summary of key achievements by region

Barwon South Western		
Key achievements	**Enablers**	**Arrangements as at May 09**
• Palliative medicine specialist funded an additional two hours per week in Warrnambool resulting in increased time on advance care planning, education and service delivery to more remote parts of region and improved support for GPs. • GP in Hamilton funded an additional four hours a week to deliver palliative care. • GP in Portland funded an additional three hours a week to deliver palliative care.	• Existing high level of engagement with GPs in the Barwon area • GPs staff the on-call palliative care roster at Barwon Health	• As per key achievement
Gippsland		
Key achievements	**Enablers**	**Arrangements as at May 09**
• Partnerships established with metropolitan services to provide palliative medicine specialist education and up to 20 hours per month secondary telephone consultation to the region. • Eleven GPs received scholarships to undertake postgraduate study in palliative care	• Project officer employed to promote the medical scholarship fund	• As per key achievement • Exploring options for establishing a primary consultation service
Grampians		
Key achievements	**Enablers**	**Arrangements as at May 09**
• Appointment of an additional full-time palliative medicine specialist resulting in increased numbers of new and reviewed assessments, more rapid response to palliative care referrals, greater equity of service delivery across the region and increased capacity to support GPs and other palliative care staff.	• Collaboration with Ballarat Division of General Practice's rural palliative care program • Supplementary funding of the new palliative medicine specialist by Ballarat Health • Cooperation with Cancer/Palliative care Nurse Navigator Project	• As per key achievement

Hume		
Key achievements	**Enablers**	**Arrangements as at May 09**
• Partnership established with Barwon Health to provide fortnightly visits to Hume region by palliative medicine specialists including primary and secondary consultation and 37 education sessions. • Senior medical officer employed three days a week with palliative care skills and experience to deliver palliative care medical services across the region.	• Pre-existing arrangement with St Vincent's Health to provide palliative care specialist medical services. Arrangement was transferred to Barwon Health when Dr Martin relocated	• Barwon Health provides secondary telephone support via the palliative care consultant • Exploring sustainability of senior medical officer's ongoing employment
Loddon Mallee		
Key achievements	**Enablers**	**Arrangements as at May 09**
• Partnership established with Peter MacCallum Cancer Centre to provide 12 hours of palliative medicine services for Mildura specialist palliative care clinic per month (26 clinics). 82 scheduled and 30 unscheduled teleconferences were held between February 2007 and February 2009. • Additional 12 hours per month of palliative medicine specialist hours for Bendigo region including 221 recorded consultations, resulting in improvements in patient outcomes, improved continuity of care for Bendigo patients and greater engagement with Bendigo GPs.	• Bendigo Health Care Group co-funds 0.2 EFT palliative medicine specialist • Sunraysia Community Health Service funds Mildura clinic clinical nurse consultant and non-medical costs	• As per key achievement • Finalising service agreement with Bendigo Healthcare Group to provide outreach services to the Echuca region

2 Introduction

Optimising access to specialist palliative care services, including specialist medical services, for all Victorians is consistent with the direction of a range of Victorian and Australian Government policies as well as Palliative Care Australia's *Standards for providing quality palliative care for all Australians* ('standards').

Key outcomes under *Strengthening palliative care: a policy for health and community care providers 2004–09*,[1] include access to appropriate and timely specialist palliative care services for all Victorians, regardless of where they live. Under the Palliative Care Australia standards, the standard of access to palliative care is that it should be available for all people based on clinical need and independent of diagnosis, age, cultural background or geography.[2] *Rural directions for a better state of health*, the Victorian Government's vision for developing the health system in rural Victoria in the future, outlines the government's commitment to promoting the health and wellbeing of rural Victorians within a contemporary health system and models of care that are strengthened and sustainable.

The Australian Government's *National palliative care strategy* is founded on a premise that helping people to die well, in an atmosphere of care and support, is integral to a comprehensive health system that supports people at all stages of life. The strategy acknowledges that many people prefer to die with the support of family and friends in their local community and that specialist palliative care services will be available to support this choice, wherever people live.[3]

For the almost 1.4 million or 27 per cent of Victorians living in rural regions,[4] the challenges of access to specialist palliative care services can be greater than for those living in metropolitan areas. Some of the factors impacting on access to health services in general, and palliative care services in particular, for rural Victorians include:

- geographical isolation
- a sparse population spread over large distances
- a high reliance on general practitioners for providing medical care
- lower standards of health among those living in rural and remote communities compared with those living in metropolitan communities.

Some of the challenges for governments, health and community service providers and clinicians in attempting to provide palliative care services to rural communities include:

- workforce recruitment and retention across all health related disciplines – medical, nursing and allied health
- maintaining and improving workforce skills for health professionals working in rural communities
- providing access to specialist support and back-up for rural health professionals
- providing integrated care.

1 Department of Human Services, 2004, *Strengthening palliative care: a policy for health and community care providers 2004–09*, State Government of Victoria, Melbourne.
2 Palliative Care Australia, 2005, *Standards for providing quality palliative care for all Australians*
3 Commonwealth of Australia, 2000, *National palliative care strategy: a national framework for palliative care service development*, Australian Government, Canberra.
4 Australian Bureau of Statistics, *Regional population growth Australia 2006–07* (Victorian population as at June 30, 2007 for all LGAs included in rural departmental regions), viewed 17 April 2009, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3218.0Main%20Features62006-07?opendocument&tabname=Summary&prodno=3218.0&issue=2006-07&num=&view>.

To assist in meeting these challenges, a range of palliative care initiatives have been developed by government agencies, peak bodies and others. These include:

- The Program of Experience in the Palliative Approach (PEPA), as a part of the National Palliative Care Program, has provided health professionals the opportunity to gain experience, knowledge and skills in palliative care through accessing clinical placements in palliative care settings.[5]
- The Australian Government Department of Health and Ageing (DoHA) Rural Palliative Care project 2008–2010 has provided funding to 11 Victorian divisions of general practice to enhance linkages among rural palliative care service providers.[6]
- Victoria's recently released Cancer Action Plan 2008–2011 aims to further improve the management of cancer in the Victorian community including increasing the capacity of palliative care services to provide care for patients in the place of their choice.[7]

The Victorian Department of Human Services' RPCMPF has strengthened and complemented other initiatives through providing funding to improve access to specialist palliative care services in rural Victoria.

5 National Palliative Care Program, *Program of experience in the palliative approach*, viewed 17 April 2009, <http://www.pepaeducation.com/>.

6 Australian General Practice Network Rural Palliative Care Project 2008–2010, viewed 17 April 2009, <http://www.agpn.com.au/site/index.cfm?display=24747>.

7 Department of Human Services, 2008, *Victoria's Cancer Action Plan 2008–2011*, viewed 17 April 2009, <http://www.health.vic.gov.au/cancer/vcap.htm>.

3 Background

The Rural Palliative Care Medical Purchasing Fund (RPCMPF) was established in 2006–07 from the Hospital Futures budget allocation. New, recurrent funding of $600,000 was allocated to improve specialist palliative care medical services in rural Victoria. This was in line with implementation of *Strengthening palliative care: a policy for health and community care providers 2004–09*.

The RPCMPF aims to:

- provide rural regions with funding to purchase additional specialist medical palliative care in order to address gaps in access to specialist medical palliative care
- build capacity for rural regions to become self-sufficient in providing specialist medical palliative care.

Proposals from rural palliative care consortia were sought to implement the RPCMPF in their region from January 2007 to June 2009. Funding allocations were determined according to the existing capacity of the region and funding allocation decisions took into account the need to promote equity of access to specialist medical palliative care service across the state. Funding allocations were made to each of the five rural palliative care consortia and each consortium has implemented the RPCMPF differently in their region. The five rural palliative care consortia are Barwon South Western, Gippsland, Grampians, Hume and Loddon Mallee.

A statewide medical scholarship fund was also established to support rural medical practitioners to upskill in palliative care. The aims of the medical scholarship fund were to:

- financially support medical practitioners in rural areas to improve their skills and confidence in palliative medicine through undertaking tertiary postgraduate education
- improve the quality and competence of palliative medicine for Victorians in rural areas.

Interested medical practitioners from the five rural regions were invited to apply for the scholarships. Scholarship eligibility was based on membership of one of General Practice Victoria's rural general practice divisions and experience in providing care for people with life-limiting illness. The medical scholarship fund is non-recurrent.

This report presents the findings of a statewide evaluation of the RPCMPF's implementation over its first two and a half years. It makes recommendations regarding recurrent funding allocation as well as support and implementation of the RPCMPF as it moves into its next phase.

4 Evaluation aims and objectives

4.1 Evaluation aim

To undertake a statewide evaluation of the RPCMPF's implementation.

4.2 Evaluation objectives

The RPCMPF evaluation objectives are to:

1. Determine the extent to which the aims of the RPCMPF have been met. These aims include:
   - expanding existing medical arrangements in regions to address service gaps
   - purchasing new medical consultancy hours in regions where there was previously no specialist medical palliative care service
   - addressing gaps through training or upskilling existing general medical providers in the region.
2. Determine the extent to which the assessment criteria for the RPCMPF proposals have been met. These criteria include the:
   - merit of the proposed benefit against the RPCMPF key performance measures (as outlined in point 1 above)
   - appropriateness of the proposed method or approach
   - reasonableness and appropriateness of the proposed budget
   - solutions being developed demonstrate potential for sustainability and ongoing benefit and, where possible, build on existing resources.
3. Determine the extent to which the RPCMPF has been implemented in a sustainable manner.
4. Identify and describe initiatives that are transferable to other regions.
5. Determine the extent to which the programs have achieved equity of access to specialist medical palliative care services across the state.
6. Identify unexpected gaps and challenges that have arisen during the RPCMPF's implementation and strategies undertaken to address these.
7. Develop recommendations concerning the options for recurrent funding allocation including an explanation of those recommendations.

5 Evaluation approach

A program logic approach was adopted for the evaluation. The approach was tailored to each of the five regions so as to capture the variations in implementation across the state. In line with program logic methodology the evaluation addressed the key evaluation objectives by examining inputs, outcomes and outputs in each of the five regions.

The key data collection methods included:

- Visits to one or more key sites in each of the five regions. The sites visited were:
  - Ballarat Health Service
  - Ballarat Hospice Care Inc.
  - Bendigo Health Care Group
  - Grace Mackellar Centre (Geelong)
  - North East Health Wangaratta
  - South West Healthcare (Warrnambool)
  - West Gippsland Healthcare Group (Warragul).
- Document review including:
  - relevant policy documents
  - RPCMPF proposals and reports
  - other documents provided by consortia and the department.
- Key informant interviews. A full list of interviewees is located in Appendix 1.
- Analysis of data that had been collected in each region throughout the RPCMPF's implementation. Available data varied from region to region in line with the variations in the way the RPCMPF was implemented and included:
  - training evaluation data
  - clinical data such as number of new and review patient contacts, contact duration and occasions of service
  - numbers of home visits, telephone consultations, face-to-face visits and travel time
  - patient functional status data
  - other data.

A descriptive approach to the data analysis was used in order to accommodate the variations in data available in each region. Key regional findings are presented in section 6 of this document.

Program logic models were developed for each region. The logic models summarise the key elements of each region's approach to implementing the RPCMPF as well as aims, inputs, outputs and outcomes. Barriers to implementation were also explored as well as methods used to overcome the barriers. The logic models are included in section 7.

The sustainability analysis in section 8 was undertaken based on a range of sustainability factors that were determined during the consultation phase. Potentially transferable elements of the RPCMPF's implementation in each region have been identified and are discussed in section 10.

A series of recommendations based on the evaluation findings has been developed. Recommendations are listed in section 12.

6 Regional findings

This section outlines the findings from each region based on:

- interview and site-visit data obtained during the consultation phase
- evaluation data collected in each region throughout the RPCMPF's implementation.

As highlighted previously, the data varied in type and quality from region to region. Where available, quantitative data has been used to support the interview findings.

For the purposes of the evaluation, a palliative medicine specialist is a doctor who holds a Fellowship of the Royal Australasian College of Physicians (FRACP) and/or a Fellowship of the Australasian Chapter of Palliative Medicine (FAChPM).[8]

In addition to palliative medicine specialists, a number of doctors working in rural Victoria have completed a range of other postgraduate courses of study in palliative care. These doctors are referred to in the report as palliative care general practitioners or palliative care consultants.

6.1 Barwon South Western

6.1.1 Background

The Barwon South Western region divides its service provision into two areas. The hub of the Barwon area is the City of Greater Geelong, Victoria's second largest city. By comparison with other areas of Victoria, Geelong is well staffed with palliative care specialists (see Table 2). It is the only rural city with a palliative care consultancy service.

The South Western area covers approximately 80 per cent of the Barwon South Western region. It includes 29 per cent of the region's population, 30 per cent of which is concentrated in Warrnambool. The South Western area was identified as having the greatest rural palliative care service needs and the RPCMPF's implementation was therefore targeted in this area.

Table 2: Barwon South Western regional demographics (including RPCMPF)

Number of palliative care specialists (EFT in region)	3.0 (Barwon) 0.7 (South Western)
Number of LGAs	9
Number of GP divisions	3
Geographical area	29,637 km^2
Population at 30 June 2007[4]	359,581 (6.9 per cent of Victorian population)
Cancer incidence[9] (2004 estimates)	1,874
Cancer deaths[10] (2004 estimates)	801
Consortium fundholder	Barwon Health Service

8 Australasian Chapter of Palliative Medicine, 2008, College AMC report, chapter submission, viewed 24 April 2009, <http://www.racp.edu.au/page/about-the-racp/structure/australasian-chapter-of-palliative-medicine>.

9,10 Cancer incidence and cancer deaths data used throughout this document are taken from: English, D., Farrugia, H., Thursfield, V., Chang, P., Giles, G., 2007, *Cancer Survival Victoria 2007*, Victorian Cancer Registry, Cancer Epidemiology Centre, Cancer Council Victoria, Melbourne.

Prior to the RPCMPF's implementation, the palliative medicine specialist in the South Western area was employed by Southwest Healthcare in Warrnambool for 48 hours a fortnight as director of palliative care. In both Hamilton and Portland a general practitioner had been allocated two hours of palliative care per week.

In Warrnambool, the palliative medicine specialist's role included:

- providing in-reach palliative care to Southwest Healthcare palliative care inpatients
- consulting with community palliative care patients in the Warrnambool region
- maintaining contact with general practitioners including preparing a monthly newsletter distributed to all general practitioners in the region
- participating in palliative care multidisciplinary team meetings
- advance care planning
- providing education and support to clinicians across the South Western area.

Prior to the RPCMPF there was no funding allocation for palliative care infrastructure, training or professional development.

6.1.2 RPCMPF outputs

6.1.2.1 New specialist medical arrangements

The RPCMPF has funded an additional four hours per fortnight (two hours per week) of palliative medicine specialist time in Warrnambool from January 2007.

Additional funding was allocated to the two general practitioners in Portland and Hamilton to:

- increase palliative care services provided to the local communities by four hours per week in Hamilton and three hours per week in Portland
- fund five days of clinical attachment programs for each general practitioner
- fund each general practitioner to attend the Barwon South Western strategic planning day.

The new arrangements were implemented in Portland from December 2007 and in Hamilton from January 2008.

6.1.2.2 Regional upskilling of general practitioners

In addition to the extra funded palliative care hours, one of the general practitioners accessed the medical scholarship fund.

As a result of the dedicated palliative care funding under the RPCMPF, these general practitioners have been able to provide direct patient primary consultation as well as secondary consultation, support and advice to other general practitioners managing palliative care patients.

The Barwon area has a high level of engagement with a small group of local general practitioners. Eight to 10 of these general practitioners are involved in a palliative care specialist interest group. General practitioners staff the on-call palliative care roster at Barwon Health.

The original RPCMPF proposal allocated funding to engage a project manager to:

- further clarify gaps in palliative care medical positions
- identify general practitioners to include in the program
- establish opportunities to engage general practitioners.

When workforce shortages proved a barrier to recruiting to this position, the consortium entered an agreement with the General Practice Association of Geelong (GPAG) to undertake these tasks. GPAG spoke to a number of general practitioners in the South Western area to identify general practitioners with an interest in increasing their engagement with palliative care. They recommended that the RPCMPF be used to support increased engagement in palliative care by the two palliative care general practitioners already working in Hamilton and Portland. The consortium reported that the arrangement with GPAG did not deliver on all of the agreed key performance indicators. As a result the agreement was not renewed after the end of the 2008–09 financial year.

The consortium has a close relationship with the Otway Division of General Practice, which is implementing a DoHA-funded Rural Palliative Care project aimed at bridging gaps between specialist palliative care and primary care providers by increasing knowledge of the palliative approach in primary care.

6.1.3 Outcomes

Barwon Health (as the consortium fundholder) established the following key performance indicators for the RPCMPF:

- provision of education to staff – number of extra hours per month
- in-reach medical consultancy (out of hours) – extra hours per month
- home visits to palliative care patients – occasions
- staff support for palliative care patients – number of hours
- palliative care input to multidisciplinary meetings – number of hours per month
- attendance at regional palliative care meetings/days
- collegial professional development – number of hours
- clinical attachment placements – number of hours.

While data on some of these key performance indicators was available from Southwest Health Palliative Care Service, limited data was available from Hamilton and Portland. As a consequence, it is difficult to quantify outcomes from the RPCMPF's implementation in those regions. The outcome data for Hamilton and Portland is based on interviews with the two funded palliative care general practitioners.

6.1.3.1 Outcomes in Warrnambool

Reporting information provided by South West Healthcare included the number of:

- registered palliative care patients
- patients seen by the palliative medicine specialist in the community, the chemotherapy unit and the palliative care unit
- hours the palliative medicine specialist spent on advance care planning, delivering education, travelling and on administrative tasks.

Figure 1 shows the number of registered palliative care patients in the Warrnambool region charted alongside the total number of community and palliative care unit consultations undertaken by the palliative medicine specialist each month from December 2005 to February 2009. While this graph does not demonstrate a significant change in the number of community and palliative care unit consultations dating from the commencement of the new specialist arrangements, Figures 2–4 reveal improved outcomes based on other parameters.

