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Expanding clinical placements to better impact future workforce development
A policy analysis approach

A universities perspective
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Presentation outline

- Highlight health student placements – importance/benefits

- Examine policies and practice that support placement expansion and workforce growth

- Describe barriers/enablers to expanding student placements where they're needed

- Propose ways to expand placements (settings of need)

Focus: allied health; workforce need, policy

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Clinical placements: vital cogs

- **Quality**
  - ➢ Essential to develop quality, capable health professionals
  - ➢ support embedding of clinical skills
  - ➢ develop trainee capacity to practice autonomously - key

- **Regulatory**
  - ➢ Mandatory (accredited pre-registration health courses)
  - ➢ Contractual requirement – D of E

Critical for students/future workforce development

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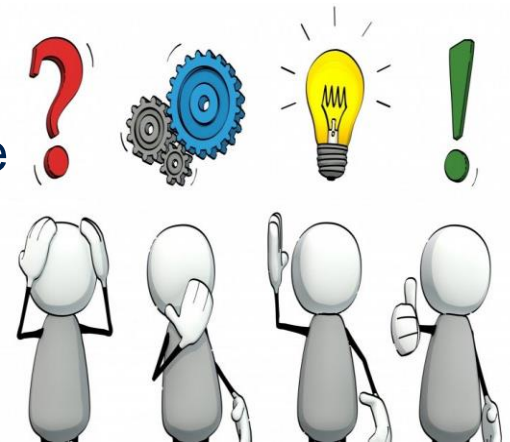
Placements – wider benefits

✓	Increase workforce capacity
✓	Support professional development/supervision
✓	Introduce service innovation
✓	Enhance patient health service perceptions
✓	Effective workforce distribution levers

Beneficial for health services/wider health system

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Has national policy recognised this?

