The Rural and Remote Area Placement Program: Lessons Learned in Regional Training Delivery

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INTRODUCTION

This paper provides an outline of progress and results for the first year of the Rural and Remote Area Placement Program (RRAPP) and provides insight to the lessons learned with regard to the design and operation of regionally-based medical training. RRAPP sites have been established at Jamestown (SA) and at Albany and Busselton (WA) during 2000. Collaboration by the national secretariat of the RRAPP and its partners in these sites has generated a twelve-month learning process on the challenges of operating regional training for junior medical officers. A summary of the strategic issues in design and evaluation, emerging from this partnership, is provided.

A review of the status of medical training in Australia over the past five years indicates that rural educational initiatives have moved a considerable way towards providing a sound, vertically integrated rural education and training pathway. This pathway, ideally, provides consistent and appropriate information, education and experience to potential rural practitioners from high school level, through to established doctors requiring continuing professional development.

The rural careers programs, rural student clubs, John Flynn Scholarships and RAMUS initiatives are creating a pool of informed and enthusiastic graduates who expect to be offered a continuing option to train in rural and remote community settings.

Until 2000 a significant gap in the continuum of rural education opportunities existed, in the absence of rural and remote community-based terms for the junior medical officer. Current training for postgraduate years 1–3 (PGY 1–3) is largely characterised by urban locations, large hospital rotations and a general paucity of broader community and general practice based experience.

A Commonwealth grant was provided in January 2000 to develop up to 20 rural and remote training sites for up to five junior medical officers per site and to explore the strategic issues related to the establishment, operation and support of such sites. The lessons learned from the RRAPP provide timely indicators for more extensive regional training initiatives currently being developed for the vocational training years.
BACKGROUND

The need for a program similar to the RRAPP has been identified in several key reports over the past five years.

In 1997, the Medical Training Review Panel First Report\textsuperscript{1} recommended:

\ldots that all postgraduate medical officer training include at least one rural term, be it in a hospital or general practice setting, and at least one community-based term, again either in general practice or a community health service.

Furthermore the Report of the Ministerial Review of General Practice Training\textsuperscript{2} in 1998, stated:

It is vital that learners have the opportunity to compare and contrast experiences in large teaching hospitals, rural hospitals, community health centres, rural health training units and general practice. Junior doctors who do not have this opportunity are much less likely to make informed choices in favour of community-based careers or develop an appreciation of general practice and the social context of health, even if they choose another arm of medical practice.

The requirement for the RRAPP, and the form it has taken, have been determined by a number of strategic imperatives that emerge from the rural workforce context in the past five years. Among these are:

\begin{itemize}
  \item the amendment to the Health Insurance Act 1973 in 1996 which effectively increased the number of pre-vocational medical practitioners practising within the public health system and limited the number located in community-based practice;
  \item the current national rural workforce crisis, which is leaving rural populations without access to medical practitioners and placing high workloads on rural practitioners;\textsuperscript{3,4}
  \item the Review of General Practice Training\textsuperscript{2} recommendations that future doctors should gain community-based general practice experience early in their careers to allow for a more balanced preparation for the realities of medical practice, and to encourage rural recruitment; and
  \item the known effect of increasing rural recruitment by exposing trainees to rural practice.\textsuperscript{5}
\end{itemize}

Preferred elements of this experience in rural and remote practice were outlined by the Commonwealth in 1998\textsuperscript{6} and included:

\begin{itemize}
  \item self-sufficiency in clinical management and emergency procedures;
  \item exposure to the difference in structure and organisation of rural health services support — including equipment and access to specialists and other health professionals;
  \item exposure to the sociological and psychological issues associated with a rural culture;
\end{itemize}
the opportunity to practise continuity of care and preventative care at the community level;

opportunities to experience a different spectrum of illness and injury, in particular in emergency medicine; and

personal and professional development in a setting with different constraints and opportunities from the hierarchy of medical faculties and teaching hospitals.

OBJECTIVES OF THE RRAPP

In response to the imperatives outlined above, RRAPP has been designed to provide junior medical officers in PGY 1 to 3 with a ten to thirteen week term in a rural general practice and rural community practice setting.

The RRAPP is a pre-vocational, generalist term designed to address the current gap in the vertical integration of training from undergraduate through PGY 1–3, to vocational training. RRAPP junior medical officers receive high-quality training in procedural and other practice skills in a wide range and depth of clinical situations that enhance further learning when the junior medical officer returns to the parent hospital.

