

Independent Evaluation of the Rural Health Multidisciplinary Training Program

**Summary of Final Report to the
Commonwealth Department of Health**
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Australia

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Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
Ahpra	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
ANMAC	Australian Nursing and Midwifery Accreditation Council
ARHEN	Australian Rural Health Education Network
ASGS	Australian Statistical Geography Standard
RA1	Australian Statistical Geography Standard Remoteness Area 1—Major City
RA2	Australian Statistical Geography Standard Remoteness Area 2—Inner Regional
RA3	Australian Statistical Geography Standard Remoteness Area 3—Outer Regional
RA4	Australian Statistical Geography Standard Remoteness Area 4—Remote
RA5	Australian Statistical Geography Standard Remoteness Area 5—Very Remote
DTERP	Dental Training Expanding Rural Placements
FRAME	Federation of Australian Medical Educators
GP	General Practitioner
IRTP	Integrated Rural Training Pipeline
LHN	Local Health Network
MDANZ	Medical Deans Australia and New Zealand
NTMP	Northern Territory Medical Program
MM	Modified Monash (Model)
PGY	Post Graduate Year
PHN	Primary Health Network
RACGP	Royal Australian College for General Practitioners
RTH	Regional Training Hub
RTO	Regional Training Organisation

RCS	Rural Clinical School
RCTS	Rural Clinical Training and Support
RHMT	Rural Health Multidisciplinary Training
RJDTIF	Rural Junior Doctor Training Innovation Fund
RWA	Rural Workforce Agency
SARRAH	Services for Australian Rural and Remote Allied Health
STP	Specialist Training Program
UDRH	University Department of Rural Health
VET	Vocational Education and Training

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Introduction

- The Rural Health Multidisciplinary Training (RHMT) program is one of several Commonwealth rural health workforce programs aiming to increase the number of health professionals working in rural, remote and regional Australia.
- The RHMT program and its precursors, demonstrate a twenty year commitment by the Commonwealth to support the training of health and medical students in rural, remote and regional Australia as an initial step towards a rural health career.
- Twenty-one universities are funded under the program, establishing a national network of 19 Rural Clinical Schools (RCSs) and 16 University Departments of Rural Health (UDRHs) to provide the infrastructure and academic networks for teaching and training.

The Evaluation

- In April 2019 KBC Australia was commissioned by the Department of Health (the Department) to undertake an evaluation of the RHMT program to:
 - Assess the extent to which the current design and delivery of the program is achieving the program's aim of improving the recruitment and retention of medical, nursing, dental and allied health professionals in rural and remote Australia
 - Consider the benefits to local health delivery from engagement in teaching and training through the RHMT program.

The Department identified eight key questions to be addressed:

1. How (well) is the RHMT program being implemented?
2. What have been the (positive and/or negative) impacts of the 2016 consolidation of previously separate training initiatives into a single program? For example, with respect to factors such as:
 - a. Opportunities for interdisciplinary training
 - b. Flexibility and innovation in delivery models
 - c. Resource management, including staffing and funding
 - d. Reporting and monitoring.
3. What (if anything) are the main challenges in the delivery of the program, and potential improvements to address these?
4. To what extent are universities meeting the program's objectives and intended outcomes?
5. What has been the impact of the RHMT program on:
 - a. The Aboriginal and Torres Strait Islander health workforce
 - b. Local communities and health services
 - c. Participation and satisfaction of rurally based and Aboriginal and Torres Strait Islander students
 - d. University health programs and curricula?

6. What are the lessons from the RHMT program for improving workforce outcomes? (Consider features/attributes of particular university programs)
 7. To what extent does the RHMT program demonstrate value for money?
 8. Is the RHMT program still an appropriate response to rural workforce shortages?
- The mixed-methods evaluation included: interviews, focus groups and roundtables with > 980 stakeholders; written submissions from peak and professional bodies (30); two national electronic surveys (Multidisciplinary Health Workforce Survey >4,000 responses; RHMT program staff survey, 411 responses); review of longitudinal workforce data, program reports and expenditure data. An Expert Reference Group provided advice in the development of the methodology and execution of the evaluation.
 - The evaluation was at a program level, not of individual universities or organisational units and inherent differences between universities based on the length of time they had been running and historical funding received was recognised.

It was not feasible to develop recommendations addressing each evaluation question separately due to the complexity of the program and interconnection of program components. Rather, recommendations are offered to improve the components of the RHMT program to ensure it continues to be an appropriate approach to addressing current and emergent rural health workforce shortages, contemporary models of care, and characteristics of the new generation of health professionals.

Overview of Program Achievements

- The RHMT program has been an appropriate response and important contributor to addressing rural health workforce shortage.
- There is a strong foundation for rural health workforce training and research in rural, remote and regional areas which is now considered routine. The maturity of the RHMT program is recognised, as is the inherent value it provides to communities and health services.
- However, there is variability between universities in delivering on targets, quality of placements, financial support from individual universities to their RCS and/or UDRH and, alignment of individual universities' goals with the RHMT program goals and intent.

Teaching Innovation

- Teaching innovation is a hallmark of the RHMT program.

Clinical Placements

- Long-term RCS placements have tripled since the early 2000s (Lyle and Greenhill, 2018) in line with the increase in RCSs. In the 2016-2018 period more than 30% of Commonwealth supported medical students spent a year or more at an RCS.

- UDRH supported nursing and allied health placements have grown from around 3,000 per year in 2004 (Lyle and Greenhill, 2018) to more than 13,000 in 2018 (Appendix A). Increased financial investment for UDRHs in the 2016 – 2018 funding agreement, coupled with introduction of placement targets were key drivers.

Workforce outcomes

- While noting that many external factors influence where health professionals work, the evaluation found strong evidence of the positive impact of longer-term rural medical placements on rural workforce outcomes.
- The evaluation's multidisciplinary Health Workforce Survey found that graduates with the most rural clinical placement student experience (average of 20 weeks) were working more in regional, rural and remote Australia¹.

Community Benefits

The RHMT program has a direct social and economic benefit to communities and regions:

- For every dollar spent under the RHMT program, another dollar is generated in the local economy (REMPPLAN, 2018; May et al., 2019).
- Service-learning models and student-led clinics have resulted in real-world training opportunities and much needed health services and therapeutic interventions to meet local gaps.
- Academic and professional staff contribute to the social fabric of the communities where they reside.
- Students contribute to communities through volunteering, mentoring young people, participation in sporting and community activities and career expos.
- Alumni of the RHMT program were identified in many communities, working in their professions and often also teaching and supervising current students.

Strengthening the RCS and UDRH Research Network

- The network has been instrumental in progressing research in rural and remote health, rural health workforce, rural health service delivery and rural training.
- Several key collaborative research efforts have informed a number of Commonwealth health workforce policy initiatives.

Value for Money

- The RCS and UDRH Network has delivered multifaceted social and economic benefits to rural communities, health and community services, rural health professionals, supervisors

¹ These nursing and allied health placements were not necessarily undertaken through the RHMT program

and students, in addition to those benefits directly related to teaching and research.

- An investment of approximately \$19,000 in 20 weeks of undergraduate rural clinical placement yields on average:
 - allied health professionals working an additional 12 hours of rural work per week¹;
 - nursing and midwifery graduates working an additional 18 hours of rural work per week¹.

Challenges and Opportunities

The RHMT program operates in an environment that has seen significant change in rural health workforce and higher education policy since its inception and continues to evolve presenting both challenges and opportunities for the RHMT program going forward.

Strategic Challenges

Complex and changing environment

- The program operates in a fragile environment where geographic health workforce maldistribution persists. This has implications for the program impacting on availability of supervisors, vulnerability of the program where clinicians need to balance student training against patient throughput and care, and student experience of rural practice.
- It is a health workforce program delivered through the higher education sector where education policies can take precedence over rural workforce policies and is impacted by changes in higher education policy and funding.
- Job opportunities for graduates of rural training are critical to deliver the strategic intent of the program. While Commonwealth, state and territory health workforce training and employment policies intersect with the RHMT program they are not consistently aligned or maximised.

Maintaining rural integrity

- Increasing fiscal pressure within the higher education sector poses challenges for the universities in ensuring their commitment to investment in rural communities, rural training and rural health research is maintained.

Alignment of program goals and outcomes with universities' sphere of influence

- While the intent of the RHMT program is to increase the number of appropriately qualified health professionals working in rural and remote Australia and ensure a well distributed health workforce, these outcomes are outside the direct sphere of influence of universities.

