Role of a Medicare Local in Primary Health Care Clinical Training

Position Paper including a Business Case

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Report Contents

Synopsis

Currently available information indicates that within the Victorian local government areas of Boroondara, Manningham, Monash and Whitehorse comprising the geographic catchment coverage for the Inner East Melbourne Medicare Local, there is likely to be around 1950 active primary health care service entities, including 186 GP practices, responding in a locally accessible way to the health and well-being needs of individuals, families and communities of this suburban Melbourne regional corridor.

Although it is not possible to say how many separate provider organisations are responsible for these service entities, the available data reveals a rich and diverse fabric of service activities with a pronounced emphasis on rapid or early intervention to address health care and related social problems before they deteriorate or to prevent problems from arising.

What is known is that the community based nature of this responsive service activity means that the service entities involved are dispersed throughout the region with many of them being small. Some are public health services, many are non-government and many are small commercial businesses whose capacity to sustain quality care for patients and clients is also dependent on being able to remain profitable.

The assurance of an appropriately trained and locally available health care workforce to staff these services continues to be a constant challenge. An important way to achieve this is by these services hosting clinical placements for health care learners, whereby learners gain practical skills shaped to local patient and client needs and are more likely to seek permanent employment in these services at the completion of their formal studies.

Unlike big teaching hospitals and other equivalent sized health care providers whose larger scale gives them many advantages for providing clinical learning placements including provision of dedicated teaching staff, learning venues and audio visual technology, primary health care services struggle to provide placements because of their dispersed geographic character and smaller size.

This paper shows how a Medicare Local reflected via an analysis of the structure, functions and field support presence of the Inner East Melbourne Medicare Local (IEMML) is able to facilitate primary health care services to offer clinical training.

A Medicare Local is a collaboratively structured, corporately sound and expertise strong primary health care service planning and development body whose charter is to support local services achieve quality improvements through partnership based strategies. Its commitment to local stakeholder engagement and the close synergies found between supporting local providers to initiate a range of service innovations or quality improvements and supporting them to build capacities for clinical learning well equips a Medicare Local, as demonstrated via IEMML, to embrace such a clinical training support role.

Included in this Paper is the presentation of a Model for IEMML to take forward this primary health care clinical training support role. The Model has been developed within the joint National and Victorian policy framework for clinical training and draws on IEMML's work in this area to date. Associated with the development of the Model is a Business Case outlining the advantages of a Medicare Local, as expressed via IEMML, providing clinical training support.

Role of a Medicare Local in Primary Health Care Clinical Training

What is this Project?

Using Inner East Melbourne Medicare Local (IEMML) as a model this project has developed a Position Paper on the Role of a Medicare Local in Primary Health Care Clinical Education and Training. Arising from its former organisational existence as a division of general practice IEMML has been active in supporting medical clinical education and training in local GP practices of the Inner East Melbourne regional catchment.

Now, as a Medicare Local, IEMML has opportunity to consider widening its clinical training support role to embrace an expanded range of local primary care services active in the catchment and the professional health care disciplines and academic courses from which these services gain their health practitioner workforce expertise.

An essential theme of the paper is that being a Medicare Local, IEMML functions as a highly accountable, collaboratively attuned and quality attentive organisation whose core business activities of primary care planning, services support and innovation are driven by evidence-based population health needs identified via its stakeholder membership base. These characteristics lend themselves well to IEMML facilitating the clinical education and training capacities of the primary health care providers of its catchment.

The Paper will help inform IEMML regarding its future strategic priorities. It will also be available for wider audiences to consider the potential of a Medicare Local in supporting clinical education and training.

A Business Case

The articulation of the clinical training role presented in this report includes an outline of a business case for a Medicare Local to adopt responsibilities in this field. The business case is progressively built throughout the paper as the discussion about IEMML's role is enlarged. It is sign posted at various points under the path finder header Key Business Case Reasons.

Medicare Local Policy Settings

Medicare Locals (MLs) are actively supporting a range of primary health care (PHC) service quality improvements within their respective geographical catchment areas of responsibility. Their policy mandate and principal source of funding to undertake this work derives from the Commonwealth Government. Even so the effective carriage of this mandate requires Medicare Locals to engage with and support a diversity of health care service providers many of whom are principally funded by and work within state health care policy arrangements. Similarly health care clinical training is a field of activity guided by and funded via Commonwealth and State policy initiatives.

Consequently this report refers to various Commonwealth and Victorian State PHC health workforce and clinical training policy initiatives that influence the work a Medicare Local does or could do. Moreover the development of this position paper has followed soon after the election of a new Commonwealth Government which is reviewing many aspects of existing national policies in these fields. It is possible that some of the conclusions reached in this document about a Medicare Local's role may need adjustment when this policy review is completed.

The steps in preparing the paper have included the conduct of interviews with senior representatives of relevant National and Victorian policy and program stakeholder organisations . The organisations were Health Workforce Australia (HWA), Australian Medicare Local Alliance

(AMLA), The Victorian Department of Health and the Victorian Clinical Training Council.

Although these representatives are not in a position to directly endorse this Paper, the principles that underlie the document were discussed in depth during each interview. It is reasonable to conclude that the content of this paper is consistent with the National and Victorian clinical training policy reform framework and accurately identifies the Nationally mandated role of a Medicare Local expressed via IEMML in supporting primary health care quality service improvements within a regional catchment.

Background for IEMML's Role

Collaboration for Quality Local Health Care

Inner East Melbourne Medicare Local's (IEMML) regional population catchment of over 618,000 people covers the municipalities of Boroondara, Manningham, Monash and Whitehorse. IEMML and its consumer and primary health care service provider partners of the regional catchment are working together to enable quality improvements in local service provision. A driving focus on population health needs, prioritising of prevention and early intervention actions, fostering consumer engagement in service planning, creating seamlessly coordinated healthcare pathways, maximising eHealth capabilities and modelling innovation in the design of service types are hallmark features of these enhancements.

Pivotal Role of Workforce

IEMML and its partners recognise that the creation of a well-trained and available professional workforce is a pivotal success factor in delivering to consumers and local communities of the catchment the primary health care benefits arising from these quality improvements.

Moreover, if health care learners gain rich and rewarding clinical training experiences from practical placements and teaching conducted in local primary health care service organisations of the regional catchment the likelihood of them wanting to return, at the completion of their studies, to these service providers for permanent employment is strengthened.

Actions Initiated by IEMML

In acknowledgment of the foundation role that workforce development has in sustaining an effective regional primary health care service system IEMML has initiated significant partnership actions. Supporting the capacities of local GP providers to host clinical placements and take up in-house clinical teaching roles has been a central purpose of this work. A brief history of these workforce actions is summarised below.

What IEMML has Done to Date

Clinical Education Alliance

IEMML in its former existence as a Division of General Practice (Melbourne East GP Network) facilitated the creation of a Clinical Education Alliance comprising representatives of Deakin, Melbourne and Monash University Medical Schools, The Victorian Metropolitan Alliance regional GP vocational training provider, the Royal Australian College of General Practice, Eastern Health Clinical School, Eastern Health regional healthcare network and and local GP practices.

The originating driving purpose for forming the Alliance was to enhance the capacities of local practices to host clinical placements and engage in clinical teaching and supervision for medical students, interns/ junior doctors and GP registrars. The Alliance has been defined via a memorandum of understanding signed by all parties.

Work Plan Objectives

The initial plan of work for the Alliance has covered four areas:

- Addressing the constraints of physical infrastructure for clinical training.

- Promoting clinical training in primary care to the community, health professionals in general practice and to the higher education sector.
- Improving the skills and confidence of health professionals in general practice in the supervision and clinical training of learners.
- Determining the capacity of practices to support students and the anticipated number of placements required.

Alignment of Activities with Clinical Training Policies

During its transition to and ongoing development as a Medicare Local, IEMML in conjunction with its Alliance partners has consolidated local training capacity building activities and actively aligned this work with Health Workforce Australia's (HWA) and the Victorian Government's. interconnected clinical training policy directions.