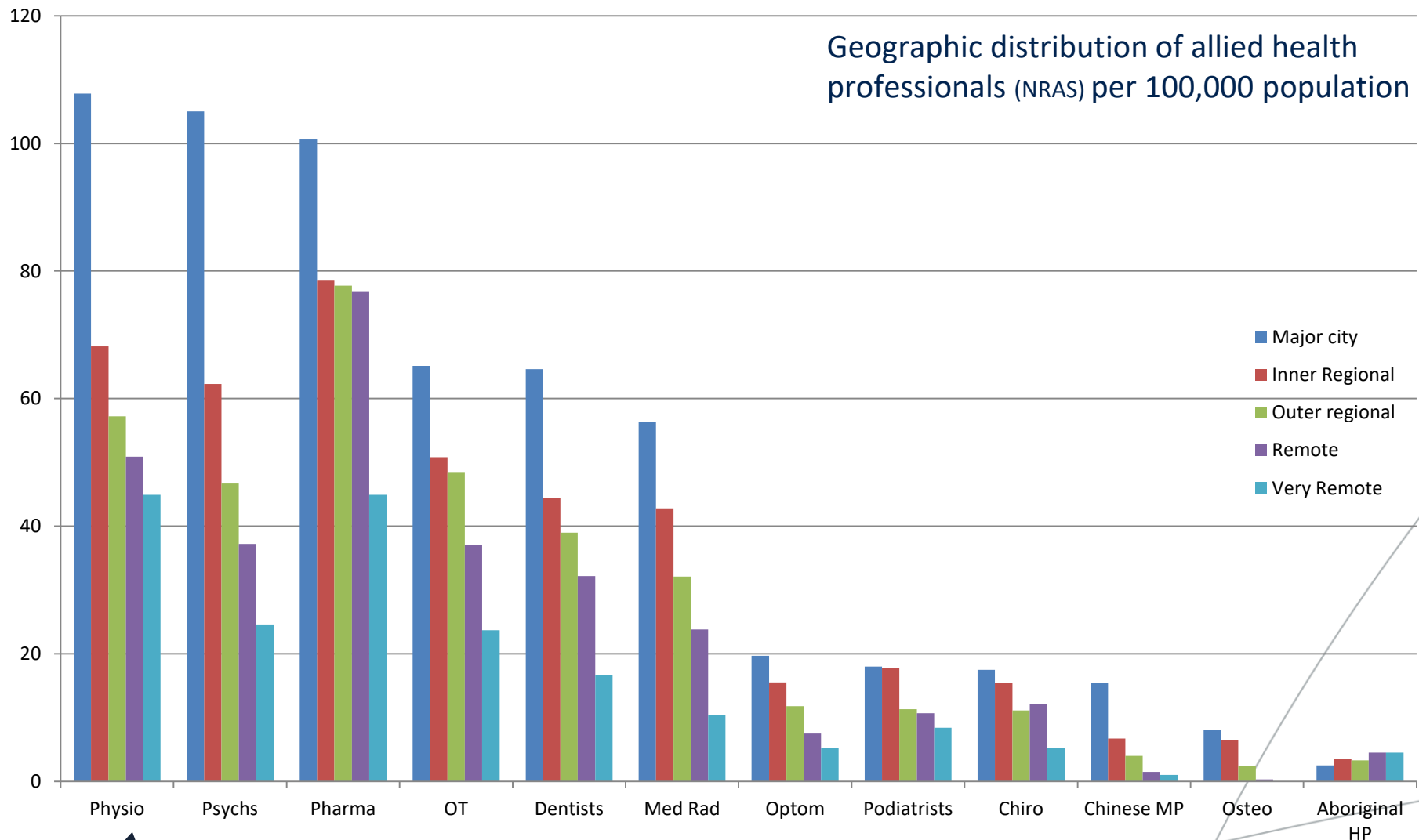| Year	Key event	Main issue
Late 1990s	UDRHs, RCSs, JFPP, DTERP, + scholarships	Rural mal-distribution education pathways to address rural health workforce issues
2001	Bonded Medical Programs (BMP/M RBS) Under reform	Rural return of service obligation for bonded medical students once qualified
2005	Productivity Commission report on Health Workforce	Clinical education pathways identified as part of workforce distribution solution, esp. for rural
2008 /11	National Health Reform Agreement (NHRA)	Health Workforce Australia (HWA), AHPRA, Clinical training fund (CTF)
2010 /12	Demand Driven System (DDS)	Equity focus in HE, incl. rural/low SES students;
2014	New Federal Government	Abolition of HWA / other health infrastructure
2015	MYEFO	Abolition of CTF, RHMT redirection

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The buts...

- Medical/rural focus (important but not the whole story)

- Lack of data/evaluations

- Changed service environment/models of care
  - NDIS
  - Aged care/ageing population
  - Digital world

- Placements mismatched to where workforce is and/or is needed (most placements in acute sector; most care delivered/needed in community)

- Lack of connected policy and planning across whole system /sectors and tiers of government (esp. since the abolition of HWA)

Rural maldistribution

Geographic distribution of allied health professionals (NRAS) per 100,000 population

Legend: Major city, Inner Regional, Outer regional, Remote, Very Remote

Categories: Physio, Psychs, Pharma, OT, Dentists, Med Rad, Optom, Podiatrists, Chiro, Chinese MP, Osteo, Aboriginal HP

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Source: DoH Workforce Fact Sheets 2016/17

Aged care and disability (i)

Allied health and medical professionals are underutilised in the aged care sector, particularly in rural and remote areas

Allied Health Professionals (AHPs) … will increasingly be required to meet the complex needs of older people in care

NDS expressed particular concern about the existing shortage of AHPs in both the disability and aged care sectors

Training courses… do not include adequate experience and exposure to the aged care system

Predicted needed aged care all workforce growth: from 366000 to 980000 by 2050 (2.7x /170% increase)

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Source: Senate Community Affairs Committee - Future of Australia's aged care sector workforce 2017

Aged care and disability (ii)