The palliative medicine specialist's travel time (Figure 2) as well as time dedicated to advance care planning (Figure 3) and education provision (Figure 4) all increased from the second half of 2007 onwards. This may reflect an increase in the quality of care the palliative medicine specialist was able to provide with the additional funding from the RPCMPF. Increased travel time may be an indicator of greater equity of service provision in remote parts of the region. Increases in time spent on advance care planning and education are also indications of a higher quality service under the RPCMPF.

Gaps in the data reflect that the palliative medicine specialist was on long service leave from August to October 2007. Data was not available for May 2006 and May 2007.

Figure 1: Number of registered palliative care patients and PMS consultations–South West region

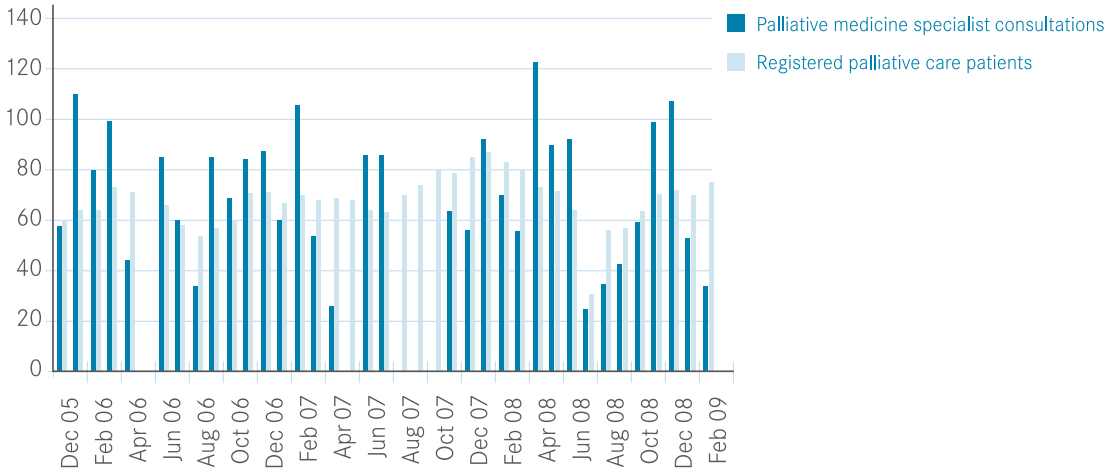


Figure 2: PMS travel time (hours)–South West region

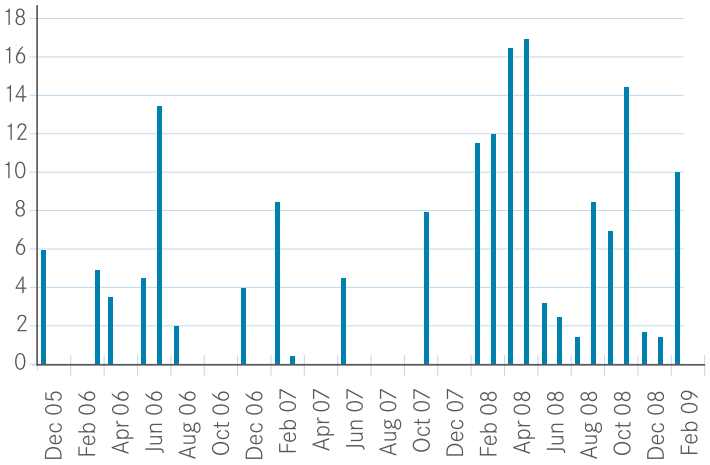


Figure 3: PMS time spent in advance care planning (hours)–South West region

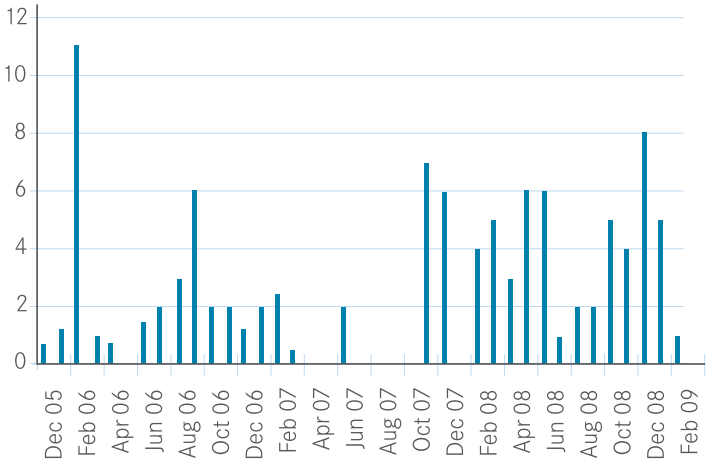
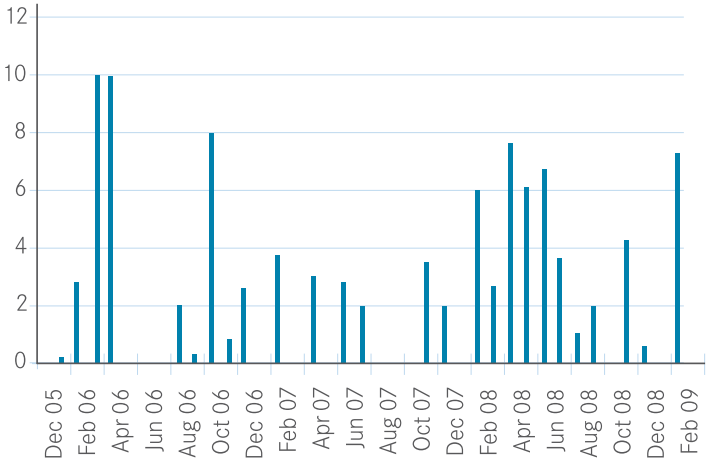


Figure 4: PMS time spent on education provision (hours)–South West region



The RPCMPF has also funded six professional development days for the Warrnambool palliative care specialist, which has enabled him to attend:

- a Motor Neurone Disease Association Victoria seminar
- palliative medicine meetings at the Cancer Council Victoria
- regional palliative care practitioners' meetings.

6.1.3.2 Outcomes in Portland

In Portland, four full-time career medical officers provide medical services to the Portland and District Hospital. One of these doctors has postgraduate qualifications and a special interest in palliative care. Since December 2007, the RPCMPF has funded three additional hours per week for her to provide palliative care services to the Portland community.

On average, one to two hours of this time is spent seeing inpatients at the hospital, an hour spent conducting home visits and up to a further hour providing telephone follow-up for community patients. As well as having conducted two formal education sessions in palliative care, her role in the hospital has provided her with opportunities to informally educate nursing staff when they are managing palliative care patients. This has reportedly improved the nurses' knowledge and confidence with prescribed medications and doses.

Hospital resource issues have sometimes resulted in the career medical officers having to cover additional rosters such as emergency department rosters. At times this has compromised the palliative care general practitioner's capacity to meet the agreed palliative care commitments. Fewer clinical attachment days were completed than funded in 2008; however, this was compensated by two to three days per semester spent in Melbourne fulfilling study commitments. No clinical attachment days have been completed to date this year.

From June 2009 the palliative care general practitioner will move to general practice and will continue to provide palliative care services to Portland for three hours a week under the RPCMPF. In this setting, her capacity to fulfil the funded palliative care commitments will be improved as she will be able to set aside dedicated palliative care session time each week.

6.1.3.3 Outcomes in Hamilton

The funded palliative care doctor in Hamilton is a general practitioner with postgraduate qualifications in palliative medicine and is a member of the Australian and New Zealand Society of Palliative Medicine (ANZSPM). The doctor's employer receives funding from Barwon Health (via the RPCMPF) for her to provide four hours of palliative care services to the Hamilton region each week.

Since January 2008 this has enabled her to provide secondary consultation and support for local clinicians seeing palliative care patients, including general practitioners, palliative care nurses, and district and other nurses. In addition, the funding has enabled her to deliver twice-yearly training for clinicians at Hamilton Hospital and be involved in other education opportunities such as delivering a full-day palliative care training day with Dr David Brumley from Ballarat. This course was targeted at general practitioner registrars as a part of the Australian General Practice Training Program. In addition the palliative care general practitioner sees palliative care patients in the hospital or in her general practice. These consultations are funded by the hospital or via Medicare.

Areas of need identified by the Hamilton palliative care general practitioner include:

- support for general practitioners in caring for palliative care patients, particularly when they are dying at home, in hospital or in aged-care facilities and have symptom management issues
- care of palliative care patients who are not registered with palliative care community agencies – these patients can reportedly fall through the gaps.

Two case examples provided by the palliative care general practitioner illustrate how her funded role in the region has led to improved patient outcomes:

> **Case example 1:** *In November 2008, a local GP contacted me regarding a patient with renal disease who had made the decision to come off dialysis after Christmas. Our initial discussion was around 30 minutes and focussed on the conversation the GP would have with the patient about coming off dialysis, the supports available to the patient and his family as well as psychosocial issues. Armed with the information from this discussion, the GP then spoke to the patient and his family. Following this he contacted me for more information about what the patient might expect once he came off dialysis. I spent a couple of hours researching this topic then spoke again with the GP. The GP then had further conversations with the patient and his family about what to expect. Ultimately, the patient's condition deteriorated and he came off dialysis earlier than he had planned. He died at home, with his family, before Christmas. His death was comfortable, with good symptom management which his GP was able to provide as a result of our discussion. The patient, family and GP all felt this was a good outcome.*

> **Case example 2:** *In February this year, I was on holidays when I received a call from a GP regarding a patient in an aged-care facility. The patient had a supportive family and suffered from dementia. She had developed acute abdominal pain for which surgery was not considered appropriate. The conversation with the GP lasted 20–30 minutes and centred on pain relief. The GP had reached the limit of the standard range of pain medications he would normally use and these had not been successful in controlling the patient's pain. I was able to offer some new ideas regarding pain relief which he then implemented. As a result of the pain management regime we discussed, the patient died peacefully in her nursing home.*

6.1.4 Remaining gaps in the region

6.1.4.1 After-hours and annual leave cover

After-hours and annual leave cover arrangements are not formalised. Doctors occasionally accept calls after hours or when they are on leave. Sometimes there is no medical cover when the palliative care doctors are on leave. Case study 2 highlights this issue. The Warrnambool data in Figures 1–4 reveals workforce gaps from August to October 2007 when the palliative medicine specialist was on leave. One general practitioner in Warrnambool has covered palliative care patients in the past; however, palliative care staff report it can be difficult for a general practitioner to step into this role when the palliative medicine specialist, who would ordinarily be available for support and back-up, is away.

In addition to lack of formalised medical cover arrangements, some on-call nurses may claim for being on call but will not claim for time spent taking phone calls when they are on call. Staff reported concern that funding from other areas will be cut if on-call expenses are claimed.

There is no after-hours psychosocial support that staff report can lead to avoidable after-hours hospital admissions for psychosocial crises. This in turn can lead to potentially avoidable increases in demand on palliative medicine specialists and other staff.

6.1.4.2 Funding for travel and other work-related expenses

Doctors report using personal mobile phones and cars for palliative care calls and visits to remote parts of the region. They perceive that options for reimbursement of these expenses are not as easily available to self-employed doctors as for those employed by organisations.

6.1.4.3 Nursing workforce

In some parts of the region it is not possible to run syringe drivers or offer nursing back-up because of inadequate nursing cover. In some instances, the unassigned bed fund has been used to fund some back-up nursing support if there is a nurse available in the region. Nurse succession planning in Hamilton is also an issue of concern with the imminent retirement of the palliative care clinical nurse consultant. Nursing workforce issues have the potential to compromise optimal provision of medical services under the RPCMPF.

6.1.4.4 Data collection

Reporting against the key performance indicators relating to the RPCMPF established by Barwon Health was incomplete, resulting in difficulty establishing whether the key performance indicators have been met.

6.1.4.5 Succession planning

Succession planning in the South Western area is a potential threat to sustainable service delivery in the short term. The three-way distribution of funding has advantages in that it builds local palliative care capacity in multiple locations and creates a collegial working environment, however, it results in a dilution of the available funding for attracting palliative care specialists into the region.

Continuing to strengthen and enhance the links between the Barwon and South Western areas may reduce this risk. A range of options is being considered by the consortium regarding succession planning in the region. It is recommended that options to be explored include supporting one of the region's palliative care funded general practitioners to engage in advanced training in palliative care. Alternatively, funding could be consolidated to support one position in the South Western area in order to attract a palliative medicine specialist into the region.

6.1.5 Inputs

Table 12 in Appendix 2 outlines RPCMPF income and expenditure from January 2007 to June 2009.

Other palliative care funding inputs in the South Western area include:

- funding the director of palliative medicine role by South West Healthcare
- palliative care general practitioners working in general practice who bill some palliative care patients via Medicare.

The budget figures indicate there is still some capacity to increase palliative care hours in a sustainable way under the current funding level. In 2008–09, only $90,356 of the year's allocation of $119,312 was used for providing palliative care specialist medical services leaving a surplus of funds for that year of $28,956. There was a total surplus of funds for the two-and-a-half-year period of $86,432.

Under current remuneration levels, the annual surplus could be used to fund an additional three to five hours of palliative care time for either the palliative medicine specialist in Warrnambool or the palliative care general practitioners in Hamilton and Portland. Some of this funding could be used for after-hours or annual leave cover or data collection support.

6.1.6 Key recommendations for Barwon South Western region

- The Barwon South Western region continues to sustain and enhance support for the South Western area through providing secondary telephone support, clinical attachment opportunities and other educational and professional development opportunities.
- The Barwon South Western region continues to undertake regional succession planning for the South Western area through ongoing sponsorship and supporting the palliative care doctors in the region and/or through exploring new ways to attract and/or retain palliative medicine specialists.
- The Barwon South Western region directs unallocated RPCMPF money to increase specialist medical palliative care service provision in the South Western area.

6.2 Gippsland

6.2.1 Background

Palliative care in Gippsland is provided by 13 services ranging from community-based generalist services to hospital-based services. There is currently no regional palliative care team in Gippsland.

Prior to implementation of the RPCMPF, the Gippsland region had no formalised access to specialist palliative care medical services. Service mapping undertaken by the consortium revealed that many local palliative care services in Gippsland had a range of informal relationships and arrangements to facilitate access to specialist palliative care medical services. However, these arrangements were limited through funding constraints and fragmentation. Arrangements were frequently reliant on goodwill from specialists and/or palliative care facilities in the metropolitan areas. Some general practitioners in the region had formal qualifications in palliative care and were offering specialist palliative care services within the community, local hospitals and residential aged care facilities (RACFs).[9]

9 Gippsland Region Palliative Care Consortium, 2009, Integrated Clinical and Education medical Service Project (ICEMSP) operational framework January 2008 – June 2009

Table 3: Gippsland regional demographics (incl. RPCMPF)

Number of palliative care specialists (EFT in region)	0
Number of LGAs	6
Number of GP divisions	3
Geographical area	41,538 km^2
Population at 30 June 2007[4]	250,846 (4.8 per cent of Victorian population)
Annual cancer incidence[9] (2004 estimates)	1,422
Annual cancer deaths[10] (2004 estimates)	568
Consortium fundholder	Central Gippsland Health Service

6.2.2 RPCMPF outputs

6.2.2.1 New specialist medical arrangements

The Gippsland Region Palliative Care Consortium (GRPCC) has formalised partnerships with the Southern Health Supportive and Palliative Care Unit, Calvary Health Care and Peninsula Health to provide the region with access to palliative care specialists funded through the RPCMPF.

The Gippsland region is divided into three areas: South, Central and East Gippsland, with each metropolitan specialist partner taking responsibility for an area. This arrangement supports informal links between regional and metropolitan hospitals that pre-dated the current arrangement as well as facilitating enhanced relationships through consistency and familiarity between metropolitan specialist partners and regional clinicians.

A memorandum of understanding was established between the GRPCC and Southern Health in March 2008. As the lead metropolitan agency Southern Health has established subcontracting arrangements with the other specialist partners, Calvary Healthcare Bethlehem and Frankston Golf Links Road Palliative Care.

The specialist hours purchased through the RPCMPF are focussed on providing skill development and education programs in palliative care and pain management for:

- general practitioners
- community and hospital-based palliative care services
- other health professionals
- the acute sector.

Specifically, the metropolitan specialist partners provide the following services:

- secondary telephone consultation services
- case reviews with general practitioners and local services
- clinical attachments
- professional education delivered by a range of palliative care staff including palliative care specialists, nurses and allied health staff
- mentoring of nurses and others by Southern Health's palliative care clinical nurse consultants.

In addition, the metropolitan specialist partners have supported:

- provision of strategic advice to the GRPCC regarding the regional plan and the implementation of the Strengthening palliative care policy
- policy and clinical input to assist services with continuing to develop best-practice models of care.

6.2.2.2 Regional upskilling of general practitioners

The consortium has been committed to improving the palliative care skills of the region's general practitioner workforce. The Gippsland region has had the greatest uptake of the medical scholarship fund with 11 out of the 14 scholarship recipients being Gippsland based. The region's success in recruiting scholarship applicants can be largely attributed to the consortium's appointment of an RPCMPF project officer, with funding from the Gippsland Regional Integrated Cancer Service (GRICS). The project officer and the consortium used a range of strategies to engage general practitioners in the program including:

- linking with local divisions of general practice to distribute information about the medical scholarship fund to all general practitioners in the region
- using the consortium website and newsletters to provide information as well as developing a brochure about the medical scholarship fund
- contacting general practitioners with a possible interest in gaining further skills in palliative care and providing them with course information and outlines relevant to their educational needs
- assisting with course applications and applications for continuing professional development (CPD) points linked to their study.

6.2.2.3 Other outputs

Other outputs in the Gippsland region include:

- developing memoranda of understanding between Central/West Gippsland, South Gippsland and East Gippsland divisions of general practice and the GRPCC to facilitate a coordinated approach to the RPCMPF's implementation
- establishing a partnership with the Gippsland and East Gippsland Aboriginal Cooperative (GEGAC) aimed at improving the rate and quality of referrals by general practitioners of Indigenous people to palliative care services. The need for cultural awareness training for general practitioners and other health professionals as well as coordinated, culturally sensitive discharge planning from hospitals with home-based services has been highlighted through this activity.