Specifically, the RRAPP aims to:

assist State and regional bodies to establish up to 20 training sites and 100 posts throughout Australia for junior medical officers in PGY 1 to 3 during years 2000–2003;

establish PGY 1 to 3 training sites in small rural and remote towns and in larger provincial towns, with special justification;

increase the number of junior medical officers in PGY 1 to 3 participating in a term of rural general practice/rural community experience;

increase the length of terms in rural practice for junior medical officers in PGY 1 to 3; and

provide a high-quality learning experience — both clinical and social — in a setting other than a major teaching or provincial hospital.

DESIGN AND DEVELOPMENT

The current work on the development of Regional Consortia for the national delivery of vocational training is facing similar challenges in basic strategic decision making. Although the RRAPP operates on a much smaller scale, the lessons learned are useful for consideration in the broader training context.
Briefly, determinants of the successful operation of the RRAPP have included:

- **partnerships** — an appropriate choice of partners in both national management and regional training models;

- **high-quality training** — the development of high-quality training and positive experience-based on:
  - clear definition of the components of high-quality training,
  - flexibility in the design of regional models,
  - fair and transparent means of administration,
  - an assurance that models are based on adequate local resources, sound costing, strong evidence of capacity to deliver and potential for sustainability; and

- **evaluation** — a well constructed evaluation model with a clear role set at each level.

**PARTNERSHIPS**

During the first year of the three-year program, the Australian College of Rural and Remote Medicine (ACRRM) has led a national consortium comprising the Commonwealth Government, the Confederation of Postgraduate Medical Education Committees (CPMEC), The Committee of Presidents of Medical Colleges (CPMC), The Royal Australian College of General Practitioners (RACGP) and the Rural Doctors Association of Australia (RDAA). The role of the consortium is to assist State-based partnerships to develop and implement innovative, regional training models. ACRRM and its partner organisations are fostering RRAPP educational initiatives that reflect the realities of rural practice and employ role models and mentors from the profession and rural community.

The choice of partners is critical to the effective operation of the consortium on a national basis. The RRAPP has not only demonstrated excellent collaboration between its RACGP and ACRRM members but, through its links with the CPMEC and the CPMC, is able to progress issues which relate to:

- the accreditation of RRAPP training and the recognition of prior learning; and

- productive relationships with staff of the key feeder hospitals plus effective linkage with established hospital terms/arrangements for junior medical officers.

Partnership with the feeder hospitals appears to be a significant component in the success and sustainability of the RRAPP training models. Particularly with regard to:

- endorsement of the rural practice rotation by the Medical Education officer/DCT or Education Panel;
♦ maintenance of consistent training objectives and communication with peers while on the RRAPP attachment;
♦ providing seamless cover for the rural rotation in respect to insurance, salary levels and other workforce items;
♦ having a point of contact at the hospital for grievance and other support processes;
♦ designing equitable processes for recruitment and selection; and
♦ providing orientation and de-briefing.

A considerable degree of flexibility is both provided and expected in the design of regional training models. The first year of operation has demonstrated that different models employ a wide variety of partnership arrangements. Key common issues appear to be:

♦ choice of partners with a clear regional priority;
♦ choice of partners that have the capacity to contribute directly to training, either in funds or in kind; and
♦ choice of partners that enable useful overlap with functions at the local level, such as teacher support and regional training.

The range of partners used so far includes procedural medical practices, local hospitals, Rural Divisions of General Practice, local universities/Centres of Rural Health/University Departments of Rural Health, Learned Colleges, state Rural Doctors’ Associations and rural community organisations.

A major demand of applicants is that they ensure the full understanding and support of the training practice and that the rural community is consulted and informed of the program. In practical terms, this means that all parties must agree on the training delivery, terms, conditions, costs, payments, levels of qualifications and administrative processes.

Also, training is unlikely to be either sustainable or a positive experience without the support of members of the community.

DEFINITION OF HIGH-QUALITY TRAINING

At the time of submission, the RRAPP Taskforce listed a range of potential characteristics of training models that were capable of being developed by State partners. These went some way to defining the basis of high-quality training experiences, positive rural experience, sustainability, cost effectiveness and value for money.

To achieve this initial level of understanding, the RRAPP ensured that the major players in training delivery were also represented on the Taskforce charged with
program design — a strategy currently being used in the development of Regional Consortia.