These directions centre upon health care service providers and educational bodies being strengthened and better resourced to offer clinical training via their participation in Regional Clinical Training Networks (CTNs) and access to quality focussed clinical learning tools.

A Best Practice Clinical Learning Environment (BPCLE) framework has been developed for application in clinical placement settings. This framework emphasises six key characteristics of high-performing clinical learning environments: (a) An organisational culture that values learning, (b) Best practice clinical practice, (c) A positive learning environment, (d) An effective health service-training provider relationship, (e) Effective communication processes and (f) Appropriate resources and facilities.

Important web tools to support clinical training have also been developed. These include: (a) viCPlace which is a secure information system that helps Victorian clinical placement providers plan and administer clinical placements with partnered education providers (EPs), and (b) viCProfile which is a statewide geographically focussed clinical training data base identifying CTN coverage, placement sites and infrastructure, placement activities, professional discipline profiles and other information.

A Victorian Clinical Training Council (VCTC) has been established for providing state-wide strategic leadership and advice on clinical training and placement issues.[1]

Advocating for Resources

IEMML and the Clinical Education Alliance were instrumental in attracting almost $1M of DoHA Commonwealth Innovative Teaching and Training (ICTTG) grant funds to secure required clinical training infrastructure in local GP practices of the catchment. This partnership has also been successful in gaining a total of $209,000 from the Victorian Expanded Settings for Clinical Placements (ESCP) grants fund, (sourced from Health Workforce Australia), for training placement capacity building in non- acute hospital/healthcare settings and from the Victorian Small Capital and Equipment (SCE) grants fund for providing small capital works and equipment to sustain clinical training in local settings.

Alliance Accomplishments –'The Placement Essentials'

Utilising these grant resources and applying the combined expertise of the Clinical Education

[1] Well placed. Well prepared. Victoria's strategic plan for clinical placements 2012-2015, Victorian Department of Health 2011, This site is the window to the Victorian Government's Strategic Framework for Clinical Training including the features summarised. http://www.health.vic.gov.au/placements/vctc.htm
A helpful equivalent window into the interconnected National clinical training policies and strategic directions is found on Health Workforce Australia's (HWA) clinical training reform pages. https://www.hwa.gov.au/work-programs/clinical-training-reform
NB, HWA refers to the regional networks as Integrated Regional Clinical Training Networks (IRCTNs), while in the Victorian context the prevailing term applying to these networks is changing from Clinical Placement Networks (CPNs) to Clinical Training Networks (CTNs), in this paper the latter Victorian term is generally used.

Alliance and IEMML, these partners have implemented a range of clinical training support initiatives which have been brought together in a coordinated strategy now titled the Placement Essentials.

Much of the initial work of the Alliance emphasised capacity building in local GP practices for the hosting of medical placements. The Placement Essentials initiative is continuing to strengthen practice capacities for medical learner hosting but is also extending such capacity building actions so that increased numbers of GP practices are in addition able to provide nursing and allied health placements.

Placement Essentials is doing this by offering web based or field liaison support to GP practices including clinical training orientation materials, teaching resources, infrastructure, IT backup, assistance in connecting practices and Universities for placement planning and allocation, enabling access by GPs and other staff to clinical supervisor training, guidance on clinical education environment best practice issues, and other help.

Actions to Date
Important actions via Placement Essentials include:

- A 12 month coordinator position based in IEMML has been established to offer clinical training capacity building field support to practices.
- Learner focused infrastructure for the conduct of placements has been constructed /installed in many practices including dedicated consulting space for learners to see patients, office outfitting, computers, and audio visual teaching equipment.
- A Placement Essentials website[2] on the main IEMML site has been created. This web portal acts as a live and interactive support gateway for practices on a range of clinical training information needs, tools and resources (such as the items listed below).
- Clinical training orientation/promotion materials including posters, fact sheets and brochures have been prepared to inform local practices about the advantages of engaging in clinical training.
- Clinical training tools, kits and resources including videos which are focussed on local practices facilitating their clinical training capacities have been developed.
- Provision of advice to practices on implementing the Victorian Best Practice Clinical Learning Environment (BPCLE) framework.
- Enabling access by practices to University clinical supervisor training programs and the local roll out of the 'Teaching on the Run' program for current and future practice based clinical supervisors.
- Up loading by IEEML to viCPlace placement availability and readiness data supplied from local practices for matching and allocation of University requests for placements.
- Enabling provision of placements in GP after hours' services.

[2] http://placements.iemml.org.au/

Business Case Reason 1 - Advantages of a Medicare Local Engaging in Clinical Training Support

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Business Case Reason 1 - Advantages of a Medicare Local Engaging in Clinical Training Support

Why IEMML Has Done This

IEMML's strategic reasons for engaging in partnership focused clinical training capacity building in primary care services as exemplified by the Alliance concept include:

a) Creating conditions in local service providers conducive to giving health care learners ready access to high quality and personally satisfying clinical training placements that will result in a strong motivation for learners to return to these services for employment at the completion of their studies.
b) Facilitating communication between local primary care services and education providers about the shaping of knowledge and skills in educational programs to achieve greatest relevance for the operational workforce needs of local services and the quality of health care these services offer.
c) Supporting productive linkages between educational bodies and service providers for the conduct of population health and service intervention research and evaluation initiatives able to strenghen quality and cultivate innovation in local primary health care provision.
d) Supporting productive linkages between educational bodies and service providers to help generate relevant continuing professional development (CPD) programs for enhancing the skills and competencies of health professionals employed by service providers.

The IEMML Clinical Training Future

Evolution as a Medicare Local

Facilitating medical clinical placements in GP environments has been to date the main point of attention for the shared work of IEMML and the Education Alliance. This work commenced during the time the Alliance was auspiced by IEMML's predecessor body the Melbourne East GP Network (MEGPN), a division of general practice. The transition of IEMML from a division of general practice dealing predominantly with GP service issues to a Medicare Local mandated to support all primary care services has been consolidated. This organisational evolution has implications for the future clinical training support responsibilities of IEMML including the ways of going forward in collaborative strategies with service provider and educational partners.

Primary Health Care Services in the Context of Medicare Locals

In order to better appreciate IEMML's PHC service support responsibilities and its possible future role in clinical training it is helpful to reflect on how primary health care services are described in the Medicare Locals context. The sketching of a practical picture of these services can be derived from Commonwealth and other related national document sources referring to the creation, aims and funding arrangements of Medicare Locals.[3]

PHC services are seen as community based with a local focus, with the providers of these services generally being of small organisational size. They are often seeking to prevent health care problems from arising or to address problems at early stages and so more readily restore individual, family and community well-being. The categories of needs based service types involved are extensive and may be delivered under public, NGO or private auspices.

Some examples include: GP services (including after-hours), mental health services, immunisation, Aboriginal & Torres Strait Islander health, suicide prevention, dietetics, chronic disease management and education, women's health, men's health, home and community

[3] Australian Government: www.**medicarelocals**.gov.au/ and Australian Medicare Local Alliance: http://amlalliance.com.au/

nursing, health promotion, aged care community based services, dentistry, pharmacy and counselling, psychology and the healthcare therapies.

A Widened Scope of Clinical Training Support

This expanded support role across the spectrum of PHC services is motivating IEMML to cultivate a widened scope for its collaborative work in supporting clinical training capacities of service providers. While remaining active in the support of GP practices, this trajectory involves extending clinical training capacity building support to many other PHC providers operating in the Inner East Melbourne Catchment. Although the extended remit is intended to still address the support for GP practices including the planning of medical placements, by necessity, a range of other health care professional disciplines and academic courses need to be encompassed in response to the workforce requirements of the diverse profile of PHC providers and service types present in the catchment.

In the first instance it is anticipated that professional disciplines and academic courses such as nursing, the health care therapies, psychology, social work and health promotion are likely to be seen as priorities for inclusion in an expanded focus.