6.2.3 Outcomes

Table 4 presents a sample of some of the educational activities delivered to the Gippsland region by the metropolitan specialist partners since July 2008. These educational activities were offered in more than 10 locations across the region.

Table 4: Educational activities delivered to the Gippsland region

Date	Activities	Specialist partner	Location	No. GPs attend	No. of others attend
1/7/08	Education session on the palliative management of MS and MND	Calvary Health Care	Warragul	4	5
2/7/08	Meeting at Maffra general practice – discussion regarding specialist partnership role	Calvary Health Care	Maffra	6	1
2/7/08	Introductory meeting and case review session with providers in Lakes Entrance	Calvary Health Care	Lakes Entrance	5	6
2/7/08	Education session on the palliative management of MS and MND to East Gippsland Division of General Practice	Calvary Health Care	Bairnsdale	4	5
5/11/08	Case review session, Orbost Regional Health	Calvary Health Care	Orbost	3	13
6/11/08	Case review session, Omeo District Health	Calvary Health Care	Omeo	0	13
6/11/08	Case review session, Central Gippsland Health Service	Calvary Health Care	Sale	1	16
17/11/08	Keynote address at Central West Division of General Practice AGM	Southern Health	Moe	12	0
18/11/08	Case review session, Latrobe Community Health Service and Latrobe Regional Hospital	Southern Health	Morwell	0	22
20/11/08	Case review session, Gippsland Southern Health Service	Peninsula Health	Leongatha	1	33
20/11/08	Bass Coast Regional Health	Peninsula Health	Wonthaggi	2	19
26/2/09	Palliative Care Update	Calvary Health Care	Sale	4	18

Formal evaluations of the education sessions undertaken by the consortium found that the following.

- Practice visits and forums organised by divisions of general practice attracted a higher number of general practitioners than case review sessions held at health services.
- Case review sessions held at health services attracted high numbers of other participants including palliative care and district nurses, practice managers and nurses, divisions of general practice staff, allied health staff, pharmacists, home and community care (HACC) coordinators/intake workers.
- An evaluation of the education session on the palliative management of multiple sclerosis and motor neurone disease delivered to the East Gippsland Division of General Practice indicated that 80 per cent of general practitioner participants rated their learning needs as having been entirely met by the session and 20 per cent partially met. Eighty per cent of general practitioner participants rated the session as entirely relevant to their practice and 20 per cent as partially relevant.

Other outcomes from the training activities reported by stakeholders include the following.

- General practitioners reported they would be more likely to contact specialist staff for secondary consultations after having met them at the education sessions.
- The case review process was reported as being an effective educational tool that has assisted the specialist partners and regional clinicians identify palliative care knowledge gaps and tailor education accordingly. A clinical nurse consultant reported that the case review sessions have encouraged the nurses to reflect on their practice and have subsequently formed the basis for practice improvement.

In May a regional palliative care forum will be held. Palliative care specialists employed by the metropolitan specialist partners will be involved as keynote speakers and other team members such as allied health staff will run concurrent workshops. Topics have been developed to target the specific needs and issues facing medical practitioners and other palliative care clinicians in the Gippsland region.

Since the start of their involvement, the specialist partners have noted a raised level of awareness of palliative care among general practitioners in the region but indicate there is little evidence of widespread upskilling of general practitioners or improvements in patient care as a result of the partnership as yet.

A telephone roster was established among the metropolitan specialist partners with the aim of providing up to 20 hours per month of secondary telephone consultation to Gippsland general practitioners. Little quantitative data was available on the uptake of this service by Gippsland general practitioners and palliative care staff. However, during February and March 2009, Southern Health report that 11 calls from Gippsland clinicians were made to palliative care medical consultants at Southern Health. These varied in duration from five to 20 minutes with an average duration of around 10 minutes. There were also six calls to nurses of approximately 10–15 minutes' duration each. The service was rarely accessed prior to that time. Calvary reports no utilisation of the telephone service. These results fall well below the service provision target of 20 hours' secondary telephone consultation per month.

Barriers to the uptake of secondary consultation identified by the consortium include:

- lack of widespread awareness among general practitioners that the service exists
- lack of availability of the service outside business hours
- reluctance of some general practitioners to acknowledge gaps in their skills and knowledge or unwillingness to 'give up' their patients.

6.2.3.1 Pathway for Improving the Care of the Dying (PICD)

PICD is an integrated care pathway based on the UK's Liverpool Care Pathway. PICD aims to improve end-of-life care delivered in non-specialist palliative care settings. The pathway was developed and piloted at Southern Health during 2006.

As a result of the partnership with Southern Health, seven hospitals in the Gippsland region participated in a retrospective audit of their end-of-life care pathways in late 2008.

Under the mentorship and training of Associate Professor Kate Jackson, two Gippsland hospitals (West Gippsland and Latrobe regional hospitals) will participate in the PICD pilot implementation prior to its broader implementation across the region. By the end of 2009 the consortium aims to have implemented PICD in at least two generalist wards in each of the region's hospitals.

6.2.3.2 Benefits for metropolitan specialist partners

Reported benefits of the partnership to the metropolitan specialist services include:

- broadening of their perspective on palliative care service delivery in rural regions
- enhanced staff learning through developing and delivering education programs.

6.2.4 Next steps

The GRPCC spent much of 2007 engaging with specialist partners, establishing links with divisions of general practice and other groups across the region and undertaking process mapping. These were viewed as important relationship foundations for the model's further development. During 2008 the specialist partnership was implemented and general practitioner upskilling commenced.

The consortium is currently developing its vision regarding next steps in implementing the RPCMPF model. In early April it endorsed a primary consultation concept involving implementation of palliative medicine specialist consultations within the region two days each fortnight with an aimed commencement timeframe prior to 30 June 2009. Consultation model and locations are yet to be negotiated.

As a result of the momentum established throughout the RPCMPF's implementation, specialists from outside the region are now expressing interest in involvement with the new primary consultation model. This is a positive change that the consortium staff believe is an outcome of the strong relationship-building that has occurred since the RPCMPF's implementation.

6.2.5 Remaining gaps in the region

6.2.5.1 Specialist medical consultation

Absence of a primary, specialist palliative care medical consultation presence in the region remains a significant gap, however, there are plans to redress this in the program's next phase.

6.2.5.2 Standardised documentation and idea-sharing

Stakeholders report that uniform documentation such as pain management charts across the region can be a barrier to good continuity of care. Further enhancement of relationships in order to support a collegial environment across the region is also seen as desirable. A new, part-time palliative care regional education officer position has been created to coordinate education and to facilitate and enhance regional relationships. Establishing a clinical practice group will aim to address uniformity of documentation across regions. This group will be supported by the metropolitan specialist partners.

6.2.6 Inputs

Table 13 in Appendix 2 outlines RPCMPF income and expenditure from January 2007 to June 2009 in the Gippsland region.

Another palliative care funding input into the region is substantial funding of the general practitioner project officer position by the Gippsland Regional Integrated Cancer Service (GRICS).

Due to the length of time it has taken to establish partnerships and commence service delivery in the region, a substantial portion of the RPCMPF remains unspent. The consortium anticipates these surplus funds will be used to support the pilot implementation of primary consultation services within the region. It will be important that the model developed can be sustained within recurrent funding levels after the initial pilot phase.

6.2.7 Key recommendations for Gippsland region

- The Gippsland region, in collaboration with its metropolitan specialist partners, continues to work towards developing and piloting a primary consultation model of palliative care medical service delivery in the region. The model will be sustainable under recurrent levels of RPCMPF.
- The Gippsland region, in collaboration with its metropolitan specialist partners, continues to work towards developing a regional palliative care team.

6.3 Grampians

6.3.1 Background

The Grampians region is serviced by inpatient and community-based palliative care services in:

- Ballarat
- Horsham
- Ararat
- Bacchus Marsh.

The Grampians regional palliative care team (GRPCT), auspiced by Ballarat Health Service provides consultation and education services to the region.

Prior to the RPCMPF, one 0.8 EFT palliative medicine specialist provided services to the Grampians region. The specialist was reportedly operating under an unsustainable workload that manifested itself in a reduced capacity to visit outlying areas of the region. Succession planning was a potential issue for the region.

Table 5: Grampians regional demographics (incl. RPCMPF)

Number of palliative care specialists (EFT in region)	1.8
Number of LGAs	11
Number of GP divisions	3
Geographical area	47,980km^2
Population at 30 June 2007[4]	216,626 (4.2 per cent of Victorian population)
Annual cancer incidence[9] (2004 estimates)	1,069
Annual cancer deaths[10] (2004 estimates)	432
Consortium fundholder	Wimmera Healthcare Group

6.3.2 RPCMPF outputs

6.3.2.1 New specialist medical arrangements

The RPCMPF has contributed to funding an additional full-time palliative medicine specialist in the Grampians region. Ballarat Health Service supplements funding for the position. Nation-wide palliative medicine workforce shortages delayed the appointment until March 2008.

The palliative medicine specialists undertake the following activities:

- providing specialist palliative care services to the eight-bed inpatient palliative care unit in Ballarat and the in-reach consultancy service to Ballarat Health Service
- providing fortnightly teleconferencing and a monthly visit to each of the three regional palliative care services in Bacchus March, Horsham and Ararat
- supporting Maryborough hospital with whom the palliative care service has historical links although it sits outside the Grampians region
- contributing to EPAL, the region's monthly electronic newsletter (each edition contains an article by one of the palliative medicine specialists on an aspect of palliative care relevant to doctors and other palliative care clinicians)
- contributing to the GRPCT regional education program.

The palliative medicine specialists alternate roles on a two-monthly basis with one specialist covering the inpatient palliative care unit and the consultancy service in Ballarat and the other undertaking the regional visits and regional education.

6.3.2.2 Regional upskilling of general practitioners

A palliative care gap analysis survey of approximately 120 general practitioners and registrars in the Grampians region was undertaken by the consortium in 2008. The response rate to the survey was almost 50 per cent and the survey's key findings were:

- The majority of general practitioners (52 per cent) reported that, on average, they would see more than five palliative care patients in a 12-month period (25 per cent reported seeing 10 or more) – this number was higher than expected prior to the gap analysis.
- General practitioners reported palliative care knowledge gaps in:
  - oncological emergencies (72 per cent)
  - end-stage nutrition (59 per cent)
  - child and adolescent palliative care (58 per cent).
- Fifty-seven doctors requested more formal training in palliative care.

The GPCC is working in close collaboration with the Ballarat Division of General Practice's Rural Palliative Care Program to address these gaps. The division's Rural Palliative Care project officer is collocated in the consortium office. This arrangement facilitates the working relationship between the partners. Together, they are developing a training program specifically targeted at general practitioners to address the gaps identified in the gap analysis survey. The palliative medicine specialists had substantial input into the survey's development and will contribute to the delivery of the general practitioner education program.

6.3.3 Outcomes

Funding from a range of sources is being directed towards achieving the aims of the RPCMPF within the region (see section 6.3.6). It is difficult to identify specific outcomes attributable to the RPCMPF; however, a comparison of new palliative care medical assessments undertaken during 2007–08 and 2008–09 shows a 63 per cent increase in the 11-month period following commencement of the new palliative medicine specialist (see Table 6).

Table 6: New palliative care medical assessments

	2007–08 0.8 EFT palliative medicine specialist	2008–09 1.8 EFT palliative medicine specialists
April	16	26
May	13	32
June	17	26
July	21	38
August	8	20
September	16	15
October	13	23
November	17	19
December	14	18
January	22	24
February	12	35
Total	**169**	**276**

Table 7 indicates that medical reviews increased by over 700 per cent over the same period. However, this data includes reviews undertaken by the nurse navigator for the 12-month period from October 2007 to October 2008. The nurse navigator position was a 0.7 EFT position funded by the Grampians Integrated Cancer Service (GICS) to improve referral pathways and continuity of care for cancer patients in the Grampians region. Figures separating out the nurse navigator and medical review consultations were not available for the evaluation.

Table 7: Palliative care medical reviews

	2007–08 0.8 EFT palliative medicine specialist	2008–09 1.8 EFT palliative medicine specialists
April	5	47
May	10	37
June	1	52
July	5	71
August	5	87
September	0	34
October	5	51
November	5	63
December	14	49
January	29	43
February	2	34
Total	**81**	**568**

The palliative medicine specialists reported the following outcomes resulting from the region's new palliative medicine workforce arrangements:

- more rapid response times to new assessments resulting in many Ballarat patients being seen the same day as they were referred
- greater equity of services across the region
- a more collegial working environment for specialists
- a more sustainable working environment
- regional capacity building through increased upskilling of general practitioners
- improved continuity of care for patients and families.

One specialist made the following observation:

> *Previously the service in Ballarat would be great but in the region people would have to wait up to two weeks to be seen and for the specialist to visit them. And then the specialist would need to leave a lot behind in Ballarat [to make the visit].*

As a result of the additional medical workforce capacity, palliative care specialists have a greater capacity to contribute to the GRPCT regional training program. This is a comprehensive training program targeted at a range of health professionals with a high proportion of content that is relevant to general practice. It includes workshops, meetings, seminars, study days and monthly twilight sessions. The program is delivered in locations across the region including Ballarat, Horsham, Bacchus March, Ararat and Stawell. This program is delivered in addition to the targeted general practitioner education program being developed through the Rural Palliative Care Project.

The twilight sessions are available via video-link to clinicians across the region and beyond. Clinicians from Maryborough regularly dial in to these sessions and the team would welcome participants dialling in from other regions across Victoria although a cost-recovery arrangement may need to be established should demand result in additional sessions being scheduled for participants outside the region.

In May 2009 the GRPCT will host a two-day palliative care conference in Creswick. The Grampians palliative medicine specialists are guest speakers at this conference along with a range of Australian and international speakers.

Evaluation of training sessions is conducted by the GRPCT. Five training evaluation summaries were reviewed as a part of this evaluation. In total, 270 participants attended these five sessions and 226 completed evaluations (83 per cent). Two of the sessions were aged-care-specific palliative care workshops, two were twilight sessions on pain and symptom management and one was a pharmacology study day. No data was available on the proportion of participants who were general practitioners. Two of the sessions were held in Horsham and three in Ballarat.

Participants were asked to rate the sessions they attended on a four-point scale of agreement based on the following statements:

- *The session was stimulating.*
- *The session was an appropriate length.*
- *The speaker communicated well.*
- *The speaker was well prepared.*
- *The speaker responded appropriately to my questions.*
- *The content was appropriate for my needs.*

An average of 79 per cent of participants strongly agreed with the above statements with 18 per cent somewhat agreeing. Only 3 per cent disagreed with the statements.

Outcomes of the training program have led to positive outcomes in upskilling palliative care clinicians in the region. A palliative care clinician gave the following example of how attending an education session resulted in an improved outcome for one of his patients:

> **Case example 3:** *I attended one of Greg's (Mewett) sessions on delirium. Two days later I was on the phone to the carer of one of the service's patients. The carer was describing symptoms that were consistent with the ones Greg had talked about in the session. This rang my alarm bells so I contacted Greg who then went to visit the patient. He confirmed that the patient did have delirium and was able to help him.*

6.3.4 Nurse practitioner scoping project

The consortium has identified palliative care nursing workforce issues as a potential barrier to optimal utilisation of the region's palliative care medical workforce.

With the department's approval, the Grampians region will use some of the RPCMPF funds to employ a project worker to identify and develop a scope of practice for a nurse practitioner role in palliative care in the rural/regional community and inpatient setting. A project officer has been appointed and commenced in late March 2009.

6.3.5 Remaining gaps

6.3.5.1 Succession planning

Medical workforce succession planning remains an issue for the Grampians region. A medical scholarship was recently awarded to a Ballarat general practitioner who will undertake a Clinical Diploma in Palliative Medicine with the Royal Australasian College of Physicians. This may result in some alleviation of palliative care workforce pressures in the region.

Ballarat Health Service currently meets three out of six criteria for an advanced regional palliative medicine training post; however, funding has been a barrier to its establishment to date. It is recommended that the region seeks funding opportunities for the establishment of this position.

6.3.6 Inputs

Table 14 in Appendix 2 outlines RPCMPF income and expenditure from January 2007 to June 2009.

Other palliative care funding inputs into the Grampians region include:

- the Cancer/Palliative Care Nurse Navigator project, which was funded by the Grampians Integrated Cancer Service
- supplementary funding of the new palliative medicine specialist by Ballarat Health Service
- the Rural Palliative Care Project managed by the Australian General Practice Network and funded by the DoHA.

6.3.7 Key recommendations for Grampians region

- The Grampians region explores funding opportunities for establishing an advanced palliative care training post at Ballarat Health Service.
- The Grampians region considers making its regional education program/s available to medical practitioners in other rural regions on a cost-recovery basis.

6.4 Hume

The Hume region is supported by a specialist palliative care regional team. Palliative care services are located in:

- Wodonga
- Wangaratta
- Benalla
- Shepparton
- Numurkah
- Seymour.

Table 8: Hume regional demographics (incl. RPCMPF)

Number of palliative care specialists (EFT in region)	0.6
Number of LGAs	12
Number of GP divisions	4
Geographical area	40,000 km^2
Population at 30 June 2007[4]	262,898 (5 per cent of Victorian population)
Annual cancer incidence[9] (2004 estimates)	1,418
Annual cancer deaths[10] (2004 estimates)	593
Consortium fundholder	Northeast Health Wangaratta

6.4.1 RPCMPF outputs

6.4.1.1 New specialist medical arrangements

From March 2007 to December 2008, the RPCMPF was used to purchase palliative care specialist medical services for the Hume region via an arrangement with Barwon Health. This was an extension of a service delivery model that had been established between St Vincent's Hospital and Ovens and King Community Health Service under the leadership of palliative medicine specialist Dr Peter Martin. The links between the Hume region and Barwon Health were formalised when Dr Martin moved from St Vincent's to Barwon Health and the RPCMPF became available.

A service agreement between Barwon Health and Ovens and King Community Health Service Inc. was established to formalise the arrangement. Under the agreement, Barwon Health made available palliative medicine specialists (initially Dr Peter Martin but over time, the role was shared among three palliative medicine specialists from Barwon Health) to provide palliative care services to the Hume region that included:

- secondary telephone consultation (up to 15 hours per month)
- twice-monthly, two-day palliative medicine specialist visits to the region to undertake:
  - face-to-face client visits in conjunction with specialist palliative care services and local medical practitioners
  - secondary consultation for specialist palliative care services and local medical practitioners including telephone and case conference discussions
  - provision of palliative care education (day and evening) to specialist palliative care services, primary care providers and local medical practitioners.