The agreed, basic training components formed the platform for work with the 2000 RRAPP sites in the development of tenders, cost structures and the evaluation framework. State training and rural organisations were asked to add to, and refine, the basic RRAPP training list in order to ensure that the Tender Proformas were appropriate for State groups to use in the development of training models that were both deliverable in practical terms and relevant to their region.

One of the main considerations of the RRAPP design was that a number of common issues, considered to be essential components of high-quality rural training, should flow through all stages of the RRAPP in 2000. These form a significant proportion of:

♦ the conceptual list of important components of quality training and positive experience developed at the start;
♦ the issues which each state was invited to use as the basis for its tender; and
♦ the platform for evaluation of the 2000 and 2001 sites.

Issues are:

♦ adherence to terms of reference and major definition of terms;
♦ comprehensiveness of arrangements for consultation at political, professional and educational levels;
♦ maintenance of lines of responsibility between players in the State in implementing the project;
♦ means used to define the type of doctor recruited and the number of posts each State can develop;
♦ means of achieving equity, ethical guidelines and a grievance process;
♦ financial arrangements — including the financing of community posts;
♦ strategies for recruitment/extraction of medical officers from their parent hospitals;
♦ ensuring a beneficial training/service mix;
♦ use of quality curriculum, educational guidelines and ensuring standards;
♦ strategies for supporting doctors and their families;
♦ strategies for supporting and resourcing teaching sites to prevent “practice burnout”; and
♦ recorded levels of satisfaction, with training and outcomes — of practices and candidates.
Also, that scope should be provided for each State tender to contain key local and regional variations that, when added to the basic training experience ensured its relevance to its context and allowed for innovation in both design and delivery.

**EVALUATION MODEL**

Certain types of situations and values are amenable to collaborative research, in which supervisors and staff in the practice setting actively participate in the study and analysis of their own progress. ACRRM and State applicants have worked together on designing:

- the tender framework;
- contracts:
  - agreements between consortium partners
  - training agreements with the practices;
- measurement instruments;
- budget frameworks; and
- joint visits to sites.

This work has been undertaken within a mutually acceptable ethical framework, using qualitative methods including interview, diaries or records of experience, observations and critical reflection.

The evaluation process was designed to produce a sound platform for decision making by Commonwealth, State and practice partners in RRAPP and to develop a better understanding of:

- the means to administer RRAPP in an effective and efficient manner;
- best practice training models — their commonalities and key differences; and
- the components of a sound internal evaluation of the RRAPP — as a step towards an evaluation tool which assists decision making about training options.

**Partnerships in evaluation**

One of the key design elements of the RRAPP was the close linkage between the national support body and the state consortia. The RRAPP submission proposed that, as part of the national evaluation arrangements, state sites would agree, at the point of tender, to form part of a broad evaluation of rural training delivery. This involved:

- gathering data and providing a consistent assessment process in line with proposed national outcomes; and
- demonstrating an understanding of the outcomes evaluation and the reporting schedule agreed by ACRRM, the National Advisory Committee and the Commonwealth.
Consistency in measurement and data collection

The means by which measurement, data and reporting might cascade from local sites to a full external evaluation has been trialled as far as possible in the 2000 RRAPP sites. The model promotes a consistent line of measurement and issues identification for RRAPP sites, the State fund-holders, the RRAPP Secretariat and the Commonwealth via its external evaluator. In all cases it is helpful that each of the parties understands at an early stage, the components undergoing evaluation.

RESULTS

Scope of the data set

The RRAPP secretariat undertook to provide evaluation reports that would particularly address:

♦ the numbers of placements and their national distribution;
♦ the components of models tendered by the States — including the effectiveness, sustainability and cost effectiveness of each with regard to the common components outlined in the tender framework, and of components unique to each State model;
♦ identification of costs associated with the training/service mix such as infrastructure, supervision and billing;
♦ recommendations to the Commonwealth regarding training options; and
♦ recommendations to the Commonwealth regarding funding of training options.

First year results

Over the first year, a number of strategies have emerged as supportive of the RRAPP objectives and of regional training initiatives in general. While these remain at a work in progress level, they do appear to indicate:

♦ sensible placement strategies for regional training models; and
♦ points on which the RRAPP process can be further evaluated.

Based on the design and operational strategies outlined in this paper, three RRAPP sites have provided regionalised training for 10 junior medical officers in PGY 1–3 during the funded period.