STATE OF THE DISABILITY
SECTOR REPORT 2018

- "Workforce challenges remain top of mind [for NDIS providers]

- 63% found it difficult to recruit disability support workers

- **Over 70% said that recruiting allied health workers was extremely or moderately difficult"**

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"Well-managed placements including allied health practicums are fundamental to career decision-making and attracting health professionals to the industry"

A MATTER OF CARE

Australia's Aged Care Workforce Strategy
Report of the Aged Care Workforce Strategy Taskforce

June 2018

Some good news

Initiative	More or less connected?	Still need to address...
Medical Workforce Strategy	Includes medical educators - early days.	Nursing and allied health workforce strategy. Whole of system workforce plan re skills, scopes of practice.
Aged Care Workforce Strategy: Industry Reference Committee (IRC); Industry Workforce Council	IRC includes some HE and VET representation.	Expanded placements in aged care services. HE voice in Aged Services Industry Workforce Council
Boosting the Local Care Workforce initiative re NDIS workforce needs	Some engagement with educators, UDRHs.	Expanded placements to disability services.
Rural Health Commissioner - medical and allied health rural pathways	Selective engagement with HE relevant to strategy	Non-rural health workforce and skills shortages (primary, aged, disability care; mental health, Indigenous health)
Medical Workforce Reform Advisory Committee (AMRAC); Nursing & Midwifery Education Advisory Network (NNMEAN)	Multiple representatives including medical educators/ VET (NNMEAN)	Allied health committee equivalent to NNMEAN/MWRAC?
RHMT Program (UDRHs, RCSs, Regional training hubs, etc) **Currently under review**	Successfully supports health and university connections in rural areas	Greater nursing and allied health focus. Intentional student inclusion?
HeaDS UPP tool	Useful national data but mainly primary care / general practice, rural focus.	Overlaying this data with data on health need, clinical placement capacity, allied health /other health professionals etc.
Digital Health CRC/digital health agency (CRC includes workforce and education)	Is engaging with HE	Ongoing and increased engagement with HE and professional Boards/accreditors
COAG Health Council, AHMAC, Principle Health Services Committee	Connected across tiers of govt. for health system/ workforce discussions	Voice of education in workforce discussions. Clear signals about state/national workforce/skills needs
Accreditation Agencies /Professional Boards. **Current Accreditation Systems Review** (ASR)	Significant intersection between accreditation councils and universities.	IPE, timely communications re future workforce/skills development relevant to accreditation/ registration.

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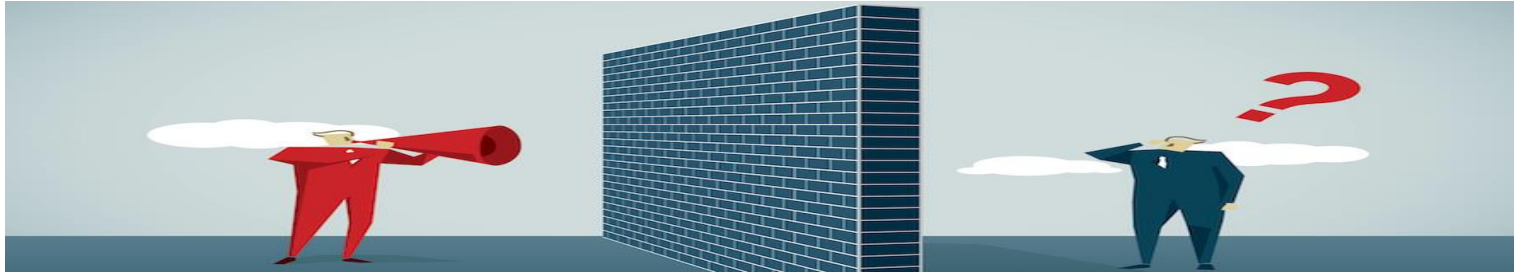
Barriers