- Universities managing Regional Training Hubs (RTHs) have limited influence in the transition of medical students to rural, regional and remote prevocational and vocational training, and currently there is no mechanism for UDRHs to support the transition of allied health and nursing students to employment in rural, remote and regional Australia.
- Universities funded under the RHMT program are directly responsible for ensuring the delivery of high quality and positive rural training experiences for students and can be influential in encouraging their graduates to pursue a rural health career. Performance should be assessed on these measures.
- Alignment of program objectives and outcomes with the education and training functions of the universities would better inform their role and responsibility in rural health training pathways and engagement with other national and jurisdictional health workforce training and employment strategies to improve rural health workforce outcomes.

Balancing quality and quantity of placements

- There is considerable variability in the quality of placements currently being delivered under the RHMT program, ranging from the provision of minimal financial or accommodation support to structured placements with high quality supervision and additional learning opportunities (Appendix A). Differentiating RHMT program placements from other clinical placements requires a focus on balancing the desire for higher numbers of placements with a focus on ensuring placements are of high quality.

Shifting the location of training to respond to rural health workforce need

- The majority of clinical placements delivered through the RHMT program occur in ASGS-RA2 areas, and much of this is in acute care settings (Appendix A). However, the emerging evidence indicates that rurality of clinical placement and placement setting are predictors for rural practice and working in smaller communities where workforce needs are greatest (Appendix B).
- While some universities have invested in and developed strong training programs in smaller communities, increased effort and investment in training in smaller communities and in primary care settings is warranted.

Promoting Aboriginal and Torres Strait Islander peoples' participation and engagement with the program

- There is variability across the RCS and UDRH network in the extent of engagement with Aboriginal and Torres Strait Islander people, organisations and communities.
- Establishing, maintaining and supporting Aboriginal and Torres Strait Islander teams within RCSs and UDRHs is essential to ensure the cultural safety of students, staff and supervisors; culturally safe placements and workplaces for Aboriginal and Torres Strait Islander students and staff and; engagement with Aboriginal Community Controlled Health Organisations (ACCHOs) and communities. This is fundamental to increasing participation and engagement of Aboriginal and Torres Strait Islander people in all aspects of the program.

Consolidation of the Program

- The intended outcomes of consolidation of the funding agreements for the Rural Clinical Training and Support (RCTS) program, UDRH and the Dental Training Expanded Rural Placements (DTERP) program into a single agreement between the Department and the respective universities has not been realised.
- Consolidation has also highlighted the complexity of internal university structures and hierarchies, and tensions with respect to funding and autonomy between medical and multidisciplinary divisions.

Strategic Opportunities

Using the evidence to inform program improvement

- Research generated through the RHMT program provides a strong evidence base to inform future rural training models to improve rural health workforce outcomes (Appendix B).

National RHMT Program Evaluation framework

- A stronger focus on evaluation at the individual university level and the program as a whole would identify what training and workforce strategies work well in which context.
- The development of an overarching monitoring and evaluation framework would enable ongoing data collection by universities for internal evaluation and quality improvement processes and, assessment of impact at a university and program level.

Alignment of the RHMT program with other Medical Workforce initiatives

- The findings of this evaluation should be considered in the development of the *National Medical Workforce Strategy* to progress rural training models that focus on the work readiness of doctors by providing more exposure in the right settings and training opportunities to promote generalist skills and interest.

Improving allied health service quality, access and distribution

- The RHMT program, through the UDRHs, can support implementation of key initiatives identified by the National Rural Health Commissioner to improve access to allied health services in rural and remote Australia (Department of Health, 2020). Specific areas include increasing undergraduate and postgraduate training opportunities and expansion of the allied health rural generalist pathway; increasing the number of Aboriginal and Torres Strait Islander allied health practitioners and; increasing culturally safe and responsive services.

Leveraging research capability

- A sound foundation of research capability has been developed across the RHMT program

sites that can be enhanced by central university support.

- Historically, much of the research and collaborations generated through the RCS and UDRH network had been resourced through research programs with specific rural streams. However, there is currently no rural health research funding source.
- Strengthening engagement with Rural Workforce Agencies (RWAs) and other rural health peak bodies should be progressed to identify and address rural health workforce questions of jurisdictional and national importance.

Recommendations

The evaluation has identified aspects of the RHMT program design and delivery to be addressed to ensure it continues to be an appropriate strategy to contribute to developing and growing a health workforce that is clinically and professionally capable and culturally responsive for rural and remote health practice.

Program Outcomes, Objectives and Principles (Recommendations 1, 2)

Recommendation 1:

The Department, in consultation with the universities, refine the objectives and outcomes of the RHMT program to better reflect the sphere of influence of the universities toward achieving the long term goal of a health workforce that is clinically and professionally capable and culturally responsive for rural and remote health practice.

Rationale:

While the intent of the RHMT program is to address rural and remote health workforce shortages, its contribution is predominantly focused on training health and medical students to develop knowledge, skills and aptitude for rural practice. The RHMT program would benefit by including focused program objectives and outcome measures that reflect the teaching and research activities of universities for which they are directly accountable.

Universities participating in the RHMT program contribute to the development of rurally capable graduates. This is through the delivery of accredited health program curricula that develops clinical and professional knowledge, understanding of Aboriginal and Torres Strait Islander health and cultural responsiveness to enable graduates to work in rural and remote models of care in a variety of clinical settings. RHMT program funding enables the delivery of this curricula by supporting students to undertake placements in rural, remote and regional locations.

Recommendation 2:

The Department, in consultation with the universities, adopt a set of principles to underpin the objectives and implementation of the RHMT program.

Principles

A set of draft principles is offered for consideration to underpin refinement of the program objectives, recognising the maturity of the RHMT program and the need to reflect the contemporary environment in order to meet current and emergent health and workforce needs of rural and remote communities. We suggest a clear and comprehensive set of objectives could replace current objectives and parameters allowing for flexibility in how individual universities meet those objectives.

Principle	Rationale
<ul style="list-style-type: none">▶ The intent of the RHMT program is to contribute to rural workforce through high quality training and facilitating student engagement with communities to influence rural career choices.	It is designed to help secure a health workforce in rural and remote Australia which is well distributed and made up of the right kind of health professionals, in the right places, at the right time.
<ul style="list-style-type: none">▶ The RHMT program is a 'value-add' program.	It aims to assist universities to enhance existing rural health professional education programs where they are committed to contributing to address the rural health workforce issues and developing and testing innovations to do so.
<ul style="list-style-type: none">▶ Full and ongoing participation by Aboriginal and Torres Strait Islander people and organisations in activities across the whole RHMT program is central to improving equity and access, strengthening cultural safety and sustaining the community responsiveness of the program.	Equity and access are fundamental to improving the meaningful participation of Aboriginal and Torres Strait Islander people in the RHMT program. Genuine partnerships with Aboriginal and Torres Strait Islander people, organisations and communities will enhance the capacity of universities to deliver on all aspects of the program. Aboriginal and Torres Strait Islander people should be actively supported to participate in the program as students, employees, leaders and partners.

Principle	Rationale
<ul style="list-style-type: none"> ▶ The RHMT program complements other rural health workforce and education programs. 	<p>It forms part of a suite of programs at Commonwealth, State and local levels and should complement, not duplicate.</p>
<ul style="list-style-type: none"> ▶ The RHMT program has a longitudinal orientation towards 'building rural careers'. 	<p>This recognises the role of universities in preparing students for rural careers and in connecting with and supporting post graduate initiatives and programs.</p>
<ul style="list-style-type: none"> ▶ The RHMT program is underpinned by a commitment to community investment and contributes to the social capital of the communities in which it is embedded. 	<p>It is important to recognise the economic, social and employment value of rural training sites to their rural communities and the contribution communities and health professionals make to student training.</p>
<ul style="list-style-type: none"> ▶ The RHMT program strongly supports high-quality education and training models that focus on developing rurally capable graduates across a range of health professions. 	<p>A generalist rural and remote workforce is required to meet the needs of rural communities including GPs, general specialists, generalist nurses and generalist allied health professionals.</p>
<ul style="list-style-type: none"> ▶ The RHMT program will be responsive to identified and changing workforce needs over time, supporting opportunities for workforce training and retention particularly in smaller communities. 	<p>Workforce shortages continue to exist in many locations, particularly in MM 3-7 areas, and these shortages have changed over time. Training should prepare health professionals to be work ready and for the workforce in the right places, that is needed now and in the future.</p>
<ul style="list-style-type: none"> ▶ The RHMT program strongly supports high quality research focused on rural workforce, rural training and service delivery and; research capacity building in rural communities. 	<p>Rurally focused research develops an evidence base to inform innovative education and training, rural workforce strategies, rural and remote models of care and service delivery.</p>

Principle	Rationale
<ul style="list-style-type: none"> ▶ The RHMT program has regular and transparent performance monitoring, review and evaluation. 	<p>The Department and universities need to be accountable for program delivery ensuring outcomes, benefits and investment is maximised.</p>
<ul style="list-style-type: none"> ▶ The RHMT program supports innovation and collaboration locally, regionally, nationally and internationally. 	<p>The RHMT program is part of a complex health workforce and higher education system where community needs, models of care and workforce needs change over time. Responding to these changes requires collaboration, agility and innovation.</p>

Student selection (Recommendation 3)

Recommendation 3:

The RHMT program requires each university to demonstrate how their selection process for rural placements identifies students with a genuine interest in rural health and preferences these students for extended and/or innovative rural placements.