In mid-2008 a Hume regional senior medical officer with substantial experience and interest in palliative care expressed interest in developing a more comprehensive role in palliative care in the region. The medical officer has postgraduate qualifications in palliative care including a Master of Palliative Care (Flinders University) and a Graduate Diploma of Palliative Medicine (University of Melbourne). The consortium viewed that he was well placed to take on the role of palliative care consultant for the region. From June 2008 he was employed one day a week with funding from the RPCMPF. During this time he was supported and mentored by the palliative medicine specialists from Barwon Health.

In December 2008 the service agreement between Barwon Health and Ovens and King was terminated and a new agreement commenced between Barwon Health and North East Health Wangaratta as the consortium fundholder. Under this agreement Barwon Health will offer a reduced service to the Hume region. It will focus on secondary telephone support to the palliative care consultant and other general practitioners in the region via the palliative care consultant. The twice-monthly visits to the region by the Barwon Health palliative medicine specialists no longer form part of the agreement. It is not clear whether this new agreement has been formalised via service agreement or a memorandum of understanding, or if it is a verbal agreement only.

From February 2008 the palliative care consultant was offered an extension of his role by two days a week, bringing his total number of days to three days. This was partially funded through surplus RPCMPF funds.

The palliative care consultant's role includes:

- face-to-face visits to clients with complex palliative care needs across the Hume region (visits take place in patients' homes, in hospital or in RACFs)
- attending case management meetings
- providing formal education sessions as well as informal education, professional development and consultative support to medical practitioners, health professionals and the Hume communities
- meeting with local general practitioners and divisions of general practice
- acting as a local palliative care resource for the region
- providing telephone consultancy to community palliative care sites across the region
- collaborating with other medical specialists in the region such as those at Goulburn Valley Health and Murray Valley Private Hospital
- networking with the Border Collaboration Cancer Services and other similar services
- facilitating the professional journal club including providing journal articles that are then filed as local resources.

In the short to medium term it was anticipated that the region would continue to have some support through Barwon Health but that this would phase out over time as the palliative care consultant expands his local role and networks. However, there is insufficient funding under the RPCMPF to sustain his employment at the current level beyond June 2009 and the consortium is currently exploring options for sustaining the model after this time.

6.4.1.2 Regional upskilling of general practitioners

During 2007–08, each of the fortnightly visits from the Barwon Health palliative care specialist medical team involved delivering an evening education session for general practitioners in addition to a daytime education session for other primary health care providers. These sessions were advertised through the monthly newsletter produced by the Hume palliative care consultancy team and distributed electronically to nearly 200 recipients including divisions of general practice, palliative care sites, primary care workers and aged-care facilities.

Case conferencing education sessions were provided by the Barwon Health team at general practice clinics around the region. Taking the consultancy service to the general practice workplace reduced the travel time for general practitioners and engaged with them in their workplace. This approach has been continued by the new palliative care consultant in 2009 and has been found to be a highly effective educational tool for general practitioners, particularly in cases where they have a current palliative care case for discussion. Secondary telephone consultation support has also provided a mechanism for upskilling general practitioners.

6.4.2 Outcomes

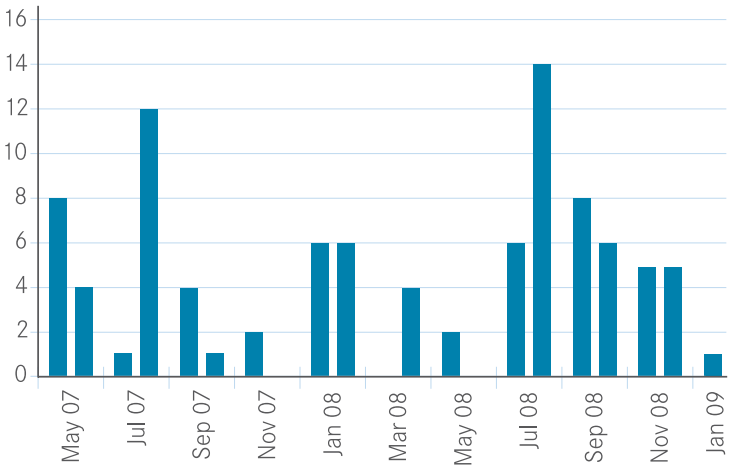
6.4.2.1 Barwon model

Fortnightly visits to the Hume region by the Barwon Health palliative medicine specialists rotated around the region with doctors attending each of the six locations approximately every three months.

While data on the specialist visits was collected at all sites, intermittent workforce shortages across the region impacted on the completeness of the datasets collected. A complete dataset from Benalla was available for the purposes of the evaluation.

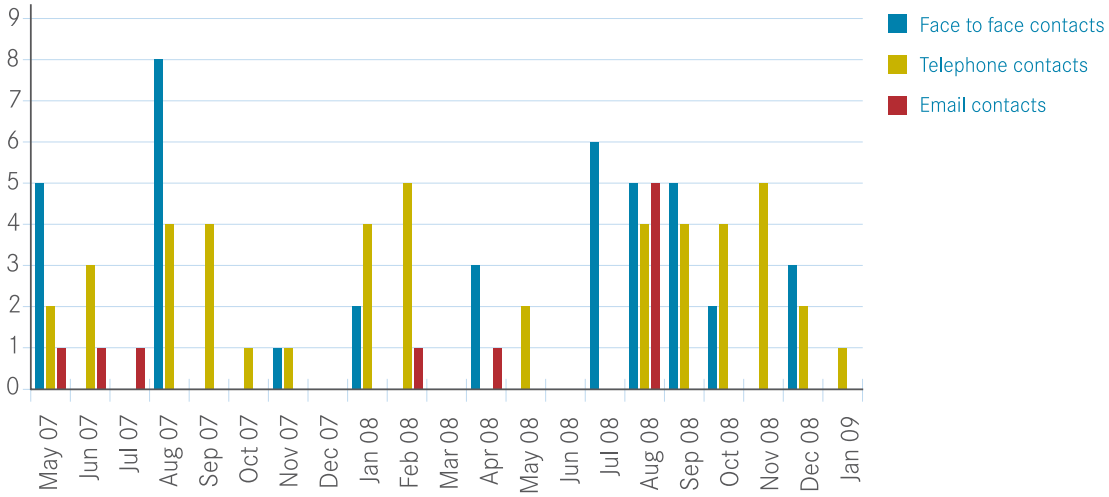
Figures 5 and 6 show the number and type of specialist contacts in Benalla between May 2007 and January 2009. Figure 5 includes contacts of all types: face-to-face, telephone or email. The chart shows high levels of activity during scheduled visits and busy periods of telephone consultation between scheduled visits.

Figure 5: Number of patient contacts–Benalla May 2007 to January 2009



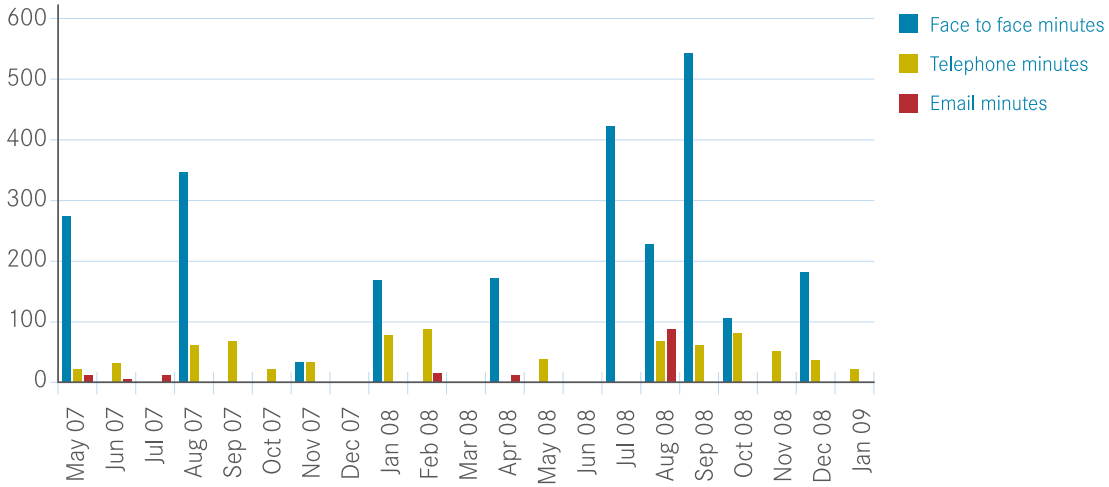
Face-to-face contacts shown in Figure 6 reflect the scheduled visits to Benalla between May 2007 and December 2008 plus two unscheduled visits in August and October. These additional visits were made in order to assist with complex cases that the palliative care service was managing at those times. The specialists visited Benalla after they had completed their scheduled visits to another site in the Hume region. This supports interview findings regarding the high level of responsiveness and goodwill of the Barwon Health specialists.

Figure 6: Contacts by type–Benalla



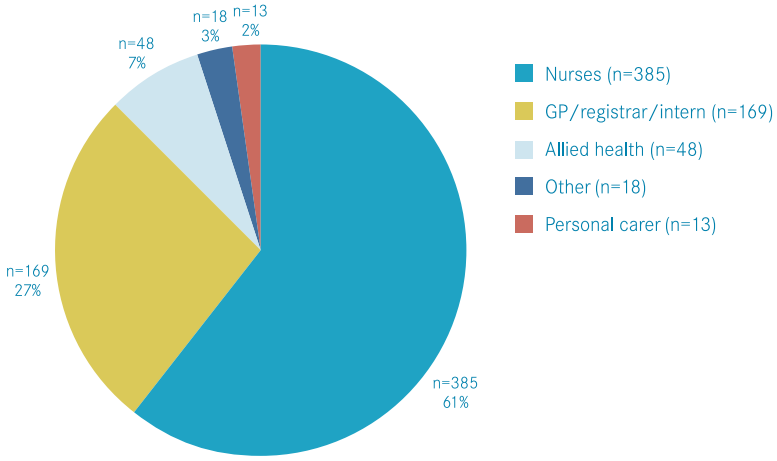
A comparison of Figures 6 and 7 shows that contact via telephone is a time-efficient method of providing palliative care support. While the number of telephone contacts is only slightly more than the number of face-to-face contacts (see Figure 6), the time spent undertaking face-to-face contact is significantly greater than the time devoted to telephone contact (see Figure 7). However, stakeholders report that face-to-face contact result in good outcomes in terms of direct patient care and upskilling of clinicians that results from joint consultations. Email was the least used method of contact recorded.

Figure 7: Contact time (minutes) by contact type–Benalla



In addition to their clinical contacts the Barwon Health palliative medicine specialists conducted 37 education sessions in the Hume region in 2008. These sessions were primarily aimed at medical and nursing staff but were also available to primary care providers from other sectors. Of the 633 participants, 169 (27 per cent) were general practitioners, registrars or interns. Figure 8 shows participants by occupation.

Figure 8: Participants of Hume 2008 consultant education sessions by occupation



Education sessions were conducted in 16 locations around the region as outlined in Table 9.

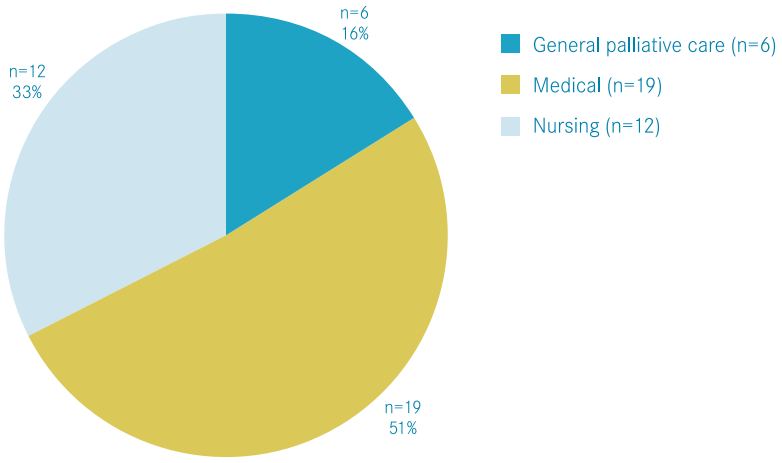
Table 9: Locations and number of sessions

Location of education sessions	Number of sessions held
Benalla	7
Wodonga	6
Wangaratta	5
Seymour	4
Mansfield	3
Shepparton	2
Alexandra	1
Beechworth	1
Cobram	1
Corryong	1
Euroa	1
Kilmore	1
Milawa	1
Myrtleford	1
Numurkah	1
Rushworth	1
Total	**37**

Fifty-one per cent of the consultant education delivered covered medical topics (see Figure 9) including:

- pain and nausea management
- palliative care approach in general practice
- complex end-stage palliative care
- opioid rotation/hyperanalgesia
- Q&A sessions
- case discussion and reviews
- update on palliative care
- if good palliative care prolongs life
- advance care planning
- respecting patient choices
- ethical decision making
- palliative care emergencies.

Figure 9: 2008 consultant education session topics



Nursing and general education topics included:

- palliative care emergencies
- pharmacology and medication management
- case study discussion
- advances in oncology
- advance care planning
- nutrition and hydration in terminal care
- assessing and managing patients' long-term palliative care needs
- clinical management issues
- case management
- clinical updates
- advances in palliative care.

No quantitative data was available on secondary telephone consultation; however, Barwon Health clinicians estimated that around 12 telephone calls per week were made by Hume palliative care clinicians to the Barwon team for secondary consultation during 2008. Of these, an average of eight calls were made by palliative care nursing staff and four by general practitioners.

One general practitioner in the region reported that the number of calls he makes to the Barwon Health specialists had decreased from 'several calls per year to once or twice per year' because of the increase in his palliative care expertise as a result of the program. The general practitioner also indicated that he believed the palliative care skills of the clinical nurses had improved as a result of the program.

Another outcome identified by this general practitioner results from the palliative medicine specialists' capacity to visit patients at home during their regional visits. He reported that previously some of these patients would almost certainly have had to go to Melbourne or Geelong for management.

Another general practitioner said:

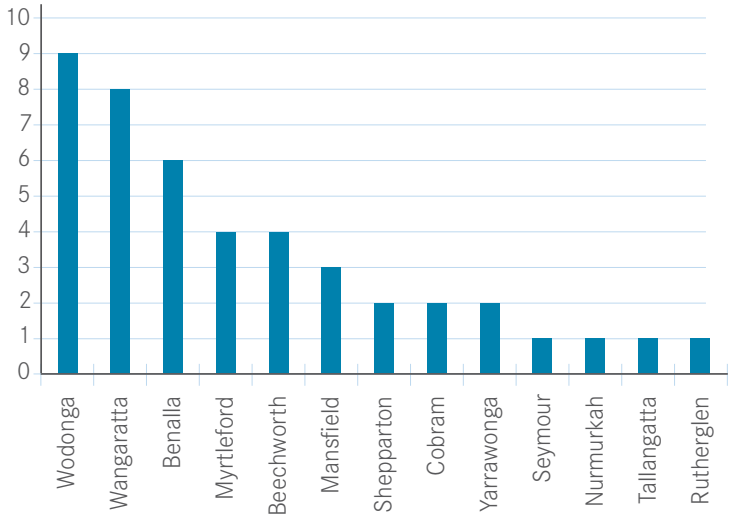
> *The clinical case meetings and dinner were a great educational tool. They were also a networking tool (that facilitated) getting to know them (the doctors) then feeling comfortable to phone them.*

6.4.2.2 Outcomes since June 2008

Since commencing in June 2008 the Hume palliative care consultant has had a gradually increasing caseload, involving provision of consultant palliative care medical services across the region. As well as travelling to sites as needed, the consultant phones sites on a weekly basis. He has established educational initiatives such as a journal club and an education program in the east of the region. He is also setting up online discussions.

Figure 10 shows the number of visits the palliative care consultant has made to towns across the region between June 2008 and March 2009.

Figure 10: Palliative care consultants visits to towns across Hume region– June 2008 to March 2009



Activities undertaken in these visits have included:

- patient assessment and visits to patients in hospital, RACFs and at home
- attendance at weekly multidisciplinary team meetings
- attendance at family meetings and case review meetings
- monthly journal club in Wangaratta and Wodonga
- delivery of palliative care educational sessions.

In addition, he provides telephone consultation to general practitioners and palliative care staff across the Hume region.

Hume general practitioners acknowledge that the new RPCMPF arrangements allow for the regional palliative care consultant to provide a greater number of palliative care medical hours and, importantly, a permanent primary consulting presence within the region. However, they expressed some disappointment regarding the diminished direct networking and contact opportunities with the Barwon Health specialists that was established under the previous model. They would prefer a continuation of quarterly or half-yearly education sessions delivered to the region by the Barwon Health specialists as well as continued access to direct secondary telephone consultation from them.

6.4.3 Gaps remaining

The new palliative care medical arrangements in the Hume region have, in effect, only been in place since March 2009 as the palliative care consultant was on leave during January and February 2009. For this reason it is too early to assess the impact on the region. However, potential risks of the new model may include:

- gaps in medical cover when the palliative care consultant is on leave (there is no established source of replacement primary consultation cover on these occasions)
- succession planning – this risk is enhanced by the lack of financial sustainability of the current arrangements (supplementary employment opportunities or additional funding for the palliative care position from other sources (as has occurred in other regions) may enhance the viability of the current arrangement; however, at the time of the evaluation, such opportunities had not emerged)
- the reduction in input to the region from the Barwon Health specialists could result in a dilution of the strong networks and partnerships between Hume clinicians and Barwon palliative medicine specialists that were established under the original model
- the collegial environment that existed with the Barwon team regularly coming into the region may not be as easily replaced with a single palliative care doctor providing services to the entire region (this could result in isolation of clinicians within the Hume region form the network of palliative medicine specialists that exist in other regions)
- uncertainty as to whether the new arrangements will satisfactorily replace the level of expertise that the Barwon palliative medicine specialists were able to contribute to the region, most particularly through the regular, formalised education sessions (the general practitioners were not aware of other education programs available in rural areas such as the training program offered by the Grampians regional palliative care team).