New or Refocussed IEMML Collaboration Arrangements

It is timely for IEMML to explore the development of new models of collaboration or the refocussing of its existing model it has facilitated if this Medicare Local is to effectively carry forward an expanded coverage of clinical training support activities. As intimated above, a necessary feature of this direction will involve IEMML engaging with a variety of academic and service provider partners in addition to those to those participating in the existing Alliance. The achievement of new or refocussed collaboration models will also require a revised understanding of IEMML's relationship with Melbourne East Clinical Training Network (CTN).

As part of its general support role in the catchment and in anticipation of a possible broadening of its clinical training support role, IEMML has become the organisational host for the Melbourne East CTN. (As noted CTNs are regional consortia established to plan and co-ordinate clinical placement developments and function under a combined mandate from Health Workforce Australia's (HWA) and the Victorian Government's clinical training policy directions).

Moreover, as part of its own strategic planning activity the Melbourne East CTN has undertaken analysis and initiated some regional stakeholder discussions about the best methods for strengthening PHC provider placement capacity in the catchment[4]. This work has recognised that a refocussed education Alliance supported by IEMML could become the conduit for achieving strengthened provider capacity.

[4] Increasing Student Clinical Placements in Primary Care Organisations within the Eastern Clinical Placement Network (ECPN). Whitehorse Community Health Service in Partnership with ECPN, known as Eastern Metropolitan Clinical Placement Network, and Darcy Associates Consulting Services, April 2012.

Business Case Reason 2- IEMML's Organisational Strengths and Purposes

Business Case Reason 2- IEMML's Organisational Strengths and Purposes

IEMML's structural and functional characteristics as a Medicare Local[5] offer many strengths to support primary care clinical training capacity building and clinical placement coordination involving a diverse range of service providers, professional health care disciplines, educational bodies and courses. These strengths are summarised below. The application of these strengths for clinical training are elaborated in Business Case Reason 3 at page 20.

Corporate Identity and Strategic Objectives.

Its corporate identity is a public company limited by guarantee. The formal company objects define a mandate for IEMML to support primary health care development and improvement. Linked to its Commonwealth funding agreement the organisation has five strategic objectives.

These are:

- Improving the patient journey through integrated and coordinated services.
- Providing support to clinicians and service providers to improve patient care.
- Identifying the health needs of local areas and developing locally focused and responsive services.
- Facilitating the implementation and successful performance of primary health care initiatives and programs.
- Being efficient and accountable with strong governance and effective management.

The GP Gateway

In its support role IEMML understands that local GPs are the frontline point of contact and expertise for most individuals and families with health care problems and a main gateway for speedily gaining the assistance, on a team work basis, of other local professional services for meeting these personal needs.

As a Medicare Local it supports a great diversity of initiatives to improve the regional primary care system and is also responsible for a range of direct patient/client services to meet identified service gaps.

Direct Patient/Client Services

The Organisation's direct patient/client services, which may also be delivered on contract by other local providers, include:

a) Various mental health initiatives.
b) Some Aboriginal health services.
c) Ensuring adequate face to face after hours GP services.
d) Aged care therapies delivered into residential care settings.
e) In home nursing care.
f) Diabetes and other chronic disease management and education.
g) Health promotion.

Service System Support Activities

Its service system support activities are extensive and carried out via focussed collaboration and engagement with local primary health care stakeholders.

Key target activities include:

[5] A detailed description of IEMML's organisational and functional features is on this Medicare Local's website, https://www.iemml.org.au/

a) Utilising a regularly updated IT innovative population health data base able to track needs trends to very local levels including contributions from catchment- based research efforts via University partners of IEMML.
b) Designing new or reshaping current service types to meet population health needs with an emphasis on health promotion, prevention, early intervention and the application of eHealth technologies such as shared patient records and tele-health.
c) Linking together various services and service types to form seamless patient/client care pathways, and responsive referral or service finding options for consumers and clinicians.
d) Supporting local clinicians and service providers across a broad spectrum of professional practise based, continuing professional development, organisational development and workforce development needs. This support recognises that service innovation cannot be achieved without a locally available and appropriately skilled health care workforce.

Small Business Support

As observed earlier, many PHC providers are small in size, they also frequently operate under privately owned auspices, which usually means that they are commercial entities required to make a profit if they are to sustain patient/client health care provision. Consequently the balancing of quality patient care objectives with viable commercial returns becomes a prominent feature in the effective management of these service bodies. Moreover in the case where these providers offer clinical placements and engage in teaching a further dimension is added into their management equation. This is about how they balance the tasks of functioning as a successful learning environment with their patient care and commercial goals.

IEMML has well developed expertise in supporting small PHC providers to integrate quality patient care and business economic objectives into a viable and robust balance. This expertise also encompasses the small provider management demands of functioning as a learning environment and offering clinical placements.

Originating from its former status as a division of general practice IEMML has actively consolidated a program of small provider engagement and support that maintains a strong focus on how such management challenges can be suitably addressed.

Accountable Governance and Stakeholder Membership and Engagement

IEMML's membership structure is indicative of a highly participatory organisation. It is governed by an appointed skills based Board of Directors required to engage with and listen to IEMML's stakeholder membership base. Stakeholder membership is available to individuals and organisations engaged in health care activities or addressing the social determinants of health in the Inner East Melbourne catchment. Stakeholders include GPs, nurses, allied health care clinicians, and practice managers together with service provider, consumer and educational bodies.

Reference Groups

Reference groups drawn from the stakeholder membership offer informed advice to the Board and senior executives about various primary health care matters, function as steering or task groups for such purposes as population health needs investigations, service planning/co-ordination initiatives and project implementation activities, or act as consultative forums.
These groups also help foster grass roots accountability by IEMML to communities, consumers and local provider bodies of the region because of the Board's obligation to consider advice and feedback from the reference groups.

Corporate Compliance and Financial Management

IEMML's Medicare Local agreement with the Commonwealth and its Company compliance status require the organisation to have in place a range of robust and transparent due diligence, financial control and accounting procedures for the management of government funding

contracts and the procurement of goods and services. Included in these arrangements are capacities to track and report expenditure against program targets and to address conflict of interest risks when awarding contracts and making similar decisions in a regional operating environment where a range of stakeholders are likely to 'wear multiple hats'. These qualities enable IEMML to be a reliable funds holder of public monies.

Community and Government Policy Imperatives

IEMML's local community responsiveness is integrated with a capacity for implementing government health care policy reforms. IEMML's local stakeholder engagement expertise is able to take forward the policy objectives of the Commonwealth and Victorian governments into the practical tasks of offering support to local service providers. IEMML is skilled in implementing health care policy reforms in local settings while avoiding the interpretation of government policy objectives to service providers in ways which impose policy driven solutions as a substitute for understanding what the needs of providers really are and for considered and respectful mutual problem solving on the ground.

In short the organisation's strategic direction is guided from two key sources, the evidence based needs of local communities expressed via IEMML's stakeholder membership and the PHC policies of government. IEMML's engagement and planning processes are adept at addressing the requirements of both sources in the achievement of primary health care quality improvements for the catchment.

PHC Services Engaging in Clinical Placements and Teaching - Challenges and Solutions

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PHC Services Engaging in Clinical Placements and Teaching - Challenges and Solutions

A diversity of PHC service entities are active in the IEMML catchment

The data shown below is intended to offer some profile indications of PHC service types and providers active in the IEMML catchment. It is presented as an introduction to understanding some of the issues that face PHC services when seeking to offer clinical training.

Table 1 is sourced from IEMML's 2013 population health needs assessment report. It shows numbers of health care services active in the IEMML catchment with breakdowns by the four local government areas and for the catchment as a whole.