Rationale:

The evaluation found variability in the processes and effectiveness of student selection for rural streaming. While the literature (and the Multidisciplinary Health Workforce survey) demonstrates that metropolitan students who have had positive rural placements of longer durations across their university program contribute to the rural workforce, rural background as a predictor for future rural work remains an important consideration. While it is difficult to assess 'genuine interest' in rural health, several universities have developed multi-dimensional selection processes for rural placements including:

- Expressions of interest to demonstrate understanding of/or commitment to rural and remote communities, their expectations of the placement and what they are seeking to learn
- Interviews
- Consideration of rural background

The increased number of tertiary health programs and student enrolments has increased the demand for student placements. Furthermore, rural placements are increasingly being recognised as opportunities for good learning experiences. Therefore, selection of students for rural placements should identify and preference students with a genuine interest in rural and remote health.

Curricula (Recommendations 4,5)

Aboriginal and Torres Strait Islander Health

Recommendation 4:

The RHMT program requires universities to demonstrate that they meet AMC, ANMAC or professional association accreditation requirements for the inclusion of Aboriginal and Torres Strait Islander health in their health program curricula.

Rationale:

The evaluation found variation between universities in the extent to which Aboriginal and Torres Strait Islander health is scaffolded into program curricula. In most universities these subjects or topics are not directly assessed.

The universities are responsible for the development and accreditation of curricula for the health programs they offer. The AMC and ANMAC mandate curriculum including Aboriginal and Torres Strait Islander health content for medical and nursing courses respectively. Allied health curricula requirements are set by the relevant professional associations. It is not the Department's role to evaluate curricula and hold universities to account for course content.

Rural Health

Recommendation 5:

The Department consult with the universities to determine how rural health could be incorporated into their health program curricula.

Rationale:

There is no mandated requirement for rural health in program curricula. Universities in receipt of RHMT program funding could show their commitment to supporting the intent of the rural workforce program by including rural health in curricula with a focus on the differences of living and working in a rural and remote community, the social determinants of health, public health issues, remote health, health inequities, health service access and equity issues for rural and remote communities.

While the RHMT program enables a selected cohort of students to contextualise their learning in a rural environment, the inclusion of topics on rural health in course curricula for all students would provide a foundation of knowledge where the graduate may be caring for rural residents in metropolitan hospitals, or for possible future work in rural areas.

Placement Quality (Recommendations 6-14)

The RHMT program has multiple and inter-twined components that hinge around the RCSs and UDRHs providing quality student placements. These include development and maintenance of supervision capacity, developing research capacity of students, the academic networks and local health and community service staff more broadly.

Recommendation 6:

In setting targets and benchmarks for both the RHMT program and individual universities, the Department should consider factors including placement location; placement setting; quality and; innovative nature of the placement.

Rationale:

Quality has not been defined under the RHMT program framework. The evaluators developed an evaluative rubric to assess the extent to which universities were delivering quality placements relevant to the intent of the RHMT program [see Appendix 11 of the final report for full rubric].

Elements of a high-quality placement:

- Placements of extended length (at least 6-8 weeks allied health and nursing; 40 weeks medicine)
- Free or highly subsidised accommodation, utilities and Wi-Fi
- Good coordination of pre-placement applications that prioritise rural background students
- Written or online preplacement information to students about local amenities, and opportunities prior to the placement e.g., short online videos where the students can view the site, the accommodation and the key contact people.
- Face to face orientation to the clinical placement and location
- Clinical training experience specifically relevant to rural and remote job opportunities
- Clear learning outcomes of the clinical placement
- Regular access to teaching clinical educators and/or supervisors of the relevant discipline
- Access to structured inter-disciplinary education and service-learning opportunities (for allied health)
- Face to face cultural safety training contextualised to the location
- Placement includes planned and structured engagement with Aboriginal and Torres Strait Islander health services and/or community organisations
- Opportunities for students to meet people and undertake activities in the local community
- Opportunity to debrief with RCS/UDRH staff about clinical placement and personal issues
- Evaluation processes for improvement

UDRHs, to a greater extent than RCSs, are challenged in consistently delivering quality placements and meeting placement targets. There is a tension between delivering high-quality innovative placements that are resource intensive or shorter and less intensive placement that 'deliver the numbers'. Placements such as service-learning and student-led clinics provide benefit to students in gaining experience in "real world" rural models of care and increase service capacity or meet gaps in a community. However, to sustain these types of service-learning placements UDRHs require a consistent stream of students who value the rural experience. Where this has been achieved, UDRHs have been able to negotiate with universities or faculties, with similar commitment to rural communities, for flexibility in placement duration and setting. Establishing, managing and maintaining partnerships with placement partners requires sustained effort by the UDRHs.

It is recognised that placement targets and benchmarks are valuable for assessing the implementation, reach and achievements of the program but more nuance is needed in the way placements are reported and data interpreted. While the value of national program targets is recognised to assess overall program achievements, it is also important that the Department retains the flexibility to negotiate targets with individual universities that reflect context, quality and promote innovation.

Recommendation 7:

To facilitate longer rural immersive placements, the RHMT program encourages:

- ▶ Universities to review allied health and nursing curricula and clinical placement requirements to enable longer rural placements in and across acute, non-acute and community care settings reflective of employment options in rural and remote communities.
- ▶ UDRHs to work with specific and/or like-minded universities or faculties and health and community services to develop longer rural immersions for nursing and allied health students, particularly to sustain student-led service-learning models.

Rationale:

The length of placements, including rural placements, are determined by each faculty in the development and accreditation of their course curricula. Furthermore, the states and territories' health departments have policies that can impact on the development of longer-term allied health and nursing placements. UDRHs have limited influence over the length of placements. However, a small number have worked with their central university to review allied health curricula and have successfully established, or are planning to establish, longer (up to a year) rural immersions. UDRHs have also been innovative in developing nursing placements in primary care, community mental health and remote health by topping and tailing acute care placements with these non-acute placements. In progressing longer placements and in different care settings, requires not only a review of allied health and nursing curricula in the first instance, but also negotiate placement length and settings with state and territory health services, as well as other placement providers.

The rural workforce literature and the Multidisciplinary Health Workforce Survey provides evidence of the positive effect of cumulative and longer duration rural placement on promoting rural work outcomes.

Cultural safety

Recommendation 8:

The RHMT program adopts the Ahpra definition of cultural safety to inform the development and delivery of cultural safety training for students, staff and supervisors.

Rationale:

Cultural safety training aims to ensure that students and staff act in ways that recognise and respect the cultural identity of a person and safely meet their needs, expectations and rights and is an essential element of quality placement and supervision.

A core requirement of the RHMT program, is for universities to report the number of students receiving “cultural training”. However, there is inconsistency in terminology used in the current RHMT program funding agreement and it is difficult to ascertain the nature or extent of cultural awareness and/or cultural safety training being delivered by universities at main campuses and how this is contextualised at rural sites.

Ahpra, through its Strategy Group, led by the Aboriginal and Torres Strait Islander members and in partnership with the National Health Leadership Forum, consulted on and finalised a baseline definition of cultural safety.² Adopting this definition and requiring universities to report against it would facilitate better understanding of the extent to which students undertaking rural placements are participating in relevant cultural safety training.

Recommendation 9:

Through the RHMT program the universities be required to demonstrate their strategy for ensuring cultural safety of student placements and workplaces for all students, staff and supervisors.

Rationale:

The current RHMT program framework focuses on developing cultural safety of non-Indigenous students on placement but is silent on ensuring culturally safe placements for Aboriginal and Torres Strait Islander students. The development of culturally safe placements and workplaces for Aboriginal and Torres Strait Islander students and staff should be explicit in future guidelines.

² <https://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx>

Engagement with Aboriginal and Torres Strait Islander people, services and communities

Recommendation 10:

Through the RHMT program, the universities are encouraged to:

- ▶ Employ senior Aboriginal and Torres Strait Islander academics in leadership positions
- ▶ Recognise and value Aboriginal and Torres Strait Islander expertise in addition to academic and/or professional qualification for employed staff and people engaged on a casual or contract basis
- ▶ Develop a team of Aboriginal and Torres Strait Islander staff to work with and enact strategies for ongoing engagement with Aboriginal and Torres Strait Islander health services, organisations and communities, deliver cultural safety training and support Aboriginal and Torres Strait Islander students on placements
- ▶ Develop tailored professional development programs aligned to career goals of Aboriginal and Torres Strait Islander staff

Rationale:

Establishing placements in ACCHOs requires the universities to have a genuine commitment to developing the cultural responsiveness of non-Indigenous students and providing reciprocal benefit to the ACCHO and/or local community. The evaluation identified numerous examples where this reciprocal benefit was evident and, in most cases the meaningful engagement with local ACCHOs was facilitated by Aboriginal and Torres Strait Islander staff taking the lead.