6.4.4 Inputs

Table 15 in Appendix 2 outlines RPCMPF income and expenditure from January 2007 to June 2009.

Another palliative care funding input into the Hume region is PEPA. One local general practitioner has undertaken a clinical attachment in Bendigo and another with Barwon Health under PEPA.

6.4.5 Key recommendations for Hume region

- The Hume region formalises and strengthens its consultation arrangements with Barwon Health or another appropriate service in order to provide specialist palliative medicine through re-establishing a service agreement or memorandum of understanding.
- The Hume region continues to work towards creating a viable and sustainable model of specialist palliative care medical service delivery.

6.5 Loddon Mallee

6.5.1 Background

The Loddon Mallee region is served by palliative care services in:

- Bendigo
- Castlemaine
- Echuca
- Kyneton
- Maryborough
- Mildura
- Swan Hill.

Prior to the RPCMPF's implementation, a 0.2 EFT palliative medicine specialist was funded by the Bendigo Health Care Group (BHCG) to provide services to Bendigo Hospice clients. There were no funded palliative medicine services to community palliative care patients, acute hospital inpatients or residential care clients in Bendigo. However, the palliative medicine specialist provided some of these services in an unfunded capacity.

A general practitioner in Castlemaine with an interest in palliative care provided some support to the Mount Alexander Community Palliative Care Service. A limited telephone consultation service was funded by Loddon Mallee palliative care and staffed by the Castlemaine general practitioner and the Bendigo palliative medicine specialist. This service was available across the region but, apart from this, there were no palliative medicine services outside Bendigo.

A specialist palliative care clinic model, using medical funding from the RPCMPF was first established in Mildura in February 2007. Since that time, the consortium has faced a range of workforce, governance and other issues that have impacted on the timing of implementing the fund in other parts of the region. As a result, implementation of the RPCMPF in Bendigo did not commence until October 2008. Implementation in other parts of the region, commencing with Echuca, is planned for the coming months.

Table 10: Loddon Mallee regional demographics (incl. RPCMPF)

Number of palliative care specialists (EFT in region)	0.4
Number of LGAs	10
Number of GP divisions	5
Geographical area	58,965 km^2
Population at 30 June 2007[4]	307,810 (5.9 per cent of Victorian population)
Annual cancer incidence[9] (2004 estimates)	1,706
Annual cancer deaths[1] (2004 estimates)	692
Consortium fundholder	Mount Alexander Hospital

6.5.2 RPCMPF outputs

6.5.2.1 New specialist medical arrangements in Mildura

Since February 2007 a palliative care specialist from the Peter MacCallum Cancer Centre (usually Dr Odette Spruyt, head of Pain and Palliative Medicine) has been funded under the RPCMPF to provide palliative care services to the Mildura Specialist Palliative Care Clinic. A formal partnership between Peter MacCallum Cancer Centre and Mount Alexander Hospital (as the fundholder for the Loddon Mallee palliative care consortium) was established under a services agreement between the two organisations.

Under the agreement, the palliative medicine specialist provides 12 hours of palliative care services to the Mildura community per month. This consists of:

- leading a palliative care outpatient clinic in Mildura one day per month (the clinic is run from the Monash University Mildura Regional Clinical School and involves assessing new patients and reviewing and managing current patients)
- providing teleconference support for a specialist palliative care nurse-led clinic once a month
- providing additional teleconference support once a fortnight.

Additional education sessions, liaison with general practitioners and completion of discharge correspondence also form part of the palliative medicine specialist's role.

In Mildura, rapid implementation of the RPCMPF was facilitated by:

- work commenced prior to the RPCMPF becoming available including appointment of a project coordinator and advisory group to establish the Mildura clinic
- availability of two palliative medicine specialists who were keen to offer their services to the region.

6.5.2.2 New specialist medical arrangements in Bendigo

Since October 2008 the RPCMPF has funded the palliative medicine specialist in Bendigo to provide an additional 12 hours of palliative care services to the Bendigo region per month. A formal partnership between the BHCG and Mount Alexander Hospital has been established under a services agreement between the two organisations.

The arrangements include:

- weekly attendance by the palliative medicine specialist at the multidisciplinary palliative care meetings at which all new clients and some review clients are discussed
- one to two home visits per week (the number of home visits is dependent on patient complexity) – these visits are mostly conducted with the community palliative care nurse and patients are prioritised according to their level of need as assessed by the community palliative care service coordinator
- secondary telephone consultation
- additional education sessions, liaison with general practitioners and completion of discharge correspondence.

The Bendigo model differs from the Mildura model of service delivery in that:

- the palliative medicine specialist works within the region in palliative care and oncology
- palliative medicine specialist primary consultation is provided on a weekly basis (three hours a week)
- services under the RPCMPF are not provided via an outpatient clinic model but rather via consultation at various locations including patients' homes.

6.5.2.3 Regional upskilling of general practitioners

In Mildura, general practitioner engagement with the palliative care clinic has been high. More than 50 per cent of Mildura general practitioners have referred patients to the clinic since it began.[10]

The Bendigo community palliative care team has established links with the Bendigo Division of General Practice, which has been implementing the Rural Palliative Care Project since October 2008. One of the project's aims is to increase engagement with general practitioners in palliative care through promoting general practitioner participation in the Bendigo palliative care multidisciplinary meeting. The Bendigo community palliative care coordinator is a member of the project working party.

A Bendigo general practitioner has received a medical scholarship and has commenced a Master of Palliative Care through Flinders University.

6.5.3 Outcomes

6.5.3.1 Outcomes in Mildura

Twenty-six clinics were held in Mildura between February 2007 and March 2009. In that time the clinic has provided consultation to 65 new patients and 101 review patients – 166 patients in total (see Figure 11). New referrals to the clinic have been made by general practitioners (n=59) and hospital medical officers (n=6).

10 Campbell, B., 2007, Mildura Specialist Palliative Care Clinic Project – final report Loddon Mallee Strengthening Palliative Care Consortium.

Figure 11: Number of Mildura palliative care clinic patients– February 2007 to March 2009

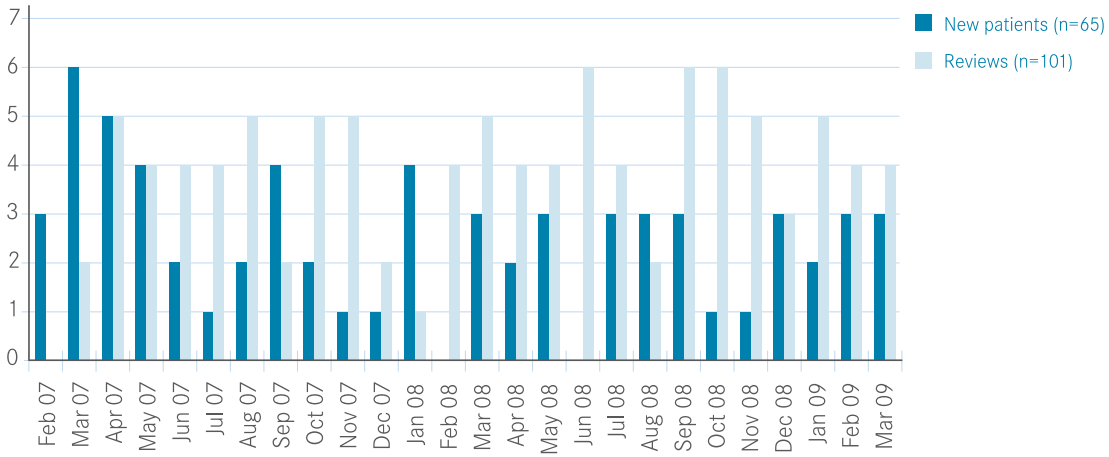
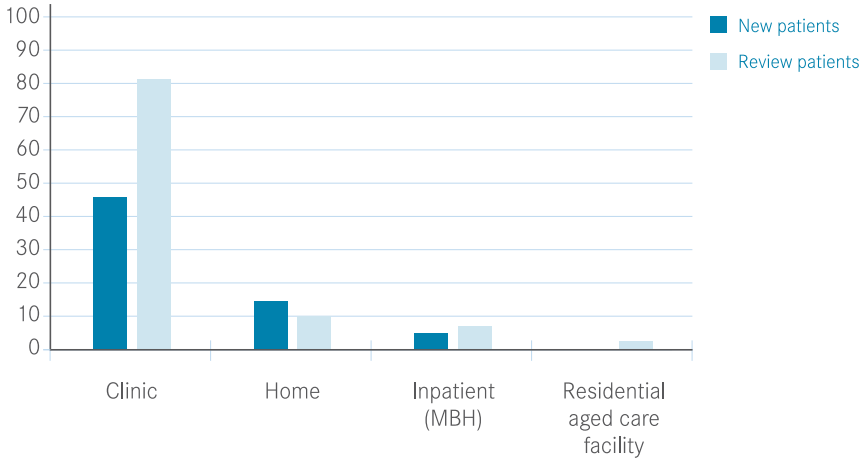


Figure 11 indicates a slight overall increasing trend in the total number of patients with a trend towards fewer new patients and more review patients.

Patients were seen in a range of locations including the outpatient clinic (77 per cent), their homes (15 per cent), Mildura Base Hospital (7 per cent) or RACFs (1 per cent). Figure 12 shows a higher proportion of new patients (21 per cent) were seen at home compared with review patients (12 per cent seen at home or in RACFs). Interview data suggests this is because new patients to the clinic tend to be less well than review patients. This is supported by the data on patient phase at consultation (see Figure 13).

Figure 12: Location of Mildura clinic consultations



Data on patients' illness phase at consultation for 13 new and 27 review patients seen in the Mildura clinic over a six-month period was provided by clinic staff. Figure 13 shows that a higher number of new patients seen in the clinic were in a deteriorating phase at the time of their consultation than those in either a stable or unstable phase. Review patients were more frequently in a stable or unstable phase rather than a deteriorating phase at the time of consultation.

Figure 13: Phase at consultation

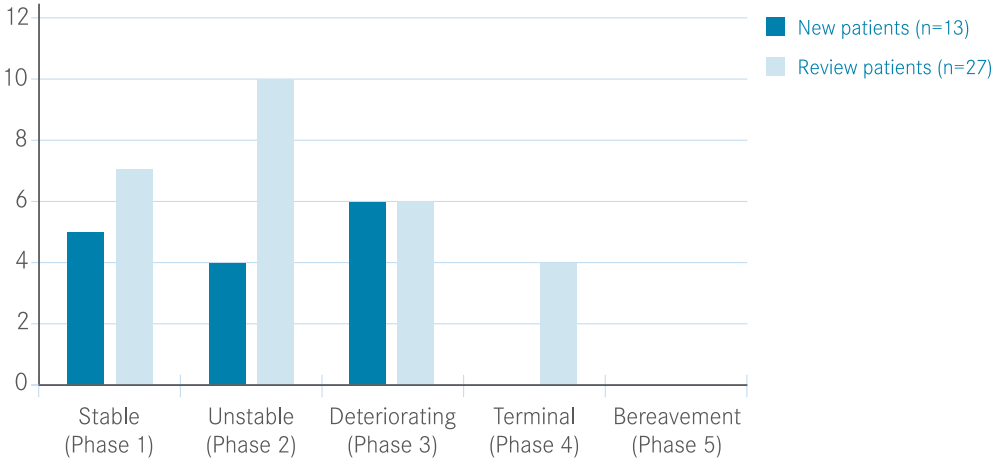
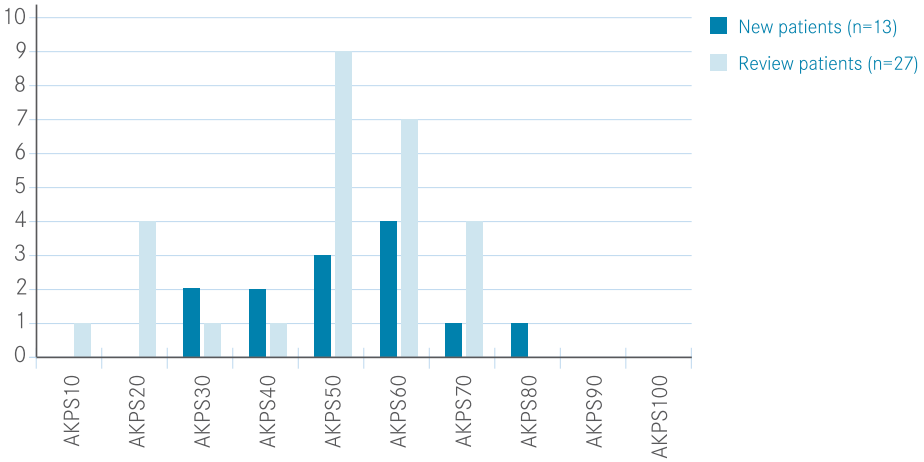


Figure 14 presents Australian Karnofsky Performance Scale (AKPS) for the same 13 new and 27 review patients. The AKPS is used to assess patient functioning and performance.[11] Interestingly, this chart shows that the performance status of new patients is skewed towards higher scores than review patients. Higher scores are indicative of a better performance status (see Appendix 3 for definitions of AKPS scores).

Figure 14: Australian Karnofsky Performance Scale (AKPS) at consultation



11 Abernethy, A.P., Shelby-James, T., Fazekas, B.S., Woods, D. and Currow, D.C., 2005, 'The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice' [electronic version]. BioMed Central Palliative Care, 4, 1–12.

There is mixed evidence regarding the clinic's impact in upskilling general practitioners in the region. One indicator that general practitioners skills in palliative care might be improving would be an overall improvement in comprehensive referral of new patients to the clinic. However, interview data suggests this is not the case.

In addition to clinic consultations, 82 scheduled weekly teleconferences between the palliative medicine specialist and Mildura palliative care staff were held. An estimated 30 unscheduled teleconferences of up to 10 minutes were also held.

Access to new medications for Mildura patients has reportedly improved since the clinic was established.

The following two case studies illustrate outcomes for two clients and their families:

> **Case example 4:** *Mark, a 44-year-old policeman was diagnosed with cancer of the pancreas. He was being cared for at home by his mother, Shirley, who was in her late seventies. When Mark developed delirium it was thought he may have to be moved to hospital. This would not have been either Mark's or his mother's wish. After consultations with the palliative medicine specialist, Mark's GP introduced nocte haloperidol, which was highly effective in dealing with Mark's delirium. Mark died peacefully at home with his mother.*

> **Case example 5:** *June, a lady in her early seventies, was diagnosed with cancer of the stomach. In the terminal phase of illness, June was semi-conscious and being nursed by her family. June had expressed her wish to die at home and her family wanted to respect this. She became unconscious and started to discharge large amounts of brown fluid from her mouth. The family was extremely distressed by this situation. June's nurse contacted the palliative medicine specialist in Melbourne by telephone. The specialist advised that inserting a naso-gastric tube may alleviate the distressing symptoms and prevent a large vomit at the time of death. This was considered a highly interventional procedure in view of her imminent death and there was a great deal of apprehension experienced by the clinicians involved. Because the medical specialist had met June in the clinic and her relationship with the nursing team was well established, the nurses agreed to pass the naso-gastric tube. This was done without difficulty and was well tolerated by June. Her symptoms were alleviated and the situation made more manageable and tolerable for the family. June died peacefully within 24 hours in her own home. For the family, being able to fulfil her wishes to die at home was extremely helpful in their bereavement. Similarly, for the nursing team, there was great satisfaction in being able to effectively relieve June and her family's distress and facilitate her dying at home. This was achievable as a result of specialist involvement in her management.*

The palliative medicine specialist delivers regular formal education sessions during visits to the region. Nine formal education sessions have been held in which participants have included general practitioners, community nurses, acute sector staff, allied health professionals and Aboriginal health service staff. An estimated six informal education sessions were also held.

6.5.3.2 Outcomes in Bendigo

Data from the Bendigo clinic is available from November 2008 to February 2009. During that period, 221 palliative medicine specialist consultations were recorded. Data on patient status (new or review) was available for 154 patients. Of these patients, 36 (23 per cent) were new patients and 118 (77 per

cent) were review patients. Diagnosis data was available for 174 patients. Of these, 164 (74 per cent) had a malignant illness and 10 (5 per cent) had a non-malignant illness.

Figure 15 shows the mode of consultation. Seventy-three consultations (33 per cent) were delivered via telephone contact with health professionals including palliative care staff, district nurses, hospice staff, medical specialists, allied health staff, pharmacists and acute hospital staff. Fourteen telephone consultations with general practitioners were recorded as well as 37 direct consultations with patients and/or carers. Twenty consultations (9 per cent) were delivered face to face.

Ten per cent (4.25 hours) of the palliative medicine specialist's time was spent travelling. The additional funded hours have also enabled the specialist to undertake more bereavement work and visits to RACFs, which was not possible prior to the RPCMPF.

Figure 15: Mode of consultation delivery

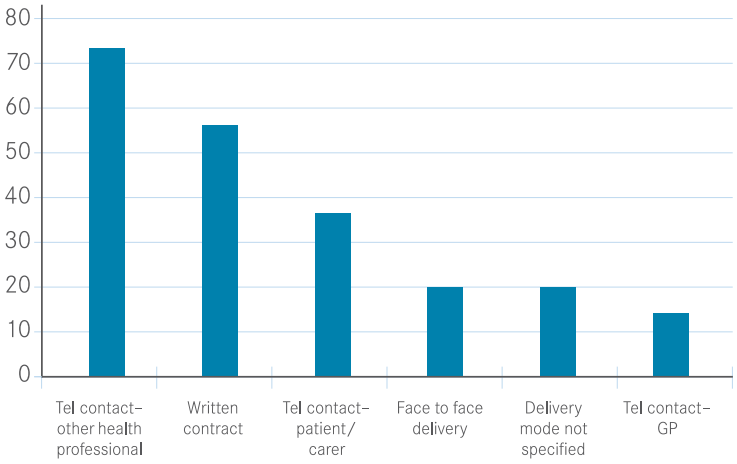


Figure 16 shows the number of new and review patients by phase at consultation. More new and review patients were in an unstable phase of their illness at the time of their consultation than were stable, deteriorating or terminal. Only two patients were recorded as receiving palliative care consultation for the first time in the terminal phase of their illness with most new patients having been seen prior to the terminal phase of their illness.