Their experiences, and those of their administrators, trainers and supporters have formed the basis for confirmation of the successful elements of the RRAPP and refinement of a small number of issues for the 2001 round.

Accepting the small numbers involved in the program, the RRAPP is unlikely to provide statistically significant results, however the type of strategic indications it can generate for rural and region initiatives is significant for future training providers.
Lessons to date include the need to:

♦ make realistic choices about consortium members — to ensure partnership at design and implementation stages by rural organisations with the capacity to authorise and deliver training;

♦ allow for States and sites to be at widely differing rates of readiness;

♦ establish an early and joint understanding of the common training components to be evaluated;

♦ use an iterative process in the design of tenders and in the application process and also to use mechanisms whereby other sites can consider and adopt the best products of more advanced applications;

♦ develop a consistent line of measurement and reporting from local to national levels and gain commitment from local sites/State partners to be party to national evaluation arrangements.

♦ promote consistency by National, State and local parties on basic definitions, legal and ethical issues — reflected in contractual arrangements;

♦ ensure clear linkages between design components, stages of implementation and evaluation;

♦ negotiate and confirm with the States a common set of training criteria on which to base both design and evaluation;

♦ allow for and encourage flexibility of local models — regional variety in training design and delivery — with appropriate justification;

♦ request evidence of a sound resource base, sustainability and cost-effectiveness for each proposed training strategy;

♦ ensure contractual arrangements include evidence of joint agreement on the training model by State fund-holder, delivering practice/community and junior medical officer;

♦ develop membership of the training consortium with regard to co-funders in cash and kind — State Government; host organisation; hospital and Divisions are regular contributors;

♦ allow adequate time required to develop the administrative and financial arrangements for the above and for the devolution of funds to training sites — the application and tender process needs a six month lead time;

♦ assume common categories and proportions of salary, training and infrastructure costs will be evident in most RRAPP budget models and also consider the impact on budgets of administration, data gathering and the GST; and
ensure applicants use established payment and workforce guidelines and structures and that budgets reflect the establishment and maintenance of nationally accepted standards of training and accreditation.

The issues above refer principally to the strategic requirements of choosing a site, ensuring adequate design and evaluation. The definition and implementation of high-quality training generate a further set of strategies that will be reported elsewhere, that begin to frame the details of each model of training.

In 2000 the RRAPP produced two very different models in three sites and the 2001 round promises a further eight regional training models, each one providing a different interpretation of the basic components of excellence defined through the Program.

CONCLUSION

This paper has outlined the background, method and early strategic lessons learned from the first year of operation of the RRAPP. It also has provided a précis of the responsibilities of the ACRRM and the RRAPP Secretariat with regard to providing a setting in which high-quality training experiences can be designed by regional groups and arrangements developed for accountability and measurement.

This account is of work in progress in the broader brief of the RRAPP, which is to enhance the amount and quality of rural training, to support junior medical officers in rural and remote practice, and to further the understanding of quality training and experience.

In addition, the evaluation process has been designed to produce a platform for decision making by Commonwealth, State and practice partners in RRAPP and to develop options on:

♦ the means to administer RRAPP in an effective and efficient manner;
♦ the design and delivery of best practice regional training models; and
♦ the means to assist decision making about training options.

Our thanks go to the dedicated and hard working practices, supervisors, junior medical officers and administrators in the states and regions who are making the RRAPP successful.

REFERENCES


3. AMWAC, Australian Medical Workforce Benchmarks, Australian Medical Workforce Advisory Committee, Sydney 1996.


AUTHORS

Dr Paul Worley studied medicine at the University of Adelaide, graduating in 1984. He married Liz in 1985 and they now have 4 primary school aged children. He was in solo rural practice at Lameroo, in the Murray Mallee region of South Australia, and then moved to a group rural practice at Clare, a wine-growing area in the mid-north of the State. In 1992 he was elected President of the Rural Doctors Association of South Australia. In 1994 he took up appointment as Senior Lecturer in Rural Health at Flinders University of South Australia. As well as maintaining an active clinical workload in both rural and urban practice, he has been responsible for co-ordinating the rapid expansion of Flinders University’s rural education programs in undergraduate and postgraduate rural practice. He is currently National Vice President of the Australian College of Rural and Remote Medicine. His passion is to encourage medical schools to see that their obligation to the communities they serve is integral to their academic leadership responsibility.

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