By strengthening Aboriginal and Torres Strait Islander teams and leadership in the RCSs and UDRHs, the universities can leverage on this expertise for input into the planning, delivery, monitoring and review of the key components of the RHMT program including teaching, placements, supervision capacity building, cultural safety of placements, cultural safety of the workplace, research, community and service engagement and community development.

UDRHs and RCSs draw on local Aboriginal and Torres Strait Islander people to fulfil a range of roles to support the delivery of cultural safety training to non-Indigenous students, supervisors and other health professionals, provide mentoring and support to Aboriginal and Torres Strait Islander students and, participate in various teaching activities. Many of these roles are performed on a casual or ad hoc basis. However, the evaluation found the inflexibility of human resource policies and processes in some universities challenged respectful engagement, employment and recognition of their Aboriginality as a qualification.

The contribution of Aboriginal and Torres Strait Islander people is an important and essential element in the education of health students, providing support and mentoring

to Aboriginal and Torres Strait islander students through their studies and, providing a practical understanding of Aboriginal and Torres Strait culture to develop cultural responsive non-Indigenous students. Appreciation of the contribution of community members to student training needs to be appropriately recognised and remunerated.

Supervision capacity and capability

Recommendation 11:

To strengthen supervision capacity and capability in rural, remote and regional sites, the RHMT program encourages universities to engage with current and potential supervisors on a regular basis to identify and implement:

- ▶ Supports and skills development required to commence or continue to provide supervision to students
- ▶ Employment or other engagement and recognition arrangements required recognising possible differences between localities, settings and disciplines
- ▶ Opportunities for localised or regional innovative supervision models.

Recommendation 12:

The RHMT program requires each university to adopt a continuous improvement process to benchmark and review the quality of placements and supervision capacity building strategies.

Rationale:

The quality of a student placement is highly dependent on the quality of supervision. Whilst the RHMT program operates in a relatively fragile workforce environment, particularly in rural and remote locations, the evaluation has identified innovative supervision models and supports structured to build and maintain local and regional capacity. UDRHs have developed supervision capacity through direct employment or sub-contracting particularly to support service-learning placements. Some RCSs have utilised this part-time employment approach as a mainstay for rural and remote sites, while other have used adjunct appointments or a mix of engagement arrangements.

RCSs and UDRHs described a range of activities employed to support supervisors to develop supervisory skills and capability, whilst recognising this was an area for ongoing effort and improvement, particularly in an environment where there is considerable movement of supervisors. An evaluative rubric for supervision capacity and capability was developed drawing on the literature, documentation provided by the RCSs and UDRHs, and consultations with supervisors, students and other stakeholders. The rubric provides a benchmark for assessing supervision capacity building and can be used by the universities for ongoing quality improvement [see Appendix 11 of the final report for full rubric].

Elements supporting the development and delivery of quality supervision

- Supporting supervisors to gain educational qualifications
- Support for supervisor-led research and/or opportunities to participate in research
- Documented governance processes to ensure supervisor safety and quality
- Building organisational capacity in local health services for supervision including administration, clinical education capability and workplace assessment capacity
- Face to face supervisor training
- Supervisor mentoring processes
- Conjoint or full adjunct appointments for supervisors with the university
- Formal processes for dealing with issues/complaints from supervisors or students
- Supervisors provided with individualised information about students' learning objectives
- Supervisors being familiar with the curriculum and assessment requirements of the various universities
- Supervisors being supported by academics and placement coordinators
- Supervisors provided with cultural safety training
- Regular feedback mechanisms
- Networking opportunities for supervisors with the RCS and UDRH

The sustainability of the RHMT program and the delivery of rural training to curricula requirements requires high quality placements underpinned by high quality supervision. Universities need to take a proactive approach to monitoring and reviewing placement quality including supervision capacity and capability.

Interprofessional learning

Recommendation 13:

The Department consult with the universities to determine how interprofessional learning could be progressed through the RHMT program.

Rationale:

Consolidation of the RHMT program was identified by the Department as a vehicle to improve the scope for interprofessional learning. However, delivery of interprofessional learning has been a challenge across most of the RCS and UDRH network with differences in curriculum requirements, placement lengths, timing of placements and different stages of student development within their course, impacting on the delivery of planned, structured and educationally relevant learning experiences. The need to develop effective interprofessional learning strategies has been identified by both FRAME and ARHEN.

There is a breadth and depth of knowledge and expertise in the academic and professional staff employed by the RCSs and UDRHs and currently limited opportunities where these groups come together to share learnings or jointly problem solve. ARHEN and FRAME could progress the development, implementation and evaluation of interprofessional learning models which would provide value and benefit to the broader network and establish a foundation for future shared work.

Responding to community and workforce need (Recommendation 14)

Recommendation 14:

In the next iteration of the program, the RHMT program requires all universities to:

- ▶ Invest to incrementally increase the proportion of placements provided in smaller communities
- ▶ Develop and sustain extended medical placements with exposure to general practice, ACCHOs, primary health care and rural hospitals to enable students to develop knowledge of the clinical skills and professional capabilities required of doctors working in rural and remote generalist models of care
- ▶ Develop longer immersive allied health and nursing placements in community and non-acute care settings in conjunction with local health and community care providers

Rationale:

Workforce maldistribution persists in rural, remote and very remote locations for general practitioners, general medical specialists, allied health professions and dentistry. While the nursing workforce is distributed across geographical areas it is an ageing workforce in rural and remote locations. The health needs of communities are changing with an ageing population, increased prevalence and acuity of chronic disease, and with this, changing models of care and approaches to service delivery are required.

To prepare the future health workforce for this changing rural health environment and workforce requirements the RHMT program needs a more nuanced approach to training that considers the evidence of the impact of placement duration, location and setting on workforce outcomes.

As a mature program, the universities can build on the training capacity that has been established, predominantly in RA2 and regional settings, as a stepping-stone, to increase and support placements and supervision in smaller towns. Where there may be limited options for extended placements in smaller communities, actively using regional towns as hubs to support students and supervisors for placements in smaller rural and remote sites should be encouraged.

Strengthening research networks (Recommendations 15,16)

Recommendation 15:

Through the RHMT program, universities be required to demonstrate that they are supporting rural research through the RCS and UDRH network by:

- ▶ Delivering high-quality research training, skills development and research support to local health professionals, supervisors, students and broader community stakeholders
- ▶ Developing regional consultative mechanisms to identify and respond to local research needs.

Rationale:

The RCS and UDRH networks have delivered on a broad program of research and built research capacity of the rural and remote health workforce. The RCS and UDRH networks undertake highly valued work at the local and regional level to build research skills and capability for students, graduates, supervisors and local health professionals and, conduct locally relevant research and evaluation.

The efforts of the RCSs and UDRHs to build local research capacity and, progress research and evaluation in response to community and stakeholder needs and priorities, demonstrates their social accountability and that of their central university and is fundamental to progressing the rural health research agenda.

Recommendation 16:

Through the RHMT program, universities be required to demonstrate how:

- ▶ RCS and UDRH researchers are mentored and supported to build their research capabilities and careers
- ▶ Targeted support and mentoring is provided for rural based early career researchers, mid-level and senior researchers to enable them to join established research teams to address national and global research questions related to rural and regional health and health workforce
- ▶ Rural research and teaching is recognised, valued and rewarded
- ▶ Collaborations with other RHMT program participants are developed and maintained to progress multi-site, multi-university and cross jurisdictional research to address nationally relevant questions and strategies for translation and dissemination

Rationale:

RHMT program sites draw on a range of funding sources to progress the rural health research agenda with access to national and competitive research funds highly dependent on academic leadership in the RCS and UDRH.

The evaluation found central universities recognition of, and support to rurally based researchers to be variable. The applied and evaluative focus of rural research coupled with the scope of work of rural researchers and academics is not well aligned to the universities' metrics for academic progression. The evaluation identified that research capability and capacity across the RCS and UDRH network could be strengthened by central universities facilitating connection to, and support from, established research teams and institutes.

Through the RHMT program the RCS and UDRH has developed a sound foundation for rural research, produced a significant body of research to progress the rural health agenda and established an evidence base for rural education and training. This rural research network can be strengthened and supported through collaborations with their central university, across universities and across jurisdictions to progress rurally focused research of national and international significance.