- Rural: placement issues/costs; Lack of new grad positions, supervision capacity

- NDIS: privatisation, no business model for student supervision

- MBS – supervision barriers and payment claims

- Aged Care Funding Instrument (ACFI) / workforce casualisation – supervision/teaching issues

- Funding freeze/cost pressures in HE

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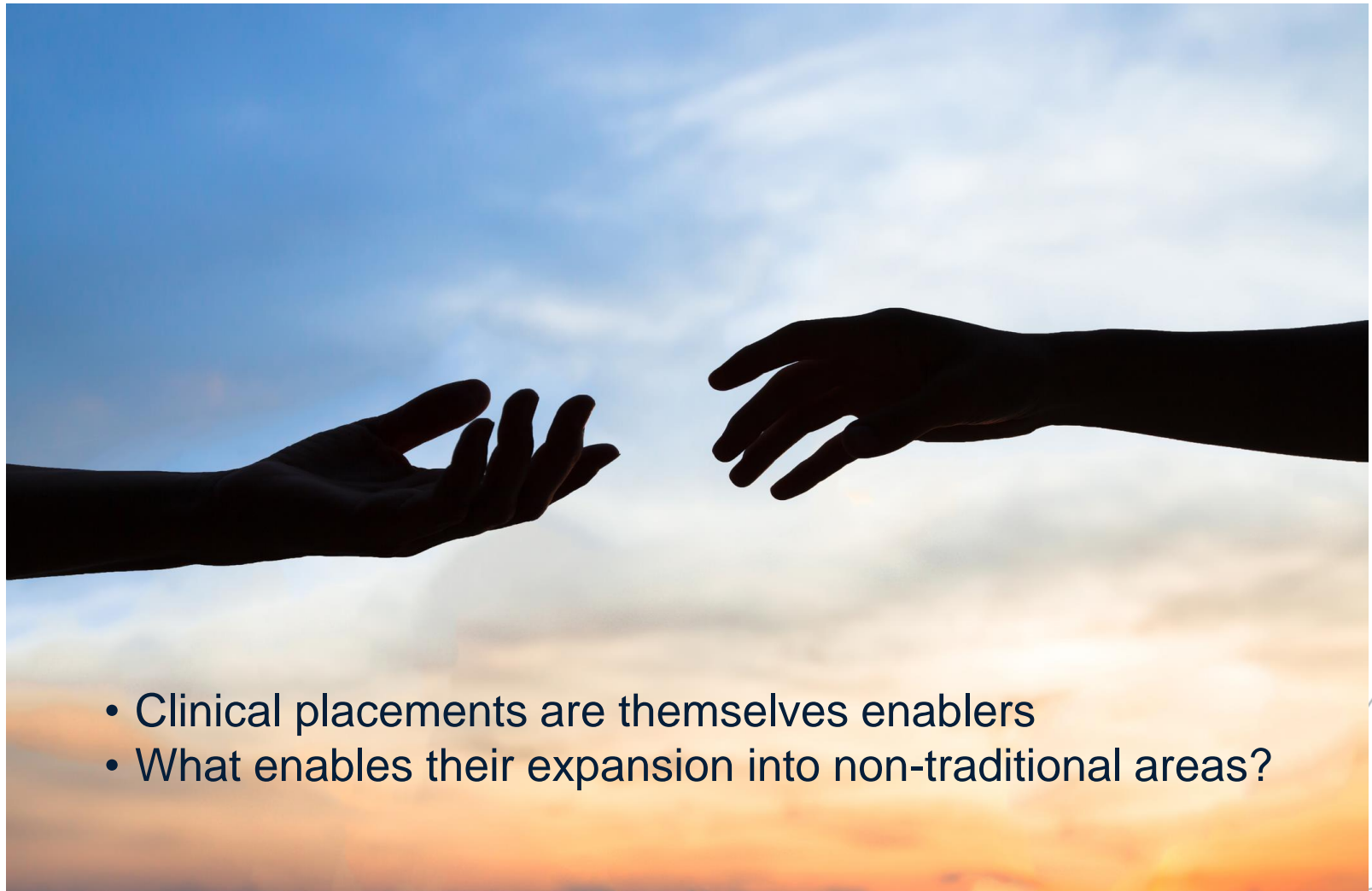
Enablers

- Clinical placements are themselves enablers
- What enables their expansion into non-traditional areas?