Figure 16: Number of new and review patients by phase at consultation

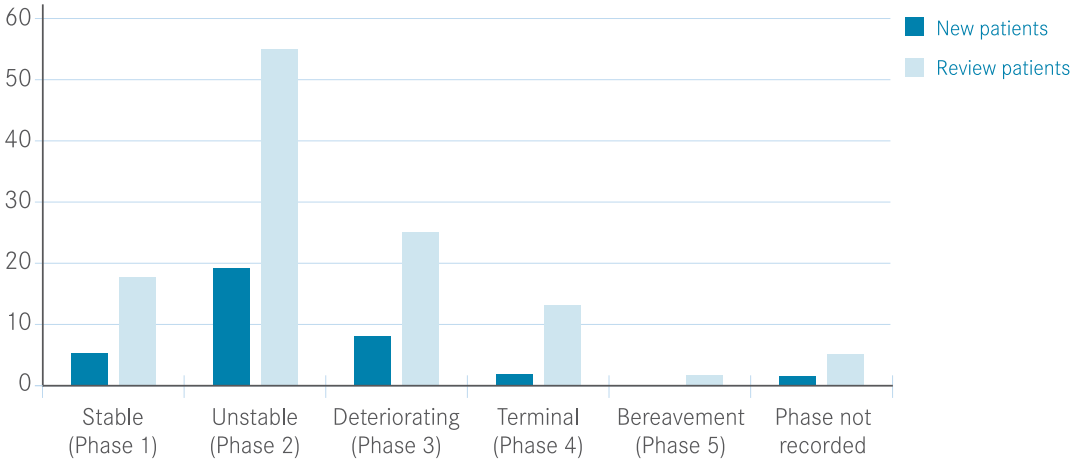
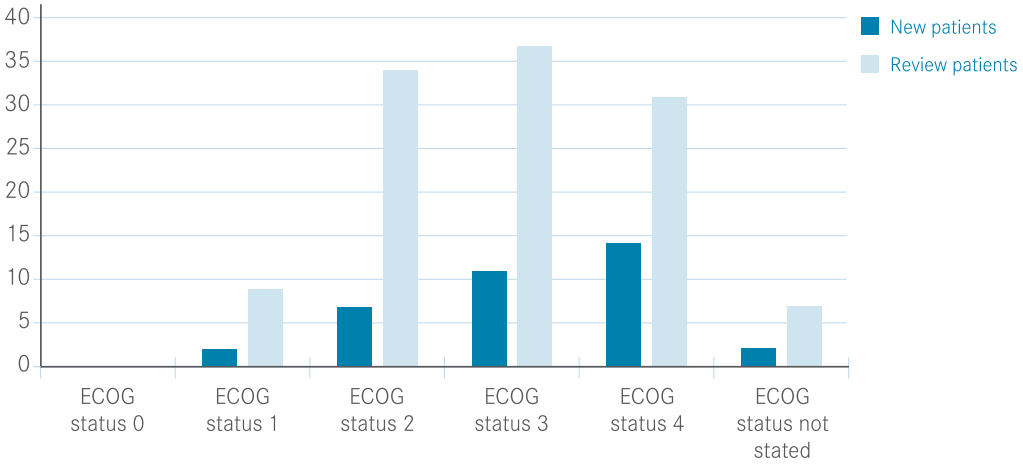


Figure 17 shows the number of new and review patients according to their ECOG performance status at consultation. ECOG performance status is a scale of performance status developed by the Eastern Cooperative Oncology Group (ECOG). It is used to assess disease progression and how this affects the daily living abilities of the patient.12 (See Appendix 3 for an explanation of ECOG scores.) Figure 17 shows that the status of new patients is skewed towards higher scores than review patients. Higher scores reflect a poorer performance status. The higher performance status of review patients may be a reflection of positive outcomes from previous palliative care and other interventions received by this group of patients.

Figure 17: ECOG status of new and review patients at consultation



The palliative medicine specialist attended 14 weekly multidisciplinary palliative care team meetings between November 2008 and February 2009. During this time, one Bendigo general practitioner attended the meeting in person and three others linked in to the meeting via teleconference as a result of the Bendigo Division of General Practice's Rural Palliative Care project. Although not formalised, anecdotal feedback obtained by the division indicates that general practitioners find participation in the meeting highly worthwhile. They reported improved outcomes for these patients as a result.

In one case, a patient had not seen his general practitioner for two years. The general practitioner was contacted by the divisional project officer and invited to join the patient discussion at the multidisciplinary meeting. Through the discussion, the general practitioner was able to fill in the gaps in his information about the patient. The patient will be returning to his general practitioner for ongoing management. In another teleconference, the palliative care specialist was able to answer the general practitioner's specific medication questions.

6.5.3.3 Other outcomes

Interviewees report benefits of both the Bendigo and Mildura models in upskilling palliative care nurses through joint home visits and clinics.

12 Oken, M., Creech, R., Tormey, D., Horton, J., Davis, T., McFadden, E., Carbone, P., 1982, 'Toxicity and response criteria of the eastern cooperative oncology group', Am J Clin Oncol 5:649–655.

Improved patient continuity of care is illustrated by the Mildura case studies and supported by interviewees in Bendigo and Mildura. The Bendigo palliative medicine specialist has used some of her additional time to telephone or visit patients who have been too unwell to visit the hospital. For one of these patients, the specialist's home visit averted an ambulance trip to the hospital which could have been followed by a long wait in the emergency department. Instead, the palliative medicine specialist dealt with the patient's immediate pain management issues at home and liaised with the Bendigo radiotherapy unit to streamline arrangements for a course of treatment for him.

6.5.4 Gaps remaining

6.5.4.1 Cover for doctors on leave

In Mildura, Dr Spruyt can be covered by other palliative care specialists from Peter Mac when she is not available. In Bendigo, there is no medical coverage when the palliative medicine specialist is on leave.

6.5.4.2 Services to other areas within Loddon Mallee

Medical services under the RPCMPF are yet to be established in other areas of Loddon Mallee. The consortium is currently finalising a service agreement with the Bendigo Healthcare group to provide outreach services to the Echuca region under the RPCMPF. Models for delivery of medical services to Kyneton, Maryborough, Swan Hill and Castlemaine under the RPCMPF are currently being developed.

6.5.5 Inputs

Table 16 in Appendix 2 outlines RPCMPF income and expenditure from January 2007 to June 2009.

Other palliative care funding inputs into the Loddon Mallee region include:

- specialist travel and accommodation is funded under the Medical Specialist Outreach Assistance Program (MSOAP)[13]
- Sunraysia Community Health Service funds other Mildura clinic costs including the clinical nurse consultant
- BHCG funds 0.2 EFT palliative medicine specialist time
- Sunraysia Community Health Service funds the non-medical costs of the Mildura clinic.

The indication from the consortium's projected budget to 2010 (as yet unendorsed) is that there are adequate funds to furnish the rest of the region with specialist consulting services as part of the RPCMPF.

6.5.6 Key recommendations for Loddon Mallee region

- The Loddon Mallee region continues to examine and explore options for expanding services to areas in which specialist palliative care medical services have not yet been established.

13 MSOAP is a national program funded by the Australian Government's rural health strategy under the Rural Specialist Support Program. It aims to increase access to specialist medical services in rural, regional and remote communities.

7 Program logic models

This section summarises the models implemented in each region, presented in a program logic framework.

Table 11: Barwon South Western – expansion of existing medical workforce

Model elements	Baseline (pre-RPCMPF)	Aims	Inputs	Outputs	Outcomes	Barriers
Increased EFT for existing palliative medicine specialist in the South Western area	0.45 EFT palliative medicine specialist	Increased provision of staff education, in-reach and community consultancy, input to weekly palliative care meetings, supervision of medical students and PEPA placements Input to service development and attendance at regional and statewide meetings	RPCMPF allocation from January 2007 to June 2009 as outlined in Appendix 2 Funding of the director of palliative medicine role by South West Healthcare (0.45 EFT) Medical scholarship fund	0.05 EFT increase for South Western palliative medicine specialist	Evidence of increased time on advance care planning, education and travel to more remote parts of region Support to regional GPs including preparation of monthly newsletter for local GPs	Succession planning remains an issue – number of funded hours a barrier to attracting/retaining palliative medicine specialists Based on current figures, this could be facilitated in a sustainable way through a further small increase in expenditure on medical services under the RPCMPF
Increased EFT funding for GP palliative care positions	GPs in Hamilton and Portland each funded for 0.05 EFT (2 hours) palliative care service provision	Increase palliative care services to local communities Provide opportunities for succession planning for senior staff positions		Hamilton GP EFT increased by 4 hours/week Portland GP EFT increased by 3 hours per week	Case studies outline examples of improved outcomes for palliative care patients as a result of better support available for GPs	Delayed implementation as a result of processes for increasing GP hours
Regional collegial professional development for South Western palliative care doctors	No funding for infrastructure, training or professional development for medical staff	Enhance capacity for medical staff to engage in professional development activities without compromising direct care priorities		Specialist attended six collegial Professional development days GPs attended collegial professional development days One applicant to medical scholarship fund	All funded palliative care doctors deliver training to other palliative care staff in the region	
Formalised GP clinical attachment programs	No funding for training or professional development	Enhance GP workforce development and training		Some clinical attachment placements completed	KPIs on clinical attachments not met.	Demands on Portland medical officer's time have compromised capacity to meet palliative care commitments
Formalise links, networks and partnerships	High engagement with local GPs in Barwon region			Enhanced relationship with Otway Division of General Practice	Otway Division Rural Palliative Care Project underway	
Employ Project Manager during six-month development phase		Maximise potential for sustainability of the program through employing a project manager		GPAG project manager and CEO funded for scoping of GP interest	Two GPs in the South Western area identified for further support and development under the RPCMPF	Difficulties recruiting project manager – delay in project start GPAG links less effective than expected

Table 12: Gippsland logic model – integrated clinical and educational model

Model elements	Baseline (pre-RPCMPF)	Aims	Inputs	Outputs	Outcomes	Barriers
Purchase of palliative medicine specialist hours	No palliative medicine specialist hours in the region	Fund palliative medicine specialist hours in the region	RPCMPF allocation from January 2007 to June 2009 as outlined in Appendix 2 Medical scholarship fund GRICS funding of GP project officer position	Palliative medicine specialist hours purchased – focussed on GP education and secondary telephone consultation	GPs reported they would be more likely to contact specialists for secondary telephone consultation after meeting them Case review process reported as being an effective educational tool, particularly for difficult/ complex cases Case review sessions have encouraged nurses to focus on their practice and formed the basis for practice improvement PICD audit completed – pilot implementation to commence	Partnerships slow to establish Commenced 2008
Partnerships between local palliative care services, GRICS, GP divisions and specialist metropolitan facilities	Informal relationships and arrangements for accessing palliative medicine specialists services from metropolitan services	Documented processes for linking to metropolitan specialist palliative care services		Partnerships and MOUs in place with GP divisions and specialist metropolitan palliative care services		
Training to upskill GPs	Some GPs with formal qualifications in palliative care providing services within the region	Increase in the number of palliative care trained GPs across the region		11 GPs have commenced tertiary studies funded through the medical scholarship fund Education sessions conducted in more than 10 centres across the region since July 2008 by metropolitan specialist partners		Participation in education sessions and case reviews lower among GPs than other health professionals
Mentoring		Develop mentoring strategy		Mentoring and training to be implemented as part of PICD implementation		
Development of next steps in model's evolution		Pilot of primary consultation model in Gippsland region		Primary consultation concept endorsed by consortium with aim to commence implementation prior to 30 June 2009		Consultation model and location to be negotiated

Table 13: Grampians logic model – appointment of a full-time palliative medicine specialist

Model elements	Baseline (pre-RPCMPF)	Aims	Inputs	Outputs	Outcomes	Barriers
Appointment of an additional full-time palliative medicine specialist (supplemented with funding from Ballarat Health Service)	0.8 EFT palliative medicine specialist – role includes clinical, educational and strategic planning as well as after-hours' support – not sustainable	Sustainable service delivery model Succession plan developed	RPCMPF allocation from January 2007 to June 2009 as outlined in Appendix 2 Ballarat Health Service supplementary funding of PMS DoHA funding of GP project officer via Rural Palliative Care Program GRICS nurse navigator project	Employment of additional palliative care specialist in the region Increased service capacity for Ballarat and support for regional services Increased capacity to contribute to regional education program	60 per cent increase in new assessments from 2007–08 to 2008–09 More rapid response times Greater equity of services across the region More collegial working environment for specialists Regional capacity building – upskilling of GPs and non-medical PC staff	Delay in recruiting palliative care specialist due to national workforce issues – commenced March 2008
Submit proposal to College of Specialists for accreditation of Ballarat Health as training post	No training position in Ballarat	Further strengthen medical workforce through establishing advanced training position in Ballarat	Further exploration of funding sources required	Currently meet three of six criteria to apply for accredited training position		Ongoing funding for training position
GP palliative care gap analysis survey by GPCC	Gaps in GP palliative care knowledge and need for further training identified	Increased education and skill development and additional clinical support for local GPs	One GP recipient of Rural Medical Scholarship to undertake Clinical Diploma in Palliative Medicine	Collaboration with Ballarat Division of GP Rural Palliative Care Project	Targeted GP training program developed to address gaps identified through GP survey	
Nurse practitioner scoping project	Nursing workforce issues pose potential barrier to optimal utilisation of medical workforce	Identify and develop scope of practice for palliative care nurse practitioner	Some RPCMPF money invested	Appointment of project officer to March 2009		

Table 14: Hume – collaborative, multidisciplinary approach

Model elements	Baseline (pre-RPCMPF)	Aims	Inputs	Outputs	Outcomes	Barriers
Purchase palliative medicine specialist services from outside the region	No palliative medicine specialist in the region Telephone-based palliative care consultancy support during office hours (interim measure) Six specialist palliative care teams would benefit from support, education and upskilling with input from palliative medicine specialists	Funded palliative medicine specialist within the region two days a fortnight Positive impact on recruitment and retention of palliative care staff in rural communities through provision of specialist medical support	RPCMPF allocation from January 2007 to June 2009 as outlined in Appendix 2	Barwon Health provided palliative medicine specialists under agreement for fortnightly rotating site visits and telephone support across region until December 2008 From 2009, fortnightly visits to the region not part of agreement with Barwon Health – telephone support via palliative care consultant	Upskilling and support of Hume clinicians through secondary telephone support, education, case review and joint consultation has led to reduced reliance on Barwon clinicians reported by some GPs	Lack of formalised agreement since December 2008 has led to some confusion among GPs in the region regarding direct access to Barwon Health specialists under the new arrangement
Attract palliative medicine specialist into region		Primary consultation across region Provision of networking and education for palliative care clinicians		From January 2009, senior medical officer with palliative care skills and experience employed as palliative care consultant within region three days a week Additional telephone support from Barwon Health specialists	Consultant visits sites across region for patient assessment, review, secondary consultation Journal clubs, education sessions, case review and multidisciplinary meetings established across region	Reduced presence of Barwon Health palliative medicine specialists in region under new arrangements No cover for provision of primary consultation within region when palliative care consultant on leave Current level not financially sustainable

Table 15: Loddon Mallee – purchase of additional, palliative medicine specialist hours

Model elements	Baseline (pre-RPCMPF)	Aims	Inputs	Outputs	Outcomes	Barriers
Purchase specialist palliative care consultant hours for Mildura clinic through agreement with Peter MacCallum Cancer Centre	No palliative care specialist outside Bendigo Limited secondary consultation telephone service to region staffed by consultant and GP depending on availability	Provide primary patient consultation for 'complex cases' through satellite clinics across the region Regional education days Mentoring and support, Telephone consultations Networking and strategic planning	Mildura and Bendigo medical consultancy hours funded by RPCMPF Funding of non-medical elements of Mildura Palliative Care clinic by Sunraysia CHS Project worker employed by LMRPCC for 12- month period to establish Mildura clinic	Peter MacCallum Cancer Centre provides 12 hours a month palliative medicine specialist under the RPCMPF for Specialist Palliative Care clinic in Mildura Weekly teleconferences and additional telephone support for clinicians as required Formal education program delivered during visits to Mildura	Upskilling of nursing staff and improved continuity of care for patients in Bendigo and Mildura Access to new medications for Mildura patients Other improvements in patient outcomes as evidenced by case studies and stakeholder comments	
Expand palliative medicine services in Bendigo to support acute, community and regional palliative care patients	0.2 EFT palliative care specialist services for Bendigo Hospice patients.		0.2 EFT palliative medicine specialist funded by Bendigo Health Care Group	Agreement with Bendigo Health Care Group (BHCG) - 12 additional palliative medicine specialist hours to Bendigo and region by palliative medicine specialist funded through RPCMPF	Improved continuity of care for Bendigo patients Local GPs participating in MD case conference with support of Bendigo DGP Performance status of review patients higher than new patients	Peter Mac unable to support additional specialist consultant hours to other areas
Expand palliative medicine services to all Loddon Mallee				Agreement established with BHCG for commencement of medical services in Echuca Services in other areas to be established		Delays establish agreements in other areas
Upskilling of GPs across region	Castlemaine GP with interest in palliative care		Bendigo Division of GP - Rural Palliative Care Project funded by DoHA	One applicant to medical scholarship fund	High level of engagement with Mildura clinic by local GPs	

8 Sustainability

This sustainability evaluation model has been developed to provide a guide to the RPCMPF's sustainability in each region. The model's development was influenced by sustainability models developed for other health care programs as cited in the literature.[14,15] A range of factors that were considered by stakeholders to enhance sustainability of the RPCMPF models was determined through the consultation process. These factors are listed in Table 16. The shaded boxes indicate that a factor may represent a potential sustainability risk in a region.