Transitioning medical students to rural work (Recommendations 17, 18)

The Department, through the funding of RTHs under the RHMT program, has extended the role of universities to support transition of medical students to rural postgraduate training (and rural work) as part of the integrated rural medical training pathway.

Recommendation 17:

Through the RHMT program, RTHs place emphasis on engagement with RCS students and junior doctors for individual vocational planning and career guidance, with linkage to a rural clinical mentor.

Rationale:

The RTHs have been established as part of the Integrated Rural Training Pipeline which recognises the gap between graduation from medical school into regional prevocational and vocational training, and variable, and often limited availability of accredited training posts.

The RTHs have described a range of strategies to support medical students and junior doctors into regional training. Only about a half were found to directly engage with medical students and junior doctors, for career planning, vocational guidance and facilitating linkage with a rural clinical mentor.

RTHs clearly have a role in supporting the transition of RCS graduates and other medical students with a genuine interest in rural health into prevocational training in the regions. The location of RTHs in regional areas positions them to directly engage and support medical students and junior doctors to develop individual training plans toward rural medical pathways. This should be a priority for all RTHs.

Recommendation 18:

To enhance the impact of RTHs at a regional level, the Department work with the state and territory governments to explore mechanisms to progress the Integrated Rural Training Pipeline with consideration of a framework that identifies shared goals, joint planning processes, and alignment of resources to support regional training and workforce development.

Rationale:

The Commonwealth funds a number of rural medical training initiatives targeting junior doctors (i.e. RJDIF) and registrars to progress GP specialist training, through the AGPT rural stream and Rural Generalist Pathway, and non-GP specialist vocational pathways through the STP-IRTP as well as STPs. In addition, the Commonwealth funds the RWAs to support the recruitment and retention of GPs to rural areas. States and territories have responsibility for the employment and training of interns, junior doctors and hospital-based registrars on vocational pathways.

The RTHs have a facilitation role to join up the Commonwealth and State initiatives to progress the Integrated Rural Training Pipeline. However, their effectiveness appears to be dependent on the strength of partnerships with the LHNs and regional hospitals. The evaluation found local relationships, local leadership, opportunities for shared investment (e.g., co-employment arrangements, contribution of STP-IRTPs) and personnel with well-developed understanding of accreditation of training posts and pathways to be key enablers.

The impact of the RTHs and the RHMT program as a whole, would be enhanced by alignment of the goals and objectives of the Commonwealth funded initiatives across the medical training pathway to completion of fellowship together with those of State and Territory employment and training initiatives.

The co-design of medical training and employment strategies at jurisdiction and regional levels offers the potential for aligned activities toward regional workforce outcomes across these programs. Partners in the co-design strategy include the University relevant to the region(s) managing the RCS and RTH; ACRRM, RACGP and the GP RTO(s); medical colleges holding STPs and STP-IRTP; LHNs managing prevocational training posts (including RJDIF) and vocational training posts; the RWA and PHN relevant to the region. The Rural Generalist Coordinating Units will also be operating in this space in 2020.

Social Accountability (Recommendation 19, 20)

Community Engagement

Recommendation 19:

The RHMT program requires the universities to have formal consultative mechanisms for engagement with communities and key stakeholders (i.e., health and community services, supervisors, local government) to:

- ▶ Identify local and regional training, research, community development priorities
- ▶ Develop, implement, monitor and review collaborations
- ▶ Progress evaluation and quality improvement of program components including placements and supervision capacity building
- ▶ Provide feedback on initiatives and activities

Rationale:

The precursors to the RHMT program were founded on innovation and community responsiveness. The establishment and maintenance of Community Boards was a requirement of earlier RCS and UDRH contracts but was not continued under the consolidation contract. Internal and external stakeholders to the RHMT program are keen that the universities and local sites remain responsive to the community and region in which they are situated. This is fundamental to the social accountability of the universities funded through the RHMT program in “directing their education, research and service activities to the priority health concerns of the community, region and nation” (Boelen & Heck, 1995).

While the maintenance of effective and meaningful community governance structures is challenging, mechanisms for the universities to engage with communities and key stakeholders for planning, evaluation and review, and quality improvement is demonstrative of their social accountability.

Community investment

Recommendation 20:

To maintain the rural integrity of the RHMT program, the Department has clear contractual requirements to protect and quarantine rural funding and maximise investment of RHMT program funds in the regions. This includes evidence of:

- ▶ Identifying and reporting on investment of RHMT program funds in rural communities
- ▶ Involvement of rurally based academics in university and faculty governance

processes

- ▶ Purchasing locally wherever possible
- ▶ Employment of local staff and engaging local contractors
- ▶ Engagement with community targeted consultative mechanisms
- ▶ Articulation and quantification of in-kind contribution by the university
- ▶ Delivering full or extended components of university degrees in regional campuses
- ▶ Senior leadership living rurally
- ▶ Employment arrangements for rurally based staff comparable to metro counterparts

Rationale:

There has been a waning in commitment to maintaining the rural integrity of the program by some universities. Centralised strategic and budgetary decisions, purchasing and human resource functions and centralisation of some key staff impacts the economic and social benefit derived through the RHMT program and accountability of the university to the communities in which they operate.

The evaluation identified that in most universities, academics and professional staff employed under the RHMT program are predominantly on fixed term contracts, as it is deemed to be external funding. This is in contrast to centrally employed staff who are more likely to be employed on continuing contracts. A clear signal of commitment to rural integrity by the universities would be the overt recognition of the embedded role of rural programs (and rural academics) in respective faculties by offering continuing contract arrangements in line with centrally based academics and professional staff.

Rural communities, rural health and community services and rural practitioners are critical to provision of the training component of the RHMT program. Therefore, the principle of community investment should underpin the RHMT program. Recognising the increasing fiscal pressure on the university sector it is important that universities maintain their commitment to rural communities and counter strategies that potentially weaken this commitment.

Measuring program impact (Recommendations 21,22)

Medicine

Recommendation 21:

The Department consult with universities to review current approaches to graduate tracking to determine an agreed methodology and variables in order to enable comparison of outcomes across universities.

Rationale:

All medical schools have progressed graduate tracking programs linking university records with Ahpra, the MSOD and FRAME student survey. The majority of studies examining workforce outcomes have reported on single-institution outcomes, with only one inter-university study reported to date. Concurrent to the RHMT program evaluation, the Department has funded MDANZ to undertake the annual MSOD survey and national trend report and explore a potential data linkage with Ahpra registration data which may inform future tracking methods.

Graduate outcome by universities has been a key metric to link training with the aims of the RHMT program. However, methodological inconsistencies do not allow for a direct quantitative comparison of single-institution RCS program outcomes limiting the assessment of the impact of the RHMT program as a whole on medical workforce outcomes.

Nursing and Allied Health

Recommendation 22:

The Department review the current requirement for UDRHs to track individual allied health and nursing students under the RHMT program agreement.

Rationale:

While the intent of graduate tracking is to determine the impact of the UDRH supported placement on rural workforce outcome, there are multiple confounders that challenge the feasibility of UDRHs tracking students and validity of findings e.g., students may be supported by more than one UDRH during the undergraduate program; often short duration placements; students can access rural placements independent of a UDRH; availability of rural employment opportunities. While there may be opportunities to develop a national data linkage mechanism between universities (not only those funded under the RHMT program) and Ahpra, this would only capture those allied health disciplines registered with Ahpra.

Program performance (Recommendations 23, 24)

Recommendation 23:

The Department develops a national monitoring and evaluation framework for the RHMT program.

Recommendation 24:

The Department require each RHMT program funded university to conduct an evaluation of their RHMT program in the next iteration of the program, using the

national monitoring and evaluation framework.

Rationale:

Evaluation of the performance of individual university programs was outside the scope of this evaluation. However, as highlighted throughout this report, the evaluation found considerable variation between universities across all aspects of the program and the extent to which they are meeting program requirements and contributing to improving workforce outcomes. Furthermore, there was limited evidence of internal evaluations of individual universities' programs.

A monitoring and evaluation framework at both a program level and individual university level would provide a stronger mechanism for assessing and monitoring performance for formative and summative purposes in the next iteration of the program. A more rigorous performance management approach would enable the Department to enhance the effectiveness of the program and to address issues of concern in a timely manner.

Funding and Innovation (Recommendations 25-29)

Program expansion

Recommendation 25:

In recognition of geographic gaps in the delivery of multidisciplinary placements, the Department investigate the feasibility of the RHMT program network expanding functions into these regions or establishment of additional UDRH(s).

Rationale:

UDRHs are located in each state and the Northern Territory. However, there are obvious geographic gaps in coverage including Central Queensland and the South West and Goldfields regions of WA.