Table 1

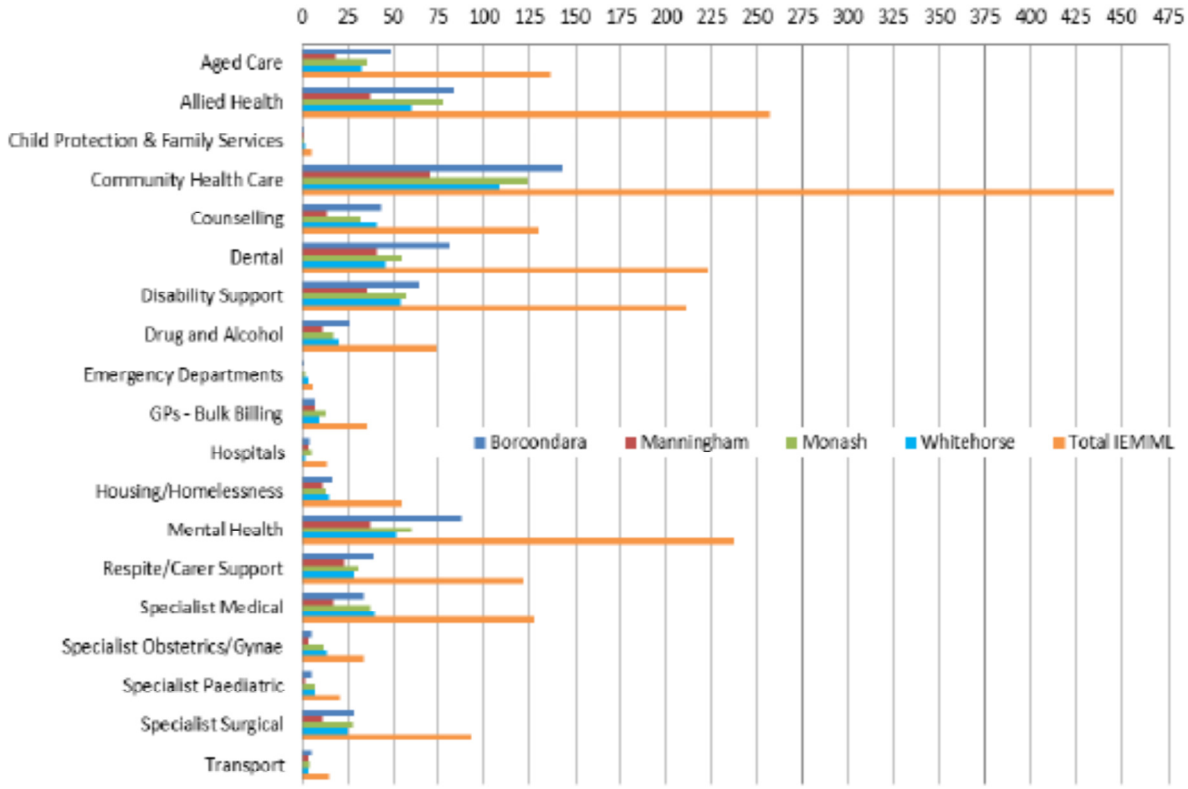

Figure 40 Range and Number of Health Service in IEMML Catchment by LGA (2013)[84]

This table is likely to include services which fall outside a working definition of primary health care (see page 9) including some or all the listings for hospital, age care, emergency and various specialist medical services. Moreover the data in this table does not directly translate into provider profiles by public, NGO or private status. As well, the service types listed may represent distinctly separate service organisations or sub elements of larger parent organisations. For working purposes this paper will refer to the services in the table as 'service entities'.

Excluding all the categories of 'service entities' in the table outside the definition of primary health care as referred to above there could be over 1800 PHC service entities active in the IEMML catchment. These will be functioning either as distinctly separate organisations and/or as sub components of a larger organisation.

Around 30 bulk billing GP services are included in the table and have been factored in to the1800

plus aggregate of service entities calculated above, however the table does not include all GP practices in the catchment. The report from which the table has been extracted does show that there are a total of 186 GP practices present in the IEMML catchment. Consequently when GP practices not shown in the table are added to the aggregate there could be approximately 1950 PHC service entities in the catchment. When all GP services are deducted from this total of 1950 at least 1760 non GP service entities appear to be involved in the catchment

Even with the limitations of the data from which this analysis is drawn the calculations provide a good indicative window about the rich diversity of PHC service activities and service entities active in IEMML's catchment. The nutshell conclusion is that there are a lot of them !

The Smaller Scale of Primary Health Care Providers.

Most primary health care is delivered by relatively small organisations operating from dispersed community locations whose nature and limited scale often constrains the extent to which they can function as viable teaching and learning environments for health care trainees and to be effectively resourced for this purpose. Reference has been made earlier to the reality that many of these small providers are commercial entities and the extent to which they can offer clinical placements is directly related to the impact this teaching commitment has on their bottom line profitability.

In contrast large acute health teaching hospitals and other equivalent scale health care providers are able to utilise teaching funds and resources with greater marginal efficiency, more readily establish teaching units and generally offer better support for clinical training.

Although in recent years improved provision by Health Workforce Australia and the Victorian Department of Health of clinical training funds for health care providers has been a welcomed advancement in the Victorian health care context, many PHC providers have not benefited as well as large health service organisations from this additional resourcing due to the limiting factors surrounding their small size.

A Virtual Clinical Training System of Small Providers

An approach for overcoming these limitations and enabling the predominantly small scale primary care service providers of the Inner East Melbourne catchment to increase the numbers of clinical placements they can host is for the providers to function collectively as a unified 'virtual' clinical training system.

Such a virtual system can generate a critical organisational mass of sufficient scale in which to imbed a range of clinical training support capabilities that cannot be achieved by small providers functioning on their own. Even so this approach can be realised without PHC providers losing their operational independence or unique organisational identities.

The Added Value of a Virtual System

Small service providers combining as a 'virtual' entity for clinical training purposes are positioned more effectively to gain practical resourcing assistance for the conduct of clinical placements including improved support for or access to:

a) enabling time release of professional staff from their direct patient/client care roles to supervise learners on placements.
b) field liaison by Universities to support clinical learning in the workplace and integrate experiential learning with the theory based curriculum aspects of educational courses.
c) professional development for the acquisition of clinical teaching skills for staff.
d) IT assistance for the information management of placements including scheduling, capacity to absorb learners, and reciprocal placement reporting/communication between service providers and Universities.

e) local teaching venues on occasions where group learning or simulated learning experiences are required.

As well this approach provides opportunity for placements to be shared amongst several small providers so that learners gain a richer mix of clinical experiences and the placement management demands on individual providers are lessened.

Better collective engagement by small service providers with Universities and other education providers active in the catchment is made possible via this approach. Service providers and educational bodies are able to address on a partnership basis key objectives such as improved regional systems based communication and co-ordination between all stakeholders in matching placement demand by Universities with placement capacity of providers.

From a University's perspective the logistic and time demands of seeking to place a single student within a small service provider can be of a similar magnitude to placing an extended cohort of students within a large teaching hospital or equivalent sized health care provider. The virtual system concept can help to bring greater efficiency into an education provider's efforts when placing students in primary care settings.

Effective collective funding advocacy to gain necessary infrastructure at service provider and regional levels for sustaining clinical training is made more viable.

Business Case Reason 3 - Why IEMML is Equipped to Support Primary Health Care Clinical Training

Business Case Reason 3 - Why IEMML is Equipped to Support Primary Health Care Clinical Training

IEMML's organisational strengths and purposes were documented in Business Case Reason 2 on page 12. These strengths are applied here to demonstrate via the modelling of future collaborative structures for clinical training support that IEMML is aptly positioned to participate in this role with the PHC service providers of the Inner East Melbourne catchment.

The Leading Drivers

Three leading drivers can be distilled from the organisational summary which motivate, equip, and justify IEMML to engage on a partnership basis with local services and educational bodies to help support the clinical teaching and learning environment capacities of PHC providers in the catchment.

These leading drivers are: (a) the need for an available and appropriately skilled local PHC work force (b) IEMML's stakeholder engagement attributes and (c) the synergies operating between PHC service improvement objectives and PHC clinical training.