Table 16: Sustainability evaluation model

Sustainability factors	Barwon South Western	Gippsland	Grampians	Hume	Loddon Mallee
Medical workforce sustainability					
Collegial clinical environment for palliative medicine specialists working within the region					
Succession plan developed/developing					
Formalised links (such as via MOU), and/or partnerships with metropolitan or other rural regions					
More than one dedicated palliative care specialist working within or visiting the region					
Ongoing mechanisms for upskilling and maintaining skills of general practitioners in the region					
Funding sustainability					
Current arrangements can be continued within the level of recurrent RPCMPF and non-RPCMPF funding					
Funding from non-RPCMPF sources on which the programs rely is not under imminent threat					
Model responsiveness to local need					
Specialist primary consultation presence within the region					
Evidence of ongoing development and evolution of the current model/s					
Access to palliative medicine specialist across the region					

14 Scroter, D., 2008, Sustainability evaluation: Development of and validation of an evaluation checklist Western Michigan University, Kalamazoo.

15 Ridde, V., Pluye, P., Queuille, L., 2009, A tool-kit for the evaluation of sustainability processes and sustainability levels of public health programs and projects McGill University, Canada [obtained via personal communication April, 2009].

All regions have established ongoing educational opportunities for general practitioners although the strength and uptake of this is variable. With the cessation of the medical scholarship fund, opportunities for rural general practitioners to engage in supported tertiary education in palliative care are reduced. It will be important that regions continue to invest resources into engagement with general practitioners to maintain the momentum developed through the medical scholarship fund including establishing and/or maintaining links with divisions of general practice.

No imminent threats to funding from non-RPCMPF sources on which the programs rely was identified. However, this does not guarantee that funding sources will not come under threat in the future.

Models are more embedded in some regions than others. In regions where models are still being bedded down, there is evidence of ongoing development and evolution of the model which is positive for sustainability.

Specific sustainability threats facing each region are outline in the next section.

8.1 Barwon South Western

Succession planning poses a potential threat to palliative care services in the South Western area. The consortium and regional stakeholders are aware of this threat and are exploring a range of options to mitigate this risk as discussed in section 6.1.4.5.

Sustainability in the South Western area is facilitated by support by from Barwon Health. This enhances the collegial environment and ongoing education and training opportunities available to clinicians in the region. Within its capacity, it is advisable for the Barwon area to continue to sustain and enhance this support to the South Western area.

8.2 Gippsland

Progress towards commencing a primary consultation model in the region is advancing. Sustainability of the current model is enhanced by formalised links and strong relationships with the specialist metropolitan partners. While the initial MOU between Southern Health and GRPCC expires on 30 June 2009, it includes an option for the partnership to be renewed for a further period of five years. From the perspective of both the specialist partners and the consortium, the model is sustainable.

In addition to a comprehensive regional education program, Gippsland has relied heavily on the medical scholarship fund for upskilling its general practitioners. As this funding is non-recurrent, there is a need for the region to shift to other methods of maintaining and increasing regional general practitioners skills in palliative care. Maintaining established links with divisions of general practice is important. Establishing the regional education position is an enabler.

8.3 Grampians

The lack of formalised links with metropolitan and/or other rural regions does not appear to pose a strong threat to sustainability in the Grampians as the region is currently well resourced with palliative medicine specialists. In addition, a local general practitioner has commenced further training in palliative care. However, formalising links with one or more metropolitan partners may further enhance the Grampians model.

More robust data collection may support the region's endeavours to seek funding for an advanced medical training position. This would facilitate succession planning and improve the model's long-term sustainability prospects.

8.4 Hume

The Hume model in its current form faces some sustainability risk factors. Potential gaps have been discussed in section 6.4.3. Funding for the palliative care consultant at the current level is not sustainable within the recurrent RPCMPF allocation and, at the time of the evaluation, no alternative funding source had been identified.

Following the transition from the previous arrangements with Barwon Health, palliative care patients within the Hume region no longer have access to primary consultation by a palliative medicine specialist within their region. General practitioners in the region no longer have direct access to the Barwon Health palliative medicine specialists with whom many have established relationships. This could lead to increased clinician isolation within the Hume region, which is a further risk to sustainable service delivery.

8.5 Loddon Mallee

Currently in Loddon Mallee, high-quality palliative care specialist medical services are available to patients in the Mildura and Bendigo areas. Based on the sustainability analysis, these services do not appear to face significant sustainability risks at this time. However, the Mildura clinic relies on Sunraysia Community Health Service to fund the non-medical components of the clinic including the nursing role, which is essential for care coordination and ongoing care when the doctor is not in the region. Mildura stakeholders have drawn attention to the added demand on Sunraysia services as a result of the support it offers to the clinic.

Provision of specialist palliative medical care outside the Mildura and Bendigo areas is yet to be established. This has recently commenced in Echuca and will commence in the coming months in the remaining Loddon Mallee areas. The consortium's projected budget to 2010 indicates there are adequate funds to furnish the rest of the region with specialist consulting services under RPCMPF.

9 The medical scholarship fund

Total RPCMPF of $200,000 was allocated to the medical scholarship fund. This is non-recurrent funding.

The aims of the medical scholarship fund were to:

- financially support medical practitioners in rural areas to improve their skills and confidence in palliative medicine through undertaking tertiary postgraduate education
- improve the quality and competence of palliative medicine for Victorians in rural areas.

Fourteen rural medical practitioners were successful in applying for a scholarship. There was one successful applicant for the medical scholarship fund from each consortium except Hume. The Gippsland region had the greatest uptake with 11 applicants.

Uptake in the Gippsland region was facilitated through employing a project officer to recruit and support doctors who expressed interest in obtaining further tertiary qualifications in palliative care. The project officer used a range of strategies to facilitate uptake of the scholarships in the Gippsland region as outlined in section 6.2.2.2.

Courses undertaken by scholarship applicants varied from a two-day professional development course to Master of Palliative Care or Master of Medicine programs. Figure 18 shows the number and percentage of applicants in each course type. The most common type of course in which applicants enrolled was a six-week short course. These short courses were all undertaken at Monash University and were undertaken in a range of areas including pain management, palliative care or family medicine.

Figure 18: Applicants in each course type

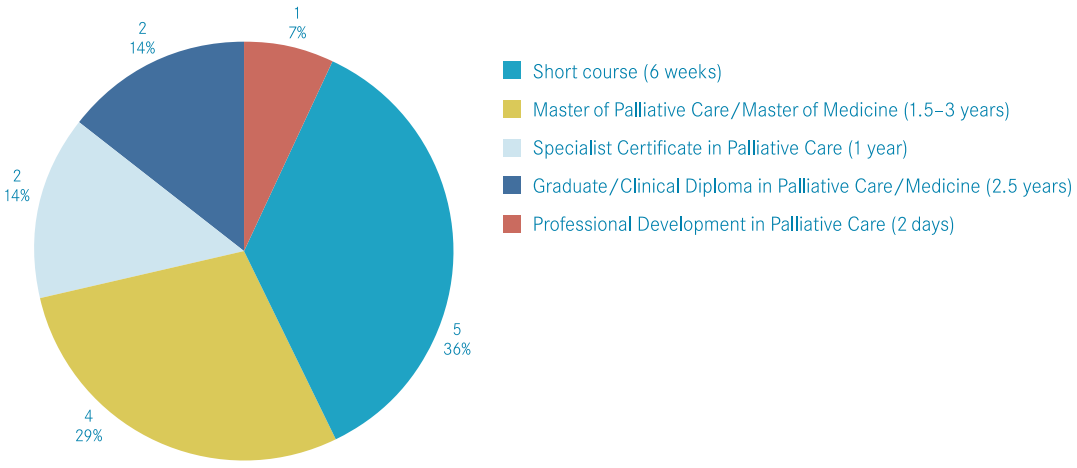
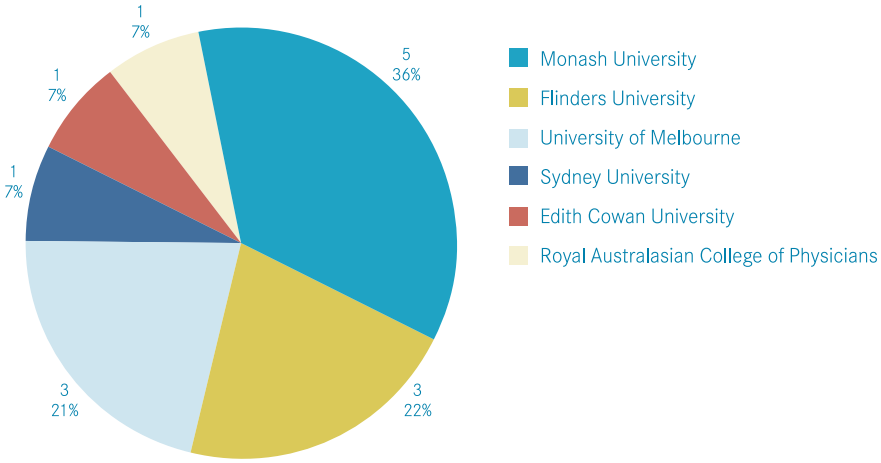


Figure 19: Universities at which applicants commenced their study



Four applicants were interviewed for this evaluation. They expressed positive views about the benefits of the study they had undertaken with the support of scholarship funding. One reported improved palliative care practice and greater confidence in managing palliative care patients. Specifically, his confidence in having conversations with patients about advance care planning and end-of-life issues has increased. Since finishing his study he has referred some patients with non-malignant disease to palliative care. He made the following comment:

> *[The study] opened my eyes that palliative care is more than just cancer stuff and I involve them [the palliative care team] earlier than I otherwise would have.*

In his view, increasing general practitioners' skills spreads the workload and expertise around the region.

Another general practitioner reported that undertaking the study has given her the time to stop and reflect on her practice. She now feels more up to date in her practice and is tapping into new resources, particularly online resources.

A clinical nurse consultant who works with general practitioners who have undertaken study in palliative care through the medical scholarship fund made the following comment:

> *General practitioners doing the courses has made it easier for the palliative care teams. The general practitioners haven't changed the team's practice [but they have] brought their skills up to where the palliative care team's skills are.*

There are still rural doctors who would be interested in increasing their palliative care skills and would benefit from scholarship support for this. One consortium manager said it would be disappointing if funding was not available to support them to undertake further study in palliative care.

Doctors who have been successful in applying for scholarships but who have not finished their study were unsure whether the allocated funding would still be available to them if it takes them longer than expected to complete their course of study. It will be important that, for these doctors, some of whom have taken on a large burden of study that may take months or years to complete, funding is set aside and continues to be paid until they have completed their study.

10 Discussion

Each of the five rural palliative care consortia has achieved the RPCMPF's aims of expanding specialist palliative care medical consulting arrangements and addressing gaps through training or upskilling general medical providers in their region. The RPCMPF has been implemented using different models in each region and the extent these models have achieved the RPCMPF's aims are outlined in section 6.

The consortia have implemented models that have built on the resources and capacity of each region and are adapted to local conditions and context. Prior to the RPCMPF's implementation, some regions had pre-existing arrangements for delivery of specialist medical palliative care services either within the region or through links and partnerships with organisations or individuals outside their regions. Overall, the consortia models have expanded and formalised these links. Where links did not exist partnerships have been established or new specialists recruited.

In implementing the RPCMPF, consortia faced a range of barriers and challenges that often required creative solutions to overcome. In particular, the difficulties faced by some rural consortia in recruiting palliative medicine specialists into their area must be acknowledged. As a relatively new area of medical specialty, palliative medicine faces challenges across Australasia in terms of workforce numbers. While these numbers are projected to increase over the coming years,[8] workforce issues to date have impacted on the capacity of palliative medicine to meet the demand for its services, particularly in rural areas. The RPCMPF has been successful in achieving increased delivery of quality palliative care medical services across rural Victoria.

Other barriers and challenges faced by the consortia are outlined in the logic tables in section 7 and predominantly include the distance and time constraints faced by rural health care providers as well as workforce shortages in project support and nursing. Nursing workforce shortages in some rural areas have the potential to impact on the medical services that can be delivered under the RPCMPF models. Current work in developing nurse practitioner models of care, either through the RPCMPF or through other funding sources, is aimed at addressing some of these nursing workforce issues.

Equity continues to be an issue in the delivery of health services in rural regions. As highlighted in section 6, there are still parts of Victoria in which palliative care patients are not able to access some services locally because there is insufficient workforce to support this. However, the RPCMPF has contributed to redressing rural access and equity issues. Some of the case examples in section 6 highlight the outcomes and benefits of the program for patients in areas that would previously not have had access to the multidisciplinary palliative care services described.

Key findings in specific areas, which have informed the recommendations, are included in the next sections.

10.1 Data

Each region was able to provide some quantitative data for this evaluation; however, good outcome data was variable in its nature and quality. Where clinical outcome data was available it provided support for the interview findings that the models of palliative care being offered in those regions are leading to improvements for patients and families. If comparable data was available across the state, a stronger evaluation of the links between funding and patient outcomes would be facilitated.

Despite the fact that the implementation models vary, there is some potential for more standardised statewide data collection. Developing a minimum dataset would improve the consortia's position to objectively present their palliative care service delivery outcomes.

The minimum dataset should be agreed across the state and be in line with data requirements for funding and reporting. However, the following data would be useful for inclusion:

- number and duration of patient contacts
- nature of primary consultation contact (such as telephone consultation or face-to-face contact)
- location of contacts (hospital, community, home, RACF)
- patient performance status and phase at consultation
- secondary consultation data including number, type and duration of telephone consultations
- evaluation of education sessions.

10.2 Palliative medicine specialists

All regions have some input from palliative medicine specialists although two regions do not currently have a primary consultation presence within the region by a palliative medicine specialist. Doctors working in palliative medicine report they prefer to work in a collegial environment. Generally this is recognised by the consortia and efforts have been made to support this preference.

The nation-wide shortage of palliative medicine specialists dictates that it may not always be possible to have a palliative medicine specialist in every rural region. However, to provide equitable access to palliative care services across the state, working towards minimum standards for specialist involvement in regional teams based on Palliative Care Australia standards[2] is highly recommended. Where regions are staffed by palliative care doctors who are not palliative medicine specialists, links and partnerships with palliative medicine specialists in other regions should continue to be developed and strengthened.

Where partnerships have been established between rural and metropolitan regions, the benefits appear to have flowed both ways. Some metropolitan stakeholders report that the rural partnerships have enhanced their understanding of the services that are available to their rural patients and improved their confidence to refer patients back to their local communities for ongoing care.

10.3 General practitioner engagement and upskilling

Benefits flowing to the general practitioner sector as a result of the RPCMPF reported by general practitioners and others included:

- a greater awareness of palliative care among some general practitioners including timing and appropriateness of referral
- increased confidence by some general practitioners to commence advance care planning conversations with palliative care patients in general practices
- more satisfactory outcomes for palliative care patients being managed by general practitioners with support from palliative medicine specialists and other doctors funded through the RPCMPF.

There is still mixed evidence regarding the overall impact of upskilling rural general practitioners on patient care. Some palliative medicine specialists report it is too early to expect to see the impacts of general practitioner upskilling on patient outcomes. Upskilling general practitioners in palliative care should be viewed as an adjunct to providing good access to palliative medicine specialists in rural regions. This is an important area for consortia to continue to direct their resources.

Substantial funding has flowed into the rural palliative care sector via the DoHA-funded Rural Palliative Care projects. A number of consortia have formed partnerships or worked closely with divisions of general practice involved in these projects. In a number of regions this has led to enhanced benefits in engagement with general practitioners in palliative care. Factors that have facilitated this collaboration included the following.

- The Grampians consortium arranged to collocate the division's Rural Palliative Care project worker in their office.
- Palliative Care clinicians in other regions such as Hume and Loddon Mallee are members of Rural Palliative Care project steering committees and working groups.
- In Barwon South Western, the Rural Palliative Care project worker is a former palliative care clinician from the South Western area and therefore has good links with clinicians across the region.
- A project officer was employed in the Gippsland region to work with general practice divisions.

Collaboration on the range of palliative care projects and programs being undertaken now and in the future is highly recommended to maximise the benefits for palliative care patients and clinicians and ensure alignment with Victorian palliative care policy direction. This would be facilitated through ongoing dialogue between the department's Cancer and Palliative Care Unit and its DoHA counterparts.

An important part of the palliative medicine specialist's role is to provide support to general practitioners caring for patients in the community. Secondary telephone consultation, case review and other elements of these models aimed to support this aspect of specialist medical palliative care service delivery. The success of these strategies has varied and appears to be influenced by:

- the presence of a primary consultation presence within a region – palliative medicine specialists working within or visiting a region and working alongside clinicians enhances relationships and breaks down barriers (stakeholders working in these environments reported that general practitioners and other clinicians were more likely to ring the palliative medicine specialist for advice)
- the reluctance of some general practitioners to seek advice from another general practitioner who they view as being only slightly more qualified than themselves (some would prefer to seek advice from a medical specialist)
- some general practitioners' reluctance to work within a secondary consultation model rather than a specialist referral model (for some general practitioners, it may take time to adapt to managing patients alongside specialist services rather than referring the patient to the specialist service for management).

10.4 Project management

The return on investment of funds directed into project support was variable. In some areas, project support led to strong results, such as engagement of general practitioners in the Gippsland region. In other areas, the consortia acknowledge poorer return on investment. The program is now reaching a level of maturity that has resulted in models being bedded down or approaching that stage in most regions. In the next phase, it would be anticipated that the need for recurrent funding to be directed to project support would be less than in the set-up stages. This would free a greater proportion of the funds to be used for direct patient clinical care.

10.5 Service delivery frameworks

Beyond the variability that has necessarily occurred in implementing the RPCMPF, there is also substantial variability across the state in palliative care service delivery frameworks. This includes the presence and composition of regional teams, the skills and experience of staff and models of working with district nursing services. Greater standardisation of service delivery is likely to result in improved equity and patient access to palliative care services across the state. The department is currently awaiting the findings of the Service Delivery Framework and Funding Model Review Project. The project aims to identify service delivery activities that meet clinical and policy goals and where these activities should occur.[16] The RPCMPF evaluation findings support implementing changes to rural service delivery frameworks that improve equity of patient access to palliative care services across the state.

10.6 Transferable learnings

In overcoming challenges and barriers to implementing contextually appropriate models, consortia developed a range of resources and tools. Some of these have application outside their region. Examples of transferable learnings include:

- using partnerships to overcome challenges in recruiting clinicians to isolated regions
- exploring a diverse range of methods to engage the general practitioner sector
- outcomes of specific projects such as the Grampians general practitioner gap analysis survey and the nurse practitioner scoping project, which may inform work undertaken in other regions
- the importance of building strong foundations, maintaining a long-term vision of continuous improvement and celebrating victories.