Expanding the RHMT program into regions where a university presence is limited or absent would enable the further development of rural placements and increased training opportunities in smaller towns and communities (MM 3-7 regions) as well as offering social, economic and workforce benefits.

Funding allocation

Recommendation 26:

The Department review the funding allocation formula for the RHMT Program to take into consideration remoteness for the delivery of the whole program.

Rationale:

Currently, each UDRH receives a comparable quantum of funding. However, there are higher operating costs for UDRHs that support and maintain staffing and supervision across dispersed communities as well as costs associated with supporting students to undertake placements (i.e. transport and relative accommodation costs in more remote locations).

The RHMT program operates within a finite budget. It is acknowledged that in the absence of an increase in program funding, reallocation of resources would be required to recognise differences in operating costs and support training in more remote environments.

Progressing innovation

Recommendation 27:

In the next iteration of the RHMT program, the Department considers:

- ▶ Establishing an innovations funding pool to support and drive new initiatives including training, research and community engagement, to enable universities to be agile and responsive within the changing rural environments in which they operate
- ▶ Targeted investment to increase training in MM 4-7 through universities that can demonstrate their capacity to deliver high quality, value for money placements in rural and remote areas.

Rationale:

The RCS and UDRH network have well established approaches to training and research in their regions. However, the evaluation has identified that the majority of medical and multidisciplinary training occurs in inner regional areas (RA2), and for medicine and nursing in the acute care setting. The benefits of allied health service-learning models have been described. There are a small number of universities that deliver the majority of their placements in RA 3-5 (MM 4-7) ³ which can be built on with targeted resourcing.

While research is a requirement of the RHMT program agreement with the universities, there is not an identified quantum of funding to progress rurally focused research specified in the agreement.

Universities should be encouraged to develop and progress new models for training and supervision, research collaborations and community consultative mechanisms

³ Currently the RHMT program uses the ASGS – RA classification of geographical remoteness. There is a recognised anomaly of this classification particularly for RA3. The Department is moving to adopt the Modified Monash (MM) Model geographic classification for all workforce programs and it is our understanding that the RHMT program will transition to MM.

to provide benefit within their own geographic region; to inform the broader RHMT program participants and; contribute to the evidence to develop rurally capable health professionals and rural workforce.

Progressing a multidisciplinary rural training and career pathway

Recommendation 28:

In the next iteration of the RHMT program, the Department resources the universities to extend the role of the UDRHs to facilitate transition of allied health and nursing students into graduate roles in rural, remote and regional areas. The key functions include:

- ▶ Augment the supervision capacity and capability of local health and community services to enable these agencies to establish graduate and early career positions (i.e., PGY 1-4)
- ▶ Engage with students on placement to provide career guidance outlining pathways to rural work and rural careers
- ▶ Provide additional education, professional development and mentoring support to new graduates and early career practitioners

Rationale:

For allied health and nursing the most significant predictive factor for long term rural practice was found to be initial rural practice i.e. the first job after an undergraduate degree (Playford et al., 2020). The evaluation identified a role for UDRHs to support transition of graduates into rural work.

This aligns with the findings of *The Educating the Nurse of the Future Review* identifying that graduate nurse positions in primary health care, community care and, rural and remote locations are novel and very limited and the need for Transition To Practice programs in settings other than acute care.

The National Rural Health Commissioner has been tasked to develop recommendations to improve the quality, equitable access and distribution of the regional, rural and remote allied health workforce. A proposed key initiative is pooled funding arrangements for place-based service models that promote supported and rewarding rural allied health careers. This dovetails with the intent of the RHMT program presenting an extended role for UDRHs for the delivery of longer rural training immersions and supporting students as they transition into early career roles.

A recent review by SARRAH of strategies for increasing recruitment and retention of allied health professionals in rural Australia (Battye et al, 2019) further describes a rural pipeline and demonstrated how the work currently undertaken by UDRHs could be extended across the career continuum including to support the transition of graduates into rural work. UDRHs have demonstrated their capacity and capability to

directly supervise students, develop and support supervision capacity of other health professionals in acute and community care settings, and provide pastoral care and support to individual students, all of which can be applied to early career graduates and the services in which they work. Furthermore, augmenting supervision capacity in local health and community services provides future benefit to the UDRH through increased student placement capacity and supervision capability.

As occurred with the establishment of the RTHs, additional investment will be required to extend the role of UDRHs to support the transition of nursing and allied health graduates into rural work.

Articulated training pathways

Recommendation 29:

The Department of Health consult with the Department of Education, Skills and Employment on the *National Regional, Rural and Remote Education Strategy* to determine the feasibility of extending the role of UDRHs into the pre-university sector and in supporting students enrolled in online health courses.

Rationale:

Stakeholders contributing to the evaluation, including the Aboriginal and Torres Strait Islander health workforce peak bodies and ACCHOs, identified a role for the UDRHs and RHMT program funded universities to develop pathways to articulate training for Enrolled Nurses, Aboriginal Health Workers/ Practitioners and Allied Health Assistants to tertiary qualifications. *The Educating the Nurse of the Future Review* identified the need for articulated training pathways from VET credentials to degrees to enable transition from Enrolled Nurse to Registered Nurse qualifications.

As locally placed entities UDRHs are well positioned to develop pathways between rural secondary schools, the VET sector and universities. UDRHs employ or contract clinical educators and there is scope to develop localised strategies to support VET trainees in the workplace.

There is also potential for UDRHs to provide educational support and placement support to rural and remote residents enrolled in online health courses. This extends opportunities for end to end training and aligns with the *National Regional, Rural and Remote Education Strategy* to improve access to tertiary study options for students in rural, remote and regional areas.

Future Direction

Program Planning and Delivery

It is our understanding that the Department intends to consult the sector on the findings and recommendations of this evaluation. This section provides suggestions about the future direction of the program to assist in the consultation process.

Drawing on the findings of the evaluation, changed operating environment, and maturity of the program, the evaluators offer a refined set of DRAFT objectives to ensure the program is contemporary and meets current needs of rural and remote communities and the workforce, and that it focuses on those areas of opportunity and potential. The heterogeneity of strategies developed by RCSs and UDRHs to deliver the components of the RHMT program tailored to local and regional health workforce and service capacity is recognised as a strength of the program. Therefore, it is suggested that each university submit a 3-5 year plan that sets out how it would work toward the goal and objectives in their region as the basis for funding and ongoing accountability.

The proposed objectives are informed by the current set of parameters and activities under which the program operates. The intent of the proposed objectives is to be specific and measurable.

Proposed Goal of the RHMT program:

To provide a clinically and professionally competent and culturally responsive health graduate workforce to meet the health care needs of communities in rural, remote and regional areas of Australia.

Proposed Outcomes of the RHMT program:

- Increased number of appropriately qualified health professionals with the clinical, professional and cultural capability and interest to work in rural, regional and remote Australia
- Increased capacity for training health students in MM 3-7 regions across Australia
- Increased opportunities for nursing, allied health and medical graduates to work in areas of rural and remote workforce need
- Increased research capability in rural, remote and regional areas addressing local and national health workforce and service priorities

Proposed Objectives:

Training

- To increase training in locations and settings that reflect current workforce and community health needs for students in a range of health disciplines

- To increase the proportion of high-quality placements delivered through the RHMT program
- To increase opportunities for service-learning placements, placements in ACCHOs and rural generalist placements across disciplines
- To incrementally increase placement capacity in small communities across all disciplines
- To develop and strengthen supervision models in small communities (MM 4-7) regions
- To establish and implement mechanisms to ensure selection processes into university AND rural placement reflect the evidence for likelihood of future rural practice
- To provide locally contextualised cultural safety training to all students on placement
- To ensure the cultural safety of all placements

Research

- To strengthen research capacity and capability in rural communities (within the RCS and UDRH, health services, students, local community)
- To establish research networks across universities and across jurisdictions to address research questions of national significance in relation to rural and remote health, workforce and service delivery

Workforce transition

- To provide vocational planning support to students on placement
- To facilitate the transition of allied health and nursing graduates (PGY1-4) to rural and remote practice
- To facilitate the transition of medical students to regional and rural prevocational training

Workforce

- To increase the number of Aboriginal and Torres Strait Islander staff employed in RHMT program units in leadership, academic and professional roles
- To maintain well supported networks of rurally based academics through employment and professional development
- To provide cultural safety training to all staff, clinical supervisors and others involved in the delivery of the RHMT program
- To provide a culturally safe workplace for all staff

Community Engagement

- To establish and maintain networks and mechanisms that demonstrate reciprocity between universities and local communities

Governance

It is recognised that current governance arrangements aim to minimise red tape while ensuring funding recipients are held accountable for meeting program requirements. In recognition of the maturity of the RHMT program and the capacity of universities it is suggested that future accountability is built around universities reporting on progress towards their agreed plan using a continuous quality improvement model, taking the focus off meeting arbitrary program targets. Individual targets for the number, type of placement, placement setting and location of placement to be provided by each university could be negotiated as part of the plan development and approval process. Reporting would be required on achievements, lessons learned and modifications to improve performance. Feedback from the evaluation emphasises the importance of the opportunity for narrative reporting to provide background and context to quantitative data such as placement numbers.