The drivers underpin and reinforce the collaborative Model outlined in later sections.

The Need for an Available and Appropriately Skilled Local PHC Workforce

IEMML's mission as a Medicare Local is to support local primary care providers of the catchment in quality advances across a range of service outcomes. The assurance of an accessible and appropriately skilled health care workforce to deliver these service enhancements to consumers and communities is an indispensable element in the equation for continuous quality improvement of the Inner East Melbourne primary health care service system. In simple terms if this workforce development does not occur then service quality improvements will not be implemented.

IEMML's stakeholder engagement attributes -Stakeholder Engagement for PHC Provider Support and Partnership Solutions

Mutual Goodwill

As a Medicare Local, IEMML recognises that its mandate to facilitate PHC quality improvements can only be realised by respectful and meaningful engagement with local service providers. Even more, IEMML understands that for this engagement to be effective it must be infused with and driven by an attentive capacity to listen to providers regarding their organisational issues, needs and challenges rather than imposing either problem definitions or preferred solutions into the way they understand their service experiences.

A Fuller Operational Understanding

IEMML is forming a variety of working relationships in the catchment with individual and groups of PHC providers across a wide array of service quality improvement objectives. If effectively cultivated one beneficial impact of these relationships is to establish a foundation of mutual goodwill between IEMML and local service providers. Moreover these relationships enable IEMML and service providers to have a fuller knowledge of each other's organisational structures and methods of functioning. As a consequence it is possible for IEMML to apply this foundation of goodwill and an increasing appreciation of the unique organisational and functional characteristics of local service providers towards the goal of supporting these providers to act as effective clinical learning environments.

It is really not possible to offer meaningful support to any service provider regarding how they could strengthen their organisation as a robust clinical training environment without first having an adequate understanding of their patient/client care service delivery objectives and methods and the underlying organisational processes that sustain this direct care. IEEML has demonstrated historically with GP services that its engagement strategies do reflect this understanding.

The local engagement role IEMML has developed with GP services in understanding practice specific patient care arrangements and business systems and then applying this understanding to assist practices in achieving service quality and operational improvements that they have identified is now being extended to a diverse range of other PHC providers.

Private Provider Engagement
Many of the PHC providers engaged in partnership activity with IEMML for service quality improvement purposes are likely to be small private providers including community pharmacies, dental services, health care therapy services and psychology /counselling services. Bringing into an effective balance the achievement of quality patient/client care outcomes and viable business economic outcomes requires careful management on the part these providers. As outlined on page 13. IEMML possesses consolidated program experience in supporting GP practices to address this balance and in doing so build a sustainable capacity to host learners. IEMML is in a position to apply this expertise to the engagement and support of these other small and profit dependent PHC providers.

Tracking Stakeholder Contacts
One of the most off putting and annoying experiences for a service provider is to have repeat visits from the same or different representatives of a an accreditation agency, funding body, policy consultation or the like where the same questions are asked again and again as though there was no memory or consolidation of information about what was discussed in earlier contacts.

IEMML's protocols for direct field engagement by staff members with local services coupled with the utilisation of its Customer Relations Management (CRM) software program and supported by an efficient reciprocal electronic communications capability with local PHC providers equips this Medicare Local to track and record all contacts it has had with local stakeholders and the arising issues or priorities which these contacts may have identified.

A consolidated picture of successive IEMML contacts with a provider including the provider's support needs is able to evolve. This prevents unnecessary duplication of purpose in later visits or contacts and enables IEMML and the provider to readily focus on problem solving about priority matters because IEMML is able to take into the visit a consolidated understanding of the challenges and issue the service provider may be confronting. These transactions are also able to be conducted within the bounds of organisational privacy and confidentiality as appropriately required by both parties.

The Conclusion
Such relationship building attributes that enable IEMML to have a valuable understanding of the operational challenges and issues facing local PHC providers can be regarded as significant strengths when considering the potential of IEMML as a Medicare Local to offer clinical training support.

Moreover the provision of support, practice wisdom and other contributions is not one sided in relation to either clinical training or wider PHC issues. As elaborated at page13 local PHC providers are or have the opportunity of: being formal IEMML stakeholder members, actively participating in IEMML reference groups, advising the IEMML Board on priorities for action, and in a variety of detailed ways contributing to IEMML facilitated planning and project activities for service development.

Synergies between service improvement and clinical training capacity
IEMML and its PHC service provider partners are seeking to initiate a range of quality improvements towards PHC provision in the Inner East Melbourne catchment. There are strong synergies between the objectives of these PHC quality improvements and the building of clinical

training capacities within local providers.

In this context IEMML's data warehouse which is holding and regularly updating a range of population health, PHC research and related service improvement data categories for the catchment can be readily applied to inform the clinical learning objectives of placements in a similar manner to it informing quality service developments.

Rich Learning from Innovation
The quality of placements including the clinical knowledge and skills they cultivate are enriched when learners are exposed to direct care service innovations and other aspects of service improvement.

Developments such as: (a) the facilitation of coordinated multidisciplinary patient journeys including the application eHealth patient records, (b) service redesign that is based on population health needs and local and wider University PHC research, (c) the conduct of local service evaluations, and (d) ensuring consumers are actively engaged in all facets of service development and evaluation, are some examples of PHC quality focussed service enhancements that IEMML and its local PHC service partners are taking forward.

It is evident that health care trainees placed in local settings who participate in innovations like these will be exposed to rich and leading edge learning opportunities.

The University Synergies
The role of universities in the IEMML environment is of itself an important driver in the pattern of synergies between service quality improvements and the quality of learning experiences available in local service settings.

The three Universities of the IEMML Clinical Education Alliance have active PHC research agreements with IEMML and/or are otherwise involved in research activities that are relevant to service providers in the catchment. Students in local placements have opportunities to build their own research skills by taking part in these research projects.

There is also another significant research connected benefit that can be realised. This is the case where a University places students in a service environment, like the IEMML catchment, that is modelling quality focussed innovation and service redesign and where the University is also undertaking local field research to inform these service improvements. In this situation the University is afforded a good window to assess whether the content or structure of its academic curriculum may need refinement to address the evolving knowledge and skill demands that arise for healthcare professionals working in these innovatively changing service settings.

Moreover this appreciation of the knowledge and skills required to work in innovatively changing services can be collaboratively applied by universities and service providers to the goal of offering highly relevant continuing professional development (CPD) to clinicians and others already working professionally in these environments.

A Possible Collaborative Model for Supporting a Virtual Primary Health Care Clinical Training System
This Model which identifies a preferred way to support PHC providers in the carriage of clinical training objectives focusses on IEMML's qualities as a Medicare Local enabling the development of a virtual system of PHC clinical training for the catchment. At various points in the outline of the Model these qualities are practically applied.

Further Consultation
The final design, operational acceptance of and funding support for the Model is subject to further

consultation between IEMML and a range of stakeholders including the Melbourne East CTN, the PHC service providers and the educational institutions active in the catchment, The Victorian Department of Health, Health Workforce Australia and the Commonwealth Department of Health.

Antecedents Informing the Model
The Model has been informed by IEMML's experience of collaborative engagement for clinical training support with the existing medically focussed Alliance. An important theme which was presented in arguments to the Commonwealth in the successful practice infrastructure joint submission by the Melbourne East GP Network (IEMML's former entity) and the Alliance was that the infrastructure could be applied to local practices of the region so they functioned as a virtual system able to sustain clinical placements at an optimal load.

It also draws from the strategic work undertaken by the Melbourne East CTN to support PHC providers which was referred to at page 10.The CTN's work proposed that an inter-sectoral group including provision of staffing support be established at IEMML to assist the clinical training effort of local PHC providers. The model reshapes aspects of this work in the light of a fuller analysis of IEMML's functioning as a Medicare Local and the idea of the PHC providers of the catchment co-operating as a virtual training system.