As the DoHA-funded Rural Palliative Care projects enter their final phases it will be important to build on their achievements, particularly where they dovetail with the aims and achievements of the RPCMPF.

16 Department of Human Services, Service Delivery Framework and Funding Model Review Project, viewed 23 April 2009, <http://www.health.vic.gov.au/palliativecare/sdffmr.htm>.

11 Conclusion

While substantial quantitative data was not available to support this evaluation, the data obtained through the mixed-method evaluation approach supports the finding that the RPCMPF has been successful in achieving its aims of increased delivery of quality palliative care services across rural Victoria.

The variation in the palliative care service delivery environment across Victoria necessitated that different approaches to the RPCMPF's implementation be adopted in each of the five rural regions. In implementing the RPCMPF, each palliative care consortia has responded to their local conditions and context. This has significantly improved rural patients' access to specialist palliative medicine consultations and opportunities for patients to remain in their own community.

All models appear to have improved general practitioners' capacity in palliative care. The medical scholarships fund has been well utilised for a range of palliative care tertiary postgraduate education opportunities resulting in increased knowledge, confidence and competence in palliative care practice.

In some regions, a range of pre-existing factors and conditions facilitated more rapid implementation of the RPCMPF. Some regions are now entering or have entered a bedding-down phase, with established models and processes. Other regions are yet to enter the bedding-down phase and in some areas, services are yet to be established. A continued focus on development and improvement will benefit all regions as they move through the next phases.

The evaluation findings support continuation of the RPCMP in all regions. A range of recommendations have been made to enhance and support the RPCMPF's effectiveness in continuing to achieve its aims as it moves into the next phase.

12 Recommendations

12.7 Statewide recommendations

1. The Department of Human Services continues to provide funding for the RPCMPF of no less than $600,000 allocated equally between the five rural regions.
2. The approach to improving access to medical palliative care services in rural regions continues to focus on:
   a. purchasing the services of palliative medicine specialists
   b. addressing gaps though the training or upskilling of existing general medical providers in rural regions.
3. Funding to approved medical scholarship fund applicants to be set aside and continue to be paid until all doctors have completed their approved courses of study.
4. The Department of Human Services works with the rural palliative care consortia to establish a minimum dataset for palliative care doctors funded under the RPCMPF. Developing the dataset will be informed by the findings of this evaluation.
5. The Department of Human Services continues to engage in dialogue with the Commonwealth Department of Health and Ageing, General Practice Victoria and other relevant groups to identify palliative care postgraduate training needs for general practitioners, to maximise the benefits of new and existing Commonwealth palliative care funding initiatives and to facilitate the alignment of these initiatives with Victorian policy direction.
6. The Cancer and Palliative Care Unit continues to engage in dialogue with other relevant areas of the department such as the Rural and Regional Health and Aged Care Services Division to facilitate greater access for general practitioners to ongoing palliative care training and skills development.
7. The refresh of the *Strengthening palliative care policy* takes into consideration the findings of this evaluation regarding the benefits of partnerships between metropolitan and rural palliative care consortia.
8. The Cancer and Palliative Care Unit continues to facilitate sharing of transferable learnings from the RPCMPF across regions providing forums for stakeholders to exchange and share ideas.
9. A full RPCMPF budget acquittal be undertaken at 30 June 2009 and surplus funds used to implement regional recommendations as negotiated with the Cancer and Palliative Care Unit.
10. The Cancer and Palliative Care Unit supports the allocation of a proportion of any funding for advanced palliative care training positions in Victoria to rural regions.

12.8 Regional recommendations

1. Each region continues to work towards improving medical palliative care services by focussing on:
   a. purchasing the services of palliative medicine specialists
   b. addressing gaps though training or upskilling existing general medical providers in rural regions.
2. The Barwon South Western region continues to sustain and enhance support for the South Western area through providing secondary telephone support, clinical attachment opportunities and other educational and professional development opportunities.
3. The Barwon South Western region continues to undertake regional succession planning for the South Western area through ongoing sponsorship and support of the palliative care doctors in the region and/or through exploring new ways to attract and/or retain palliative medicine specialists for the region.
4. The Barwon South Western region directs unallocated RPCMPF money to increase specialist medical palliative care service provision in the South Western area.
5. The Gippsland region, in collaboration with its metropolitan specialist partners, continues to work towards developing and piloting a primary consultation model of palliative care medical service delivery in the region. The model will be sustainable under recurrent levels of RPCMPF.
6. The Gippsland region, in collaboration with its metropolitan specialist partners, continues to work towards developing a regional palliative care team.
7. The Grampians region explores funding opportunities for establishing an advanced palliative care training post at Ballarat Health Service.
8. The Grampians region considers making its regional education program/s available to medical practitioners in other rural regions on a cost-recovery basis.
9. The Hume region formalises and strengthens its consultation arrangements with Barwon Health or another appropriate service in order to provide specialist palliative medicine through re-establishing a service agreement or memorandum of understanding.
10. The Hume region continues to work towards creating a viable and sustainable model of specialist palliative care medical service delivery.
11. The Loddon Mallee region continues to examine and explore options for expanding services to areas in which specialist palliative care medical services have not yet been established.
12. All rural palliative care consortia continue to monitor and evaluate the sustainability and viability of their specialist palliative care medical service delivery models.
13. The consortia continue to explore ways to provide financial and other support for rural general practitioners to undertake postgraduate tertiary study in palliative care including through existing avenues such as the department's Extended Skills Program for general practitioners, the Palliative Care Foundation and others.

Appendix 1: List of evaluation interviewees

Interviewee	Position	Organisation
Barwon South Western		
Ms Lise Pitman	Consortium Chair	Barwon South Western PCC
Ms Heather Robinson	Consortium Manager	Barwon South Western PCC
Dr Peter Martin	Regional Clinical Director of Palliative Medicine	Barwon Health
Dr Eric Fairbank	Director of Palliative Care	South West Healthcare
Dr Sue Robertson	General Practitioner	Hamilton
Ms Bev Quinn	Bereavement Counsellor/Educator	South West Healthcare
Ms Bev King	Palliative Care Clinical Nurse Consultant	South West Healthcare
Dr Annie Hattingh	General Practitioner	Portland
Gippsland		
Ms Anne Curtain	Consortium Chair	Gippsland Region Palliative Care Consortium
Dr Anthony Hooper	Consortium Manager	Gippsland Region Palliative Care Consortium
Ms Mary Hartwig	Community Services Manager – Home Nursing	Central Gippsland Health Service
Ms Kate Graham	Formerly Consortium Project Officer	Gippsland Region Palliative Care Consortium
A/Professor Kate Jackson	Director, Supportive and Palliative Care	Southern Health
Dr Jane Fischer	CEO/Medical Director/Palliative Care Specialist	Calvary Healthcare Bethlehem
Dr Tony Richards	General Practitioner	Central Gippsland Health Service
Dr David Monash	General Practitioner	Mason House Medical – Sale
Grampians		
Ms Claire McKenna	Consortium Manager	Grampians Regional Palliative Care Consortium
Ms Jade Odgers	Coordinator, Grampians Regional Palliative Care Team	Ballarat Health Service
Dr Greg Mewett	Palliative Care Specialist	Ballarat Health Service
Dr David Brumley	Palliative Care Specialist	Ballarat Health Service
Ms Jan Milliken	Clinical Nurse Consultant	Ballarat Health Service
Mr Bill Weidner	Social Worker	Ballarat Hospice Care Inc.
Ms Paula Desnoy	Project Officer	Ballarat and District Division of General Practice
Hume		
Ms Catherine Hattersley	Consortium Manager	Hume Palliative Care Northeast Health Wangaratta
Ms Carmel Smith	Executive Officer	Goulburn Valley Hospice
Dr Alex Traill	General Practitioner	Wangaratta
Dr Joseph Ding	Medical Palliative Care Consultant	Hume Palliative Care Consortium
Ms Erica Ruck	Program Manager, Community Consultancy and Care	Ovens and King Community Health Service
Ms Heather Wickham	Clinical Nurse Specialist	Northeast Health Wangaratta Palliative Care
Dr Chris O'Brien	General Practitioner	Bright

Interviewee	Position	Organisation
Dr Ian Grant	Specialist Palliative Care Specialist	Barwon Health
Loddon Mallee		
Ms Trish O'Hara	Consortium Manager	Loddon Mallee Palliative Care Consortium
Ms Maggie Fernie	Program and Service Advisor, Sub-acute and Ambulatory Services	Department of Human Services, Loddon Mallee Region
Dr Odette Spruyt	Director, Pain and Palliative Care	Peter MacCallum Cancer Centre
Dr Becky Chapman	Palliative Care Specialist	Bendigo Health Care Group
Ms Bertilla Campbell	Coordinator, Palliative Care	Sunraysia Community Health Service
Mr Mark McCarty	Program Manager, Home Nursing Support Services	Bendigo Health Care Group
Ms Angela Munro	Clinical Coordinator, Palliative Care and District Nursing	Bendigo Health Care Group
Ms Merrill Cole	Palliative Care Clinical Nurse Consultant/Unit Manager District Nursing Services	Mount Alexander Hospital
Dr Louisa Hope	General Practitioner – Moyston Street Clinic	Castlemaine
Ms Chris Fischley	Program Manager	Central Victoria GP Network

Other organisations and institutions consulted

Individual	Position	Organisation
Ms Danielle Clayman	Palliative Care and Advance Care Planning Program Consultant	General Practice Victoria
Dr Mark Boughey	President Elect	Australasian Chapter of Palliative Medicine Specialists
Dr Karen Cooper	Executive Director	Australian and New Zealand Society of Palliative Medicine
Dr Pierre Pluye	Assistant Professor	McGill University, Department of Family Medicine
Dr Richard Mullaly	Chief Executive Officer	Medical Practitioners Board of Victoria

Appendix 2: Budgets

Budget information included in this section is based on the best available data from consortia. Some consortia had difficulties accessing information through their consortium fundholder's finance department.

Budgets have been projected until the end of June 2009 – this may result in irregularities in the figures presented here and the surplus amounts held by consortia at the end of the 2009–10 financial year. It is recommended that a full budget acquittal of the RPCMPF be undertaken at the end of the 2009–10 financial year.

Table 12: Barwon South Western

Income	**Jan 07 – Jun 07**	**Jul 07 – Jun 08**	**Jul 08 – Jun 09**	**Total allocated**
Allocated budget	62,336	119,312	119,312	300,960
Carry over surplus/deficit		46,400	57,476	86,432
Total		**165,712**	**176,788**	
Expenditure	**Jan 07 – Jun 07**	**Jul 07 – Jun 08**	**Jul 08 – Jun 09**	**Total allocated**
Increased EFT for South Western palliative care medical consultant: 0.05 EFT @ $150/hour	7,800	15,600	15,600	39,000
On-costs (calculated at 12 per cent)	936	1,872	1,872	4,680
Specialist professional development	7,200	14,400	14,400	36,000
Increased EFT for South Western general practitioners @ $110/hour:				
Hamilton – 4 hours/week (From Jan 2008)		11,440	22,800	34,240
Portland – 3 hours/week (From Dec 2007)		9,900	19,800	29,700
GP clinical attachment programs		8,800	8,800	17,600
Administrative support		10,000		10,000
Attendance at BSW strategic planning day		880	1,760	2,640
GP registration at ANZSPM Conference 08		2,000		2,000
GST			**5,324**	**5,324**
GP Association of Geelong activity:				
GPAG program officer 8 hours/week @ $30/hour		15,100		15,100
GPAG CEO 1 hour/week @ $70/hour		4,402		4,402
GP advisors		12,584		12,584
Administration		1,258		1,258
Total	**15,936**	**108,236**	**90,356**	**214,528**
Surplus/(deficit)	**46,400**	**57,476**	**86,432**	**86,432**

Table 13: Gippsland

Income	Jan 07 – Jun 07	Jul 07 – Jun 08	Jul 08 – Feb 09 (actual)	Budget 2008–09 (projected)	Total allocated at Feb 09
Allocated budget	54,000	120,000	124,000	124,000	298,000
Carry over surplus/(deficit)		54,000	125,288	125,288	162,278
Total		**174,000**	**249,288**	**249,288**	
Expenditure	**Jan 07 – Jun 07**	**Jul 07 – Jun 08**	**Jul 08 – Feb 09 (actual)**	**?????**	**Total allocated at Feb 09**
Metropolitan specialist palliative medicine consultancy – Gippsland South		10,310	86,369	120,000	96,679
Overheads and related costs		12,487	641	2,000	13,128
GP training		915		1,000	915
GRPCC administration costs		25,000		25,000	25,000
Total	**0**	**48,712**	**87,010**	**148,000**	**135,722**
Surplus/(deficit)	**54,000**	**125,288**	**162,278**	**101,288**	**162,278**

Table 14: Grampians

Income	Jan 07 – Jun 07	Jul 07 – Jun 08	Jul 08 – Jun 09	Total allocated
Allocated budget	60,000	120,000	120,000	300,000
Carry over surplus/deficit		60,000	128,941	96,745
Total		**180,000**	**248,941**	
Expenditure	**Jan 07 – Jun 07**	**Jul 07 – Jun 08**	**Jul 08 – Jun 09**	**Total allocated**
Contribution to funding 1.0 EFT palliative care specialist from March 2008 (remainder of cost borne by Ballarat Health Service)		40,000	120,000	160,000
Purchase of phone for tele-links		475		475
Project worker wages		7,084		7,084
Project worker recruitment		3,500		3,500
Employment of project worker to scope rural palliative care nurse practitioner role			32,196	32,196
Total	**0**	**51,059**	**152,196**	**203,255**
Surplus/(deficit)	**60,000**	**128,941**	**96,745**	**96,745**

Table 15: Hume

Income	Jan 07 – Jun 07	Jul 07 – Jun 08	Jul 08 – Mar 09 (actual)	Budget 2008–09	Total allocated at March 09
Allocated budget	62,100	120,810	122,810	122,810	305,720
Carry over surplus/deficit		62,100	61,982	61,982	74,065
Total		**182,910**	**184,792**	**184,792**	
Expenditure	**Jan 07 – Jun 07**	**Jul 07 – Jun 08**	**Jul 08 – Mar 09 (actual)**	**Budget 2008–09**	**Total allocated at March 09**
Barwon Health medical model		105,360	57,755	62,059	163,115
General practitioner		15,568	52,972	92,972	68,540
GP conference				1,000	
GP travel expenses				5,000	
Rural GP education				15,000	
Professional support and development				3,000	
Other GP office expenses				2,000	
Total		**120,928**	**110,727**	**181,031**	**231,655**
Surplus/(deficit)	**62,100**	**61,982**	**74,065**	**3,761**	**74,065**

Table 16: Loddon Mallee

Income	Jan 07 – Jun 07	Jul 07 – Jun 08	Jul 08 – Jun 09	Total allocated
Allocated budget	65,550	120,000	115,350	300,900
Carry over surplus/deficit		41,005	109,584	168,412
Total		**161,005**	**224,934**	
Expenditure	**Jan 07 – Jun 07**	**Jul 07 – Jun 08**	**Jul 08 – Jun 09**	**Total allocated**
Specialist – Mildura Feb 08 to June 09 @ $2,355.15/4 weeks (x19)	24,545	9,421	32,972	66,938
Specialist – Bendigo Oct 08 to June 09 @ $2,355/4 weeks (x9)			21,195	21,195
Specialist – Echuca May 09 to June 09 @ $1,177.5/4 weeks (x2)			2,355	2,355
Committed (not spent)				
Set up support each agency $6,000 x 7		42,000		42,000
Total	**24,545**	**51,421**	**56,522**	**132,488**
Surplus/(deficit)	**41,005**	**109,584**	**168,412**	**168,412**

Appendix 3: Performance scales

Eastern Cooperative Oncology Group (ECOG) scale

ECOG score	Functional level
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature such as light housework, office work.
2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50 per cent of waking hours.
3	Capable of only limited self-care, confined to bed or chair more than 50 per cent of waking hours.
4	Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair.
5	Dead.

Australian Karnofsky Performance Scale (AKPS)[13]

Definition	%	Criteria
Able to carry on normal activity and to work. No special care is needed.	100	Normal; no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs of symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work. Able to live at home, care for most personal needs. A varying amount of assistance is needed.	70	Cares for self. Unable to carry on normal activity or to do active work.
	60	Able to care for most needs, but requires occasional assistance.
	50	Considerable assistance and frequent medical care required.
Unable to care for self. Requires equivalent of institutional or hospital care. Disease may be progressing rapidly.	40	In bed more than 50 per cent of the time.
	30	Almost completely bed-bound.
	20	Totally bedfast and requiring extensive nursing care by professionals and/or family.
	10	Comatose or barely arousable.
	0	Dead.

Appendix 4: Summary of abbreviations used in the report

Abbreviation	
AKPS	Australian Karnofsky Performance Scale
ANZSPM	Australian and New Zealand Society for Palliative Medicine
BHCG	Bendigo Health Care Group
BSWPCC	Barwon South Western Palliative Care Consortium
DoHA	Department of Health and Ageing
ECOG	Eastern Co-operative Oncology Group
FRACP	Fellow of the Royal Australasian College of Palliative Medicine
FAChPM	Fellow of the Australasian Chapter of Palliative Medicine
GICS	Grampians Integrated Cancer Service
GPAG	General Practice Association of Geelong
GPCC	Grampians Region Palliative Care Consortium
GRICS	Gippsland Regional Integrated Cancer Service
GRPCC	Gippsland Region Palliative Care Consortium
GRPCT	Grampians regional palliative care team
HACC	Home and Community Care
HPCC	Hume Palliative Care Consortium
KPI	key performance indicator
LMPCC	Loddon Mallee Palliative Care Consortium
MOU	memorandum of understanding
MND	motor neurone disease
MNDAV	Motor Neurone Disease Association Victoria
MS	multiple sclerosis
PCA	Palliative Care Australia
PCU	Palliative Care Unit
PEPA	Program in the Palliative Approach
PICD	Pathway for Improving the Care of the Dying
PMP	palliative medicine specialist
RACF	residential aged care facility
RPCMPF	Rural Palliative Care Medical Purchasing Fund