Reporting and Accountability

Key elements of the plan would include:

- Overview of region(s) including current workforce needs and challenges
- Existing number, type and location of placements (as a baseline for comparison)
- Activities planned to meet objectives in key operational areas:
 - Training
 - Research
 - Workforce
 - Workforce transition
 - Community engagement
- Targets for number, type of placement, placement setting and location of placements on annual basis
- Research approach including:
 - Employment of researchers
 - Capacity building activities
 - Collaborations
- Participation of Aboriginal and Torres Strait Islander staff and students across all RHMT program activities:
 - Employment and professional development of Aboriginal and Torres Strait Islander staff
 - Support for Aboriginal and Torres Strait Islander students
- Community engagement and reciprocity including strategies for investing in, supporting and, being responsive to local communities

For the purposes of overall program monitoring and evaluation a minimum data set could be

developed including:

- Annual program level student tracking report
- Conversion of RCS students to rural internships
- New service-learning placements (type, duration and location)
- Medical placements (duration, setting, rurality, rural origin)
- Conversion of allied health and nursing students to rural, remote and regional positions
- Number of Aboriginal and Torres Strait Islander staff employed, including position types

References

- Battye, K., Roufeil, L., Edwards, M., Hardaker, L., Janssen, T., Wilkins, R. (2019). *Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review. Services for Australian Rural and Remote Allied Health (SARRAH)*
- Boelen, C., & Heck, J. (1995). *Defining and measuring the social accountability of medical schools*. Geneva: World Health Organization.
- Department of Education and Training. (2019). *Australian Government response for the Review of the Higher Education Provider Categories Standards Review*. Canberra: Australian Government, Department of Education and Training.
- Department of Health. (2019a). *Educating the Nurse of the Future. Report of the Independent Review of Nursing Education*. Canberra: Australian Government, Department of Health.
- Department of Health. (2020). *Rural Health Commissioner Report. Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*. Canberra: Australian Government, Department of Health.
- Kondalsamy-Chennakesavan, S., Eley, D. S., Ranmuthugala, G., Chater, A. B., Toombs, M. R., Darshan, D., & Nicholson, G. C. (2015). Determinants of rural practice: positive interaction between rural background and rural undergraduate training. *Medical Journal of Australia*, 202(1), 41-45.
- Kwan, M. M., Kondalsamy-Chennakesavan, S., Ranmuthugala, G., Toombs, M. R., & Nicholson, G. C. (2017). The rural pipeline to longer-term rural practice: general practitioners and specialists. *PLoS One*, 12(7), e0180394.
- Lyle, D., & Greenhill, J. (2018). Two decades of building capacity in rural health education, training and research in Australia: University Departments of Rural Health and Rural Clinical Schools. *Australian Journal of Rural Health*, 26(5), 314-322.
- May, J., Lang, J., Bill, A., & Stefanov, I. (2019). Joining the dots -quantifying the value of rural health training to community. *Proceedings, National Rural Health Conference, Hobart*.
- McGirr, J., Seal, A., Barnard, A., Cheek, C., Garne, D. L., Greenhill, J., . . . McLeod, J. (2019). The Australian Rural Clinical School (RCS) program supports rural medical workforce: evidence from a cross-sectional study of 12 RCSs.
- O'Sullivan, B.G., & McGrail, M.R. (2020). Effective dimensions of rural undergraduate training and the value of training policies for encouraging rural work. *Medical Education*, 54: 364-374
- O'Sullivan, B., McGrail, M., Russell, D., Walker, J., Chambers, H., Major, L., & Langham, R. (2018). Duration and setting of rural immersion during the medical degree relates to rural work outcomes. *Medical education*, 52(8), 803-815.
- Playford, D., Moran, M., & Thompson, S. (2020). Factors associated with rural work for nursing and allied health graduates 15–17 years after an undergraduate rural placement through the University Department of Rural Health program. *Rural Remote Health*, 20(5334). doi:10.22605/RRH5334
- Playford, D., Ngo, H., Gupta, S., & Puddey, I. (2017). Opting for rural practice: the influence of medical student origin, intention and immersion experience. *Medical Journal of Australia*, 207(4), 154-158.
- REMPPLAN (2018). Monash Rural Health Socio-Economic Analysis: Project undertaken for Monash

University. Bendigo.

Woolley, T., Sen Gupta, T., Murray, R., & Hays, R. (2014). Predictors of rural practice location for James Cook University MBBS graduates at postgraduate year 5. *Australian Journal of Rural Health*, 22(4), 165-171.

Appendix A: Student Placements

Clinical placements

The nature and length of placements provided under the RHMT program vary across universities and disciplines, depending on individual course requirements.

In 2018, **997** graduating medical students completed clinical placement of a year or more at an RCS, an increase from 893 in 2015. The number of graduating medical students completing a short rural medical placement decreased from 2,528 students (93%) in 2015 to 2,411 students (83.4%) in 2018. This decrease corresponds to the reduction of the short rural clinical placement target from 100% (pre-consolidation) to 50% (post-consolidation).

In 2018, the RCSs provided a total of 6,384 rural placements for medical students of which 1,627 (25%) were long placements and 4,757 (75%) short placements. In total the RCSs supported 95,961 placement weeks.

In 2018, a total of **13,133** placements were provided by 15 UDRHs, totalling 65,014 placement weeks with an average length of 5 weeks. 58% of UDRH placements were in nursing and midwifery, 38% were in allied health and 4% were in dentistry and oral health.

Universities are required to provide placements in RA2-5 regions. In 2018:

- Approximately one quarter (27%) of long medical placements were in RA3-5 locations, while the majority (73%) were in RA2 (inner regional) locations
- Almost one-third (31%) of allied health and nursing placements were in RA3 locations, while over half were in RA2 locations.

Approximately two thirds of long-term medical placement weeks are in the hospital setting and one third in GP and other primary care settings. Hospital-based training does not necessarily expose students to the breadth of the generalist medical workforce that will be required to meet the health needs of rural communities now and in the future.

Allied health placement settings include acute care, primary care and a range of non-traditional community-based settings. Nursing placements are predominantly in the acute care setting aligned with curricula requirements.

Quality of Placements

While RHMT program recipients are required to deliver high quality placements, 'quality' is not clearly defined or described in the RHMT program framework. The quality of a placement is closely linked to supervision capacity which is dependent on local academic and professional networks.

To enable an assessment of quality placements the evaluation team developed rubrics to assess quality placements; supervision capacity building and; research capacity building. The rubrics considered the requirements of the program (articulated in program parameters), the literature

and consultations with stakeholders.

The evaluation found strong evidence that there is a high degree of variability relating to quality and considerable disparity in support for students between disciplines and sites.

Using the evaluation rubrics:

- The majority of RCS placements were rated as **very good**
- In relation to UDRH managed placements, allied health placements were rated from **excellent to poor**, and nursing placements were rated from **very good to poor**

Key areas where placement quality varied included:

- The extent of planned and structured engagement with Aboriginal and Torres Strait Islander health services and organisations
- Availability and delivery of locally relevant cultural safety training
- Delivery of interdisciplinary training
- Providing students with clinical experience relevant to rural health jobs

Enablers *contributing to the delivery of high quality placements include:*

- ▶ Focus by RHMT program sites on the delivery of “hidden curriculum” including accommodation, mentoring, cultural orientation, community engagement and pastoral care
- ▶ Investment by UDRHs and RCSs in developing strong connections with local Aboriginal and Torres Strait Islander communities and health services
- ▶ Investment in developing innovative placements, in particular service-learning models in a range of community settings through strong local leadership
- ▶ Support for supervisors including orientation and professional development
- ▶ Models of cross disciplinary supervision that enhance placement capacity.

Challenges *for universities in delivering high quality placements include:*

- ▶ The high cost for both universities and students of doing business as well as logistical challenges in delivering placements in remote locations
- ▶ Students receive varying financial support to undertake rural and remote placements, with support differing between RHMT program funded universities, the student’s home university and between disciplines
- ▶ Current reporting metrics do not reward quality or innovation as they do not differentiate between low and high-quality placements or the financial and in-kind investment required to establish and maintain innovative placements
- ▶ The fragility of the rural health workforce in some locations creates challenges for recruiting and retaining supervisors
- ▶ Lack of capacity for and focus on interdisciplinary learning

- ▶ Service-learning placements require strategies to minimise service disruption and provide continuity of care for clients which can be challenging for UDRHs when working with multiple universities
- ▶ Establishing and maintaining student accommodation and teaching infrastructure to expand placement activity.