Undertaking Support Functions on Behalf of the Melbourne East CTN
The creation of the current IEMML Clinical Education Alliance predated the implementation of Clinical Training Networks (CTNs) in Victoria. The Alliance's original design did not specifically address operational relationships with a CTN. Even so, productive working relationships have evolved between the Melbourne East CTN, IEMML and the Alliance. These include IEMML becoming the organisational host for the CTN, CTN support for advancing the Placements' Essentials strategy summarised at page 6 and IEMML having CTN membership.

The joint HWA and Victorian Government clinical training policy framework charges CTNs with fostering a range of regional clinical training partnership activities to facilitate placements. It is therefore important that future relationships between IEMML and the Melbourne East CTN are clear in the context of IEMML seeking to widen its clinical training support role.

The strength of CTNs rest in their character of being flexible partnership groupings of regional service and educational stakeholders committed to quality focussed and efficiently organised clinical training. Each CTN has a staffed secretariat contracted via the Victorian Department of Health, supported by a Departmental allocated secretariat budget held by a host agency. Their flexible and responsive network nature also means that CTNs do not have any formalised legal organisational status. IEMML does have such legal status, being a registered company and these differences are relevant in understanding how the Melbourne East CTN and IEMML can co-operate in the future.

Because it is not a defined legal entity a CTN cannot hold funds, enter into contracts, directly employ staff, directly take responsibility for managing and maintaining physical or eHealth infrastructure, engage in purchasing, take direct responsibility for privacy or confidentially issues in research or consultations surrounding clinical training or undertake a range of similar business functions routinely discharged by many health sector organisations.

Where these business functions are required to advance clinical training in a region or locality the Victorian Department of Health and CTNs are looking to other options for gaining this capability. Sometimes the Department can do this directly on behalf of CTNs. Nevertheless in a Government policy framework that emphasises regional collaboration and locally relevant training, increasing attention is being given to CTNs partnering with regional or local organisations able to discharge such business functions.

The Model embodies this approach in proposing future partnership links between IEMML and the Melbourne East CTN. It enables IEMML's business capabilities to be applied to the partnership with the CTN and also the added value arising from IEMML's Leading Drivers.

The Model outlines IEMML undertaking a range of tasks on behalf of the CTN regarding field liaison, support engagement and communication with local PHC providers. Nevertheless the discharge of these responsibilities would occur under a defined form of direction, guidance and/or governance from the CTN. Several options are identified for this CTN role to occur.

Envisaged in the Model is the creation of a business platform for PHC clinical training support imbedded in IEMML. The business platform is intended to provide PHC clinical training support capabilities and functions directed to the very large number of target PHC service entities and the organisations responsible for these entities dispersed throughout the catchment, (provisionally estimated to be at least 1760 entities excluding GP practices, see page 17). Given its flexible, semi-formal and network nature these capabilities and functions cannot be fully carried by the CTN in a direct manner to such a potentially large and dispersed service stakeholder clientele.

Amongst these capabilities are: (a) a range of infrastructure supports including electronic field communication and clinical training data gathering and storage, and ready access to meeting and group learning venues, and (b) the employment of an appropriate and sufficient staff team. The infrastructure and staff team envisaged for the platform would be deployed to enable strong reciprocal communication, field liaison, outreach and other support with local PHC services.

Moreover the business platform is able to leverage IEMML's PHC quality focussed service improvement strengths to enhance clinical training local capacity building and placement provision. The strengths have been summarised as three Leading Drivers (presented at page 20) and are: (a) The Need for an Available and Appropriately Skilled Local PHC Workforce (b) IEMML's Stakeholder Engagement Attributes and (c) The Synergies Operating Between PHC Service Improvement and PHC Clinical Training.

Educational and Partnership Stakeholder Scope

The Victorian Department of Health and HWA intend that the joint clinical training policy framework will actively extend to post professional entry, post graduate and specialist qualification levels in addition to supporting for professional entry qualifications. The recent establishment of the Victorian Clinical Training Council which was transitioned from the Victorian Clinical Placements Council reflects this evolution.

The existing Clinical Education Alliance facilitated by IEMML has prioritised clinical training support to enhance the capacities of GP practices in the catchment to host learners. The support endeavours of IEMML and the Alliance have mainly focussed on the placement requirements for undergraduate medical students to have experiences in general practice settings and to some extent also nursing students. Even so, the Alliance has a commitment to support practices in offering placements at all phases of the medical learning pathway which leads to specialist level recognition as a qualified general practitioner. Commencing with medical undergraduates this pathway also includes medical interns, junior doctors and GP registrars.

Educational stakeholder members of the Alliance are senior GP teaching academic, including head and deputy head, representatives of the GP departments within Deakin, Melbourne and Monash University medical schools, the Eastern Health Clinical school (which has medical teaching roles in the catchment for Deakin and Monash), the Victorian Metropolitan Alliance (VMA) being the Melbourne area GP vocational regional training provider (RTP) and the Royal Australian College of General Practice (RACGP) being the specialist medical college awarding general practitioner recognition and which has various curriculum or standards setting

responsibilities along the learning pathway but with a main emphasis on GP registrar training. The service provider stakeholders are representatives of the 186 GP practices in the catchment. Adding to this profile of stakeholder involvement the Alliance has facilitated GP practice placements for nursing students from Deakin University, a member of the Alliance, and from the Australian Catholic University (ACU) which is not a member.

The Current IEMML Alliance Stakeholder Profile
In summary terms the Alliance has addressed clinical training support objectives involving: (a) ***2*** academic disciplines ie medicine and nursing, involving (b) ***6*** accredited courses ie the university undergraduate medical programs of Deakin Monash and Melbourne, the university undergraduate nursing programs of Deakin and ACU, and the GP specialist vocational program of the VMA ,(c) ***6*** educational bodies - 4 Universities being Deakin, Monash, Melbourne and ACU, - 1 specialist training provider being the VMA and -1 specialist professional college being the RACGP (d) within ***1*** PHC service subsector ie 186 GP practices.

Multiplication of Stakeholder Involvement
As IEMML addresses a commitment to expand its clinical training support role to other PHC service subsectors the numbers of stakeholder elements potentially involved in a partnership frame can rapidly multiply as shown below.

Primary Health Care Service Definitions
Further consultation and data analysis by stakeholders in the catchment seems warranted to confirm an agreed operational definition of primary health care services including the service subsectors, service types, and service entities that may be involved in this definition. Gaining a more accurate quantitative projection of the numbers active in each of the definitional categories is also needed.

The PHC strategic work of the Melbourne East CTN identifies that the following 10 service categories could fall within an operational definition of community-based primary care services: Community health services (CHS), Medicare Locals and their stakeholder members including GPs, community-based mental health services, community-based aged care, private allied health services, alcohol and other drug services, dental services, disability services, pharmacy services and Royal District Nursing Service.

The numbers of service stakeholders in the frame.
There are estimated to be at least 1760 non GP PHC service entities active in the catchment and when GP services are added this total is around 1950. It is not clear how many separate service organisations are in this estimate. Realistically not all the service entities and organisations are likely to express a commitment to hosting clinical placements, but the figures are still indicative of a large clinical training support target clientele.

AHPRA and Other Relevant PHC Professions
The Australian Health Practitioners Regulatory Authority (AHPRA) has jurisdictional responsibilities for 15 health professions. Arguably the following 12 are suggested has having possible immediate relevance to catchment PHC services being: Aboriginal and Torres Strait Islander Health Practitioner, Chinese Medicine Practitioner (including 3 sub divisions), Chiropractor, Dental Practitioner (including 5 sub divisions), Medical Practitioner, Nurse (including 2 sub divisions), Occupational Therapist, Optometrist, Osteopath, Pharmacist, Physiotherapist and Podiatrist.[6]. Other non AHPRA regulated professions that seem relevant and

[6] The Australian Health Practitioners Regulatory Authority, http://www.ahpra.gov.au/Registration/Registers-of-Practitioners/Professions-and-Divisions.aspx

can be added to this list include Social Work, Dietetics, Health Promotion plus others. All in all there appear to be at least 15 professions and additional 10 subdivisions of this total likely to be in the frame.