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Case study 1:
Falls prevention through aged care university student placements

Background:
- 44 residents, 94 recorded falls, 74 (78%) requiring clinical attention
- Fall occurrence every 5 to 6 days. Relevant co-morbidities (osteo, prior hip fracture etc)

Intervention:
- Falls prevention and strength program developed / implemented by physio students on placements
- Provide access to physio expertise beyond that available through ACFI

Aim:
- Reduce falls; improve resident independence and QoL
- Clinical and broader aged care learning experience for students

Results:
- Falls decreased drastically (evaluation measures still in progress);
- residents and staff reported improved mobility and strength (key factor to falls reduction)

Enablers:
- Collaborative partnership between university, UDRH and aged care facility
- Funding support
- Interdisciplinary supervision
- Year round student placements (service continuity)

Challenges:
- ACFI funds affected by resident improvement
- Resourcing
- Ensuring sufficient students for year round placements (collaboration/coordination with other unis)

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Case study from Sydney university. More info: https://bit.ly/33c8I4b

Case Study 2:

Aged care workforce capacity growth through student placements

Background:

- Workforce need identified in local aged care facility (ACF) in late 2015
- Opportunity to assist ACF through student placements recognised by university

Intervention:

- Student participation unit for placement coordination set up at the ACF
- Diverse clinical and non-clinical student placements developed/implemented
- 40 residents consented to participate

Aim:

- Build workforce capacity in aged care
- Contribute to service delivery/resident outcomes
- Develop student skills in working with older adults (clinical and non-clinical)

Results:

- 400+ multi-d health/other students hosted (2016/17)
- 326 extra group engagement activities (in OT alone)
- Multiple new programs→implemented e.g.
  - exercise prescriptions   functional & social gains
  - OT student delivery of Cog. Stimulation Therapy
- Increased student ACF employment post placement (on graduation)

Enablers:

- Strong university/ACF collaborative partnership
- ACF recognition of broad student value
- Embedding structured learning into placements
- Lead clinical educator appointment

Challenges:

- Cross and multi-disciplinary supervision models
- Supervision funding

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Case Study from UniSA. More info: https://bit.ly/2T0RJgg

What's still missing?

- Whole of system workforce planning agency
  - ➢ Cross-sector, cross-discipline, multi-stakeholder
  - ➢ Accessible, comprehensive national data

- Supervision capacity building support and resourcing

- Policy support/regulatory change

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Expanding placements: What we really need

- An enduring health workforce planning mechanism to
  - Gather and link relevant data (including health and education data)
  - Identify need
  - Coordinate all the players – shared responsibilities
  - Fund innovation
  - Develop whole of Gov policies

- Fund university-service partnerships (esp. for aged and disability care)
  - TRACS (Teaching & Research Aged Care services) – best example of benefits
  - CTF (clinical training fund) also showed promise
  - Initial funding to establish collaboration and build capacity
  - Smaller ongoing funding

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The Necessary Things

- Rural:
  - ➢ RHMT expansion: increase focus on allied health and nursing
  - ➢ Rural allied health pathway paper: multiple policy options proposed (not all supported by UA)
  - ➢ Rural generalist pathway (post registration, less focus on clinical placement approach per se but still requires education pathway)

- Disability/other private practice settings (MBS):
  - ➢ Need policy / regulatory change that offers a business model for student supervision under the NDIS/in private practice
  - ➢ Remove limitations to supervision and MBS claiming and/or
  - ➢ Implement a teaching PIP for allied health

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