Appendix B: Predictors for rural medical practice

Predictor	Odds Ratio range (95% CI)	References
Duration of RCS placement:		
1 year	1.79 – 2.85 (1.15 – 4.58)	Kondalsamy-Chennakesavan et al. (2015); Kwan et al. (2017); O’Sullivan et al. (2018); Playford et al. (2017)
Greater than 1 year	3.0 (2.3 – 4.0)	O’Sullivan and McGrail (2020)
2 years	2.26 – 5.38 (1.54 – 9.20)	Kondalsamy-Chennakesavan et al. (2015); Kwan et al. (2017); O’Sullivan et al. (2018)
2+ years	4.43 (3.03 – 6.47)	O’Sullivan et al. (2018)
Remoteness of Placement		
MM 2-3	1.3 (1.1 -1.6)	O’Sullivan and McGrail (2020)
MM 4-7	1.8 (1.5-2.1)	
Rural background	2.10 – 3.91 (1.37 – 7.21)	(Kondalsamy-Chennakesavan et al., 2015; Kwan et al., 2017; McGirr et al., 2019; O’Sullivan et al., 2018; Playford et al., 2017)
Rural return of service obligation	1.63 – 2.34 (1.19 – 3.98)	O’Sullivan et al. (2018)
Placement setting:		
Regional hospital	1.94 (1.39 – 2.70)	O’Sullivan et al. (2018)
Regional hospital and rural general practice	3.26 (2.31 – 4.61)	O’Sullivan et al. (2018)
Rural general practice only	1.91 (1.06 – 3.45)	O’Sullivan et al. (2018)
Rural internship	3.90 (1.9 – 8.0)	Woolley et al. (2014)
GP (vs non-GP specialist) training	3.44 (2.16 – 5.47)	Kwan et al. (2017)
Prevocational (vs specialist)	1.39 (0.78 – 2.48)	Kwan et al. (2017)
International student	5.70 (3.92 – 8.27)	O’Sullivan et al. (2018)
Aboriginal and Torres Strait Islander heritage	5.6 (1.2 – 26.9)	Woolley et al. (2014)
Rural background (vs metro) of partner	3.08 (1.96 – 4.84)	Kondalsamy-Chennakesavan et al. (2015)
Single (vs married)	1.98 (1.28 – 3.06)	Kondalsamy-Chennakesavan et al. (2015)

Appendix C: Northern Territory Medical Program

The Northern Territory Medical Program (NTMP) delivered by Flinders University differs to the other medical programs funded under the RHMT program. It was specifically established to address medical workforce shortages in the Northern Territory and increase the number of Aboriginal and Torres Strait Islander doctors trained and working in the Northern Territory. The NTMP is co-funded by the Northern Territory Government and the Australian Government through the RHMT program (not via the Education portfolio). Priority is given to Aboriginal and Torres Strait Islander Territorians and non-Indigenous Territorians. RHMT program funding requires Flinders University to admit 24 students into the NTMP each year.

Entry to the NTMP is through the Charles Darwin University Bachelor of Clinical Science undergraduate pathway or through a Flinders University graduate entry pathway. Additional support, previously identified as the Indigenous Transition Pathways to Medicine Program, is provided via the Flinders RHMT agreement to prepare Aboriginal and Torres Strait Islander people to gain entry into the NTMP through their ongoing education.

The Northern Territory Government requires graduating doctors to complete a two year return of service obligation, through the Northern Territory Bonded Medical Scheme, which will increase to four years for students graduating in 2020 and onwards.

Key Findings

Over the 2016-2018 period, the NTMP has filled the 24 training places each year, as it has done since inception in 2011.

The NTMP has a target of enrolling eight Aboriginal and Torres Strait Islander students each year. While this enrolment target has not yet been achieved, the NTMP enrolled 19 Aboriginal and Torres Strait Islander students between 2012 and 2018, with eight graduates at the end of 2018. To date, there have not been any Aboriginal and Torres Strait Islander students enter the program through the Charles Darwin University undergraduate pathway.

Enablers to developing Northern Territory medical workforce capacity and capability

- ▶ Common interests and shared goals to grow a medical workforce fit for purpose for the Northern Territory was evident among key stakeholders to support integrated medical education and training (stakeholders included the Northern Territory Government, Top End Health Service, Central Australian Health Service, Aboriginal Medical Services Alliance Northern Territory and the ACCHO sector, Northern Territory General Practice Education and Flinders University Northern Territory).

Challenges

- ▶ Progressing Aboriginal and Torres Strait Islander entry into, and continuation in the NTMP is challenged by extended vacancies in the Aboriginal Education and Training Support team including the Elders on Campus program.

- ▶ Maintenance of a pool of Aboriginal and Torres Strait people to undertake mentoring and teaching roles for Aboriginal and Torres Strait Islander students and non-Indigenous students.
- ▶ Limited specialist vocational training opportunities in the Northern Territory is a barrier to longer-term retention of NTMP graduates.

Lessons learned

Aboriginal and Torres Strait Islander participation in the NTMP could be enhanced through development of a bridging program for secondary school students into the Charles Darwin University pathway; extension of the Elders on Campus program to remote RCS sites (Nhulunbuy, Katherine and Tennant Creek); ongoing tutoring program for medical students and; facilitation of peer support strategies.

Students value the practical strategies offered through the NTMP to develop contextual understanding of Aboriginal health and engage effectively and respectfully with Aboriginal and Torres Strait Islander people.

Promoting understanding and knowledge to improve the health status of Aboriginal and Torres Strait Islander people could be strengthened by development of Rural, Remote and Aboriginal Health assessable subjects delivered to students across the program (Northern Territory and SA) in preclinical and clinical years, noting that students from the SA campus also undertake extended placements in the Northern Territory.

Recommendations: NTMP

Recommendations identified in the Summary Report are relevant to the NTMP, with those outlined below targeted to strengthening specific aspects of the NTMP.

Strengthening pathways for Aboriginal and Torres Strait Islander Territorians into the NTMP

Flinders University has developed a Reconciliation Action Plan and is a signatory to the Universities Australia Indigenous Strategy (2017-2020), providing a vehicle for the university and faculty to focus effort to progress and monitor activities relevant to implementation of the Indigenous Transition Pathways to Medicine Program and support Aboriginal and Torres Strait Islander student enrolments and graduation.

NTMP Recommendation 1:

- ▶ Through the RHMT program, the NTMP establishes a bridging program for Aboriginal and Torres Strait Islander secondary school students into the Charles Darwin University Bachelor of Clinical Science program. To promote the NTMP to secondary school students, the Aboriginal Education Support Team utilise opportunities such as engagement with the Indigenous Allied Health Australia health academy.

NTMP Recommendation 2:

Through the RHMT program the NTMP provide further support to Aboriginal and Torres Strait Islander students to complete the NTMP including:

- ▶ Expanding the Elders on Campus program for cultural mentoring and support currently offered in Darwin and Alice Springs, to Nhulunbuy, Katherine and Tennant Creek
- ▶ Introduce a tutoring program that commences at orientation and continues across the program, including assistance in developing study skills and systems for study
- ▶ Establish opportunities for Aboriginal and Torres Strait Islander students to regular meet and develop a peer network (across years)
- ▶ Place and support Aboriginal and Torres Strait Islander students in pairs wherever feasible.

Selection of undergraduate students into the NTMP

NTMP Recommendation 3:

- ▶ To ensure NTMP graduates are ‘fit for the Northern Territory context’, the NTMP in collaboration with Charles Darwin University, could introduce a multi-faceted selection process that includes an expression of interest where the applicant demonstrates their understanding of and commitment to Northern Territory service, rural and remote health service delivery and Aboriginal and Torres Strait Islander health, with a follow up interview for short-listed candidates.

Promoting understanding and knowledge to improve the health status of Aboriginal and Torres Strait Islander people

Early and ongoing exposure to Aboriginal and Torres Strait Islander health and engagement with Aboriginal patients was identified as a point of difference for non-Indigenous students of the NTMP compared with students of other universities. Promoting understanding and knowledge to improve the health status of Aboriginal and Torres Strait Islander people could be strengthened by development of a Rural, Remote and Aboriginal Health assessable subjects delivered to students across the Flinders University medical program in preclinical and clinical years. The NTMP hosts students from the South Australia campus for short and long placements.

NTMP Recommendation 4:

- ▶ The NTMP in conjunction with Flinders University SA campus develops Rural, Remote and Aboriginal Health assessable subjects delivered to students across the program (Northern Territory and SA) in preclinical and clinical years.