An Estimate of Educational Organisations
Indicative information sourced via IEMML and the Melbourne East CTN suggest that at least the following 8 education institutions (excluding professional associations/ health colleges) are or are likely to be active with PHC clinical training in the catchment. University of Melbourne, Monash University, Deakin University, Latrobe University, Swinburne University (Higher Education and TAFE), Box Hill Institute, Victorian Metropolitan Alliance and the Australian Catholic University.

Accredited Courses
The total number of health profession accredited courses seeking to place learners in PHC settings in the catchment has not been equated, however the figure is expected to be very considerable.

Summary of Stakeholder Elements
This projections of stakeholder elements in the frame have identified possibly (a) 10 main PHC service providers categories representing around 1950 service entities of which upwards of 1760 are non GP service entities (b) at least 15 health professions with another 10 subdivisions, (c) at least 8 educational institution's, and (d) an uncalculated but on a prima facie basis a large number of accredited courses.

Additional data extraction, analysis and reports generation by IEMML and the Melbourne East CTN including both detailed interrogation and updating of viCProfile is likely to provide more accurate projections about this stakeholder profile including a quantitative estimate of the numbers of accredited courses in the frame.

Phasing in an IEMML Facilitated PHC Alliance/ Partnership
Given the extensive stakeholder elements involved in creating a PHC clinical training support Alliance it will be necessary to phase in this development on a carefully managed basis. Extensive consultation with catchment stakeholders is required to ensure a structure is developed which is suitable and user friendly for both services and educational bodies.

Community Health Services
It is suggested that the first phase could focus on the clinical training support needs surrounding the four community health services (CHSs) of the catchment. These providers are arguably the largest PHC bodies in the catchment and deliver a variety of service types. Moreover they are likely to be parent organisations for a range of the service entities listed earlier. Collectively the CHSs are likely to be in a position to readily identify a concentrated range of workforce needs and clinical training issues which can be assessed for planning and development purposes. This starting point should result in a quicker development momentum than an approach which commenced with the smaller PHC provider organisations and service entities dispersed throughout of the catchment.

A productive consultative and planning methodology might begin by the CHSs identifying collectively the five highest priority health workforce professions/ and related academic disciplines for which placements need to be effected including key issues and challenges involved. Once this baseline information has been assembled it would be possible to map the accredited courses and educational bodies which relate to these priorities. At this point a core of information should become evident to determine which specific stakeholders could form the nucleus of an Alliance. Later steps would include defining the structure of the Alliance, clarifying how it would relate to both the business platform and the CTN and the preparation of an Alliance work-plan.

Extending the Service Sectors Covered
Once this initial Alliance structure became operational further steps could commence about extending Alliance coverage to address the requirements of other PHC providers in the catchment. The small private providers could perhaps be the next PHC service group for priority consideration. They are likely to face significant challenges in offering clinical placements because of their limited scale and the demands of balancing their direct care and commercial goals. The learnings from building the first phase of the Alliance would be helpful in proceeding with the second. On this basis the Alliance coverage could be incrementally expanded over a set time period to address all PHC providers in the catchment.

As these phases are rolled out it can be anticipated that a range of stakeholder sub groupings will need to be established within the Alliance's governing structure and for the carriage of its work plans. These sub groups could be based upon service sub sectors, health profession/ academic discipline categories or other rationale.

Model Diagram
The Model is depicted at Figure 1 below

Platform
The Platform is shown in the large left hand box. It identifies infrastructure support and people support capabilities and a summary of functions and tasks these capabilities are able to offer PHC providers. Also shown are the IEMML three Leading Drivers which can be leveraged to enhance the effectiveness of the clinical training support functions and tasks being delivered via the platform.

Partnership Governance and CTN Accountability
Three options of partnership governance for the platform including CTN accountability arrangements or linkages are shown in the three right hand boxes

Option One identifies a Cross Sectoral Alliance/Partnership Governance Structure as a subcommittee of the CTN.

Option Two identifies a free standing PHC Clinical Training Alliance/ Partnership undertaking agreed functions in partnership with or on behalf of the CTN.

Option Three identifies an expanded version of the existing IEMML supported GP focussed Clinical Education Alliance undertaking agreed functions in partnership with or on behalf of the CTN.

In each case within the governance structure working groups are shown to address discipline and service sub sector specific issues.

Fig 1

IEMML Primary Care Clinical Training Support Business Platform Capability

(Assisting the carriage of Victorian/ Melbourne East Clinical Training Network (CTN) support objectives for clinical training by Primary Health Care Service Providers (PHC- SPs) in the IEMML catchment)

Support from Infrastructure

1.Real time multi media communication with local PHC-SPs.
- ●Collect and collate data re placement offers/availability for uploading on viCplace to support the annual placement planning cycle.
- ●Uploading local PHC services information to viCProfile.
- ●On line support/help desk for the conduct of local placements.
- ●On line support for BPCLE implementation.
- ●Scheduling support events eg clinical supervisor CPD.

2. Access to venues/ technology for group/conference focussed clinical training and support events including group learning, simulation based education and training (SBET) and meetings with education providers.

Support from People

(Field support team: starting configuration possibly circa 2 EFT health professional / work place learning competencies, 1EFT admin support, 0.5 EFT IT competencies)

Field Support to PHC- SPs for Clinical Training
- ●Implementation of CTN work plans relating to PHC – SPs.
- ●BPCLE implementation.
- ●Site based problem solving assistance on clinical training issues.
- ●Facilitating shared placements across services
- ● Arranging meetings, conferences and support events re clinical training involving local services and/or education providers.

Leveraging the IEMML Leading Drivers

Skilled Local Workforce.- Stakeholder Engagement.- Service Improvement Synergies.
- ● Utilising IEMML's evolving electronic/digital communication, interactive web and data collection attributes with local services including CRM, ehealth, tele-health, other modes
- ●Utilising IEMML's meeting spaces and meeting technology..
- ●Access to IEMML supported catchment data warehouse/related sources re. population health profiles, service profiles, research and de- identified PHC service activity/patient journey data to inform curricula and clinical learning goals surrounding placements and help build local training capacities.

Governance Option 1

1. The Primary Health Care Clinical Training Alliance/Partnership is a Sub - Committee of Melbourne East Clinical Training Network with representation from PHC- SPs, higher education and Vet providers and professional colleges active in the IEMML catchment.

2.Working groups including other co-optees to address discipline and service sub sector specific placement and sub sector issues.

Governance Option 2

1.Primary Health Care Clinical Training Alliance/Partnership.
A free standing collaboration of representatives from PHC- SPs and higher education and Vet providers and professional colleges active in the IEMML catchment, with support from IEMML.

2. Undertaking agreed functions in partnership with or on behalf of the CTN to support PHC clinical training in the IEMML catchment.

3. Working groups including other co-optees to address discipline and service sub sector specific placement issues.

Governance Option 3

1. Expansion of the existing IEMML supported and GP focussed Clinical Education Alliance.
Extension of service provider & educational institution/ academic discipline membership to address a wider spectrum PHC clinical training support needs in the IEMML catchment.

2. Undertaking agreed functions in partnership with or on behalf of the CTN to support PHC clinical training in the IEMML catchment.

3. Working groups including other co-optees to address discipline and service sub sector specific placement issues.

Functional Activities of the Model

The work objectives of the PHC Alliance/Partnership will be discharged by using the capabilities of the business platform. They are expected to be similar to the functions being currently undertaken by the existing IEMML Clinical Education Alliance and described by the Placement Essentials strategy at Page 6.

Envisaged work objectives, tasks and activities include:

- Addressing learner focused infrastructure needs in PHS Services for the conduct of placements including dedicated consulting space for learners to see patients, office outfitting, computers, and audio visual teaching equipment.
- Provision of a website on the main IEMML site. This web portal will act as a live and interactive support gateway for PHC services on a range of clinical training information needs, tools and resources (such as the items listed below).
- Developing clinical training orientation/promotion materials including posters, fact sheets and brochures to inform PHC services about the advantages of engaging in clinical training.
- Developing clinical training tools, kits and resources including videos which are focussed on local PHC services to facilitate their clinical training capacities and enabling access to similar materials prepared by HWA and the Victorian Department of Health.
- Provision of advice and guidance to PHC services about implementing the Victorian Best Practice Clinical Learning Environment (BPCLE) framework.
- Developing and/or enabling access by local PHC services to clinical supervisor training programs.
- Up loading by IEEML to viCPlace, placement availability and readiness data supplied from local PHC services for matching and allocation of education provider requests for placements.
- Up loading by IEEML to viCProfile, of a range of catchment information and data about PHC service profiles, population health needs, service development activity, workforce profiles and other categories relevant to clinical education.
- Helping to implement simulated learning for PHC services.[7]
- Operating a help desk for PHC services on clinical training issues.
- Ensuring direct field liaison and on the ground support to local PHC services on various clinical training issues including from the listing above.

The initial staffing group of the platform is provisionally identified as 2 EFT of staff with suitable health professional and or work place learning competencies, 1EFT of administrative support and 0.5 EFT of appropriate IT competencies. The group will be responsible for undertaking most of these work activities.

Work Planning and the Prevention of Duplication

These work activities will be expressed in work plans prepared under the auspice of the CTN or in partnership with the CTN depending on the final nature of the governance structure adopted for the Model. The preparation of the work plans will ensure that there is no duplication of functions or resources usage in relation to work carried out by an IEMML facilitated Alliance or Partnership and other PHC support work occurring under CTN auspice.

As part of the process of implementing this Model including the assignment of resources to the platform, and in finalising agreement about the tasks undertaken by the PHC Alliance/

[7] This will primarily involve the enabling of access by PHC Services to Victorian and HWA developed simulated learning materials and opportunities , see Victorian Strategy for the Development of Simulation-based Education and Training (2012-2015) - October 2011, http://www.health.vic.gov.au/placements/resources/index.htm and HWA, Simulated Learning Environments (SLEs) and other pages, http://www.hwa.gov.au/work-programs/clinical-training-reform/simulated-learning-environments-sles

Partnership it is proposed that a gap analysis be initiated. This could identify what the CTN is best able to do directly to support PHC clinical training needs and what support needs would still remain. The unmet needs would become the remit of the PHC Alliance/Partnership and the resources invested in the platform would be in proportion to the effort required to address these unmet needs.

Costing of the Model and Co -Investment by IEMML

As the Model will require further consultation with a range of stakeholders to gain a consensus of acceptance and to shape the final details of structure and functions it is premature to undertake any comprehensive costing of its implementation.

Even so, based on staffing cost information supplied by IEMML the annual salary budget for the staffing group inclusive of 20% on costs is around $370,000. This level of basic salary cost is likely to be included in any funding proposal to government for sustaining the Model. However such costs do need to be seen in the light of the Model leveraging a range of existing IEMML resources and functions for the benefit of PHC clinical training support as identified via the Leading Drivers. It will be possible to calculate the dollar value of this leveraging contribution by IEMML.

Funds Pooling

Interviews with HWA and Victorian Department of Health representatives in the process of preparing this paper indicated that collaborative national / state investigations are in place to review costs and funding arrangements that impact clinical education and placements. One allocation principle being re-examined is that of the dollars for placement funding following the student. If this principle was reinvigorated and applied to funding PHC placements in the IEMML catchment a very diverse pattern of funds disbursement may possibly eventuate including a wide dispersal of limited allocations to many small providers.

Subject to consultation with PHC providers there may be greater cost effectiveness gains for them if components of such a funding stream were pooled to enable strengthened collective capability for deploying a larger concentration of resources and infrastructure towards their clinical training support needs. This pooling concept may have some appeal to PHC providers of the catchment and could be further considered as one method of contributing towards the sustainability of the Model.

Funding Agreements

In the case where IEMML was seeking funding support from the Victorian Department of Health for the Model some baseline criteria would need to be addressed. It could be anticipated that any forthcoming funding allocation would be dependent upon clear agreement about roles, functions and capabilities between Melbourne East CTN, IEMML, the Platform and the governance structure of PHC Alliance/ Partnership.

Policy Issues and Budget Sustainability

Policy Issues and Budget Sustainability

An Unfunded Clinical Training Support Role

The IEMML facilitated Alliance has gained very significant clinical training infrastructure funds for investment in local services, however since the Alliance's inception the underlying planning, coordination and stakeholder liaison tasks involved have been predominantly resourced from IEMML's (and its predecessor's) core funding provision without substantial ear marked monies being provided to the organisation to cover the real costs of this intensive work.

IEMML has regarded these activities as foundation work because it enables the creation of a skilled and accessible primary health care workforce in the catchment, which underpins the achievement of many other Medicare Local goals. Nevertheless the carriage of this effort has placed the organisation under very considerable budgetary pressure.

Recent History

In the 2008 study commissioned by Deakin, Melbourne and Monash Universities to assess the capacities of Victorian GP practices to provide clinical placements for projected large increases in university enrolments of medical students [8] an assessment was undertaken about the role of the then Victorian Divisions of General Practice toward clinical training support for GP practices. The study concluded that a number of divisions had been active in this work and that the general characteristics of divisions made them well suited for this role. It also observed that on the occasions the role had been undertaken the divisions involved did so without receiving any or only very inadequate allocations of dedicated recurrent program funding from the Commonwealth to sustain this demanding field activity. Recommendations in the report included several policy advocacy actions directed at gaining improved Commonwealth funding recognition of a division's role in this sphere. These actions were carried forward by several stakeholder groups associated with the study project including General Practice Victoria (now known as Networking Health Victoria) and the Australian General Practice Network the national body which preceded the creation of the Australian Medicare Local Alliance.

Current Commonwealth Funding Arrangements

In the evolution of Divisions of General Practice to Medicare Locals this lack of clear funding recognition by the Commonwealth has remained. As analysed in this Paper, the development of an accessible appropriately trained local PHC workforce, with clinical training support being applied as a pivotal tool for this development, is a critical success factor for enabling a range of other PHC quality initiatives to be implemented. Nevertheless this goal is not explicitly identified by the Commonwealth as a central strategic objective that Medicare Locals are obliged to achieve via their core funding agreement. In effect it becomes a discretionary and secondary activity that a Medicare Local may choose to pursue via an interpretation of local catchment priorities within one or more of the five main strategic objectives which the Commonwealth sets for a Medicare Local. In IEMML's case this activity is incorporated into the strategic objective dealing with the provision of support to clinicians and service providers to improve patient care.

The end result of this field not being recognised as a central strategic objective is that Medicare Locals do not get sufficient Commonwealth funding support for this role and must continually stretch and juggle resources if they wish to maintain work in this field such as clinical training support. One reason for the preparation of this Paper has been to assist some renewed policy advocacy for improved recognition by the Commonwealth of these workforce objectives.

Victorian Government Recognition

Another important goal of the development of this Paper has been to demonstrate to the

[8] Medical Student Clinical Placements in Victorian General Practices, Deakin University, Monash University, University of Melbourne, prepared by Burgell Consulting, 2008. http://www.health.vic.gov.au/placements/resources/index.htm

Victorian Government the value a Medicare Local has in supporting PHC clinical training. It will be possible for the strengths reflected in the Paper to be applied in Medicare Local funding submissions to the Victorian Government for sustaining roles in this field.

Paradoxically even though Medicare Locals are organisations of Commonwealth creation they appear to gain greater recognition by the Victorian Government for their clinical training support role. This is evident in that a seat has been made available on the Victorian Clinical Training Council for a representative of the Australian Medicare Local Alliance and Medicare Locals' participation on CTNs is welcomed. As well several Medicare Local clinical training funding submissions have already been successful with the Victorian Department of Health.