Sustainable Rural Health Project

BULOKE | LODDON | GANNAWARRA

The way forward to sustainable rural health

Findings from co-design in Buloke, Loddon, and Gannawarra with recommendations for sustainable rural health

Acknowledgement of Country

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries, following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young people for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuing cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us.

We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing. We extend that respect to all Aboriginal and Torres Strait Islander peoples.

This activity is funded by Murray PHN through the Australian Government's PHN Program.

While the Australian Government contributed funding for this material, it has not reviewed the content and is not responsible for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

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Murray (PHN) Primary Health Network: Bendigo, Australia.

Executive summary

VISION

To safeguard healthcare services in the region, now and for future generations, Murray PHN (Primary Health Network) together with Boort District Health, Inglewood & Districts Health Service, East Wimmera Health Services and Northern District Community Health are co-designing new healthcare models and strategies to increase rural health system sustainability.

Health system sustainability is impacted by a range of different influences on the health system including workforce, service and program models, funding and government policy. The vision for this project is to tackle multiple system challenges through a partnership approach, that values local knowledge while drawing from best practice examples in the international research literature, to find out what works and how it can be sustained over the long term.

BACKGROUND

The co-design research presented in this report to community was conducted in the first year of the Sustainable Rural Health project. It was led by the Integrated Health Network (IHN) Alliance, a regional panel of health services that is actively involved in co-planning for the Buloke, Loddon and Gannawarra (BLG) regions, on behalf of the broader BLG Health & Wellbeing Executive Network.

The co-design research was also supported by Monash University, and one of the pilot models being implemented has received funding from the La Trobe University Violet Vines Marshman Centre for Rural Health Research and Murray PHN.

AIM

To co-design place-based and evidence-informed models that contribute towards building a sustainable rural health system aligned to community priorities in the Buloke, Loddon and Gannawarra regions.

CO-DESIGN JOURNEY

The research focused on getting local perspectives to inform models that are best suited to the BLG. Interviews with people from the region were held between July-November 2022. Valuable insights and perspectives were provided by healthcare professionals, consumers, carers, parents, community leaders and volunteers.

Two initial priorities were proposed to stimulate discussion, which were general practitioner (GP) recruitment and retention, and increasing access to primary care for people with chronic health conditions. Professional participants were also provided with a handout of potential systems strategies drawn from policy and evidence reviews as a discussion tool.

Insights drawn from a range of sources informed the co-design process including project governance meetings, community engagement through events, health services meetings and informal conversations. Preliminary findings were posted online for a period of review and feedback via an anonymous online survey. The proposed models were designed to be place-based, to incorporate community assets and draw from the experiences, perspectives and opinions of community members who participated in the co-design process, and to be evidence-informed, using existing and new research, funding and policy opportunities.

Findings

BULOKE, LODDON AND GANNAWARRA HEALTH PRIORITIES

Co-design discussions with healthcare professionals, consumers and carers were used to identify health priorities for the region. Healthcare professionals identified priorities of:

1. healthcare accessibility and affordability
2. health priority areas
3. other determinants of health.

Healthcare consumers and carers identified priorities of:

1. number of GPs, accessibility and continuity of care
2. care for the ageing person
3. timely emergency care.

While there were differences in priorities many aspects reflected shared priorities, which has provided a focus for the design of pilot models:

Healthcare accessibility and affordability across the continuum of care, from primary care to specialists and urgent care, and for specific community groups who experience healthcare barriers.

BULOKE LODDON GANNAWARRA HEALTH SYSTEM STRENGTHS AND CHALLENGES

The experiences of healthcare professionals, consumers and carers provided valuable insights into health system strengths and challenges to inform the proposed models.

The main health system strengths were:

1. commitment to rural communities
2. rural communities as spaces for innovation and satisfying careers.

The key health system challenges were:

1. patient transport
2. aged care
3. health system navigation
4. workforce shortages.

SUSTAINABILITY BARRIERS, ENABLERS AND RESOURCES

Key barriers, enablers and resources were identified through the co-design process and mapped to pilot models.

PROPOSED SUSTAINABLE RURAL HEALTH PROJECT STRATEGIES AND MODELS

A range of creative, innovative and expert strategies and models were proposed as part of the co-design process, which have informed the refinement of design principles and the development of three interrelated streams of work:

1. workforce advocacy, recruitment and strengthening
2. integrated rural primary care services
3. innovative employment models and models of care.

Current trial models and strategies that are underway are mapped to the three streams, with recommendations for further potential models or strategies which draw from local opportunities and exemplars.

NEXT STEPS

The co-design findings provide critical insights into local priorities, health system strengths and challenges, barriers, enablers and resources, which can be leveraged for health system change.

Three interrelated streams of work are proposed, that together, aim to enhance health system sustainability via a multi-level systems strategy. The next steps are to confirm and implement the pilot models with key partners and to evaluate sustainability and community health outcomes.

Shared vision for sustainable rural health

Rural communities need locally accessible health services for maintaining good health and wellbeing, recovering from injury and illness, and managing chronic conditions. But long-standing recruitment challenges and other factors make it increasingly difficult to maintain health services in communities.

Murray PHN is working together with Boort District Health, Inglewood & Districts Health Service, East Wimmera Health Services and Northern District Community Health to respond to, and plan for this impending health system crisis, and tackle problems in the health system through an innovative partnership approach called the Integrated Health Network (IHN) Alliance.

Between July to November 2022, the IHN Alliance led a co-design research process to gain an in-depth understanding of the issues and challenges impacting healthcare access and service delivery in the Buloke, Loddon and Gannawarra region. This included identifying community priorities and ideas for health system change. The findings have been used to co-design new healthcare strategies and services, which aim to make sure the health system can provide services needed by communities now and for future generations.

People from the Buloke, Loddon, and Gannawarra region shared their insights and ideas, including healthcare professionals, consumers, carers, parents, community leaders and volunteers. Their valuable insights have helped to identify local priorities, strengths and challenges and other factors that are important for accessing services and achieving good health outcomes.

This report contains the co-design findings and describes how community perspectives were used to create design principles to support partnership work going forward and a plan with recommendations for models to trial in the region to build sustainability in the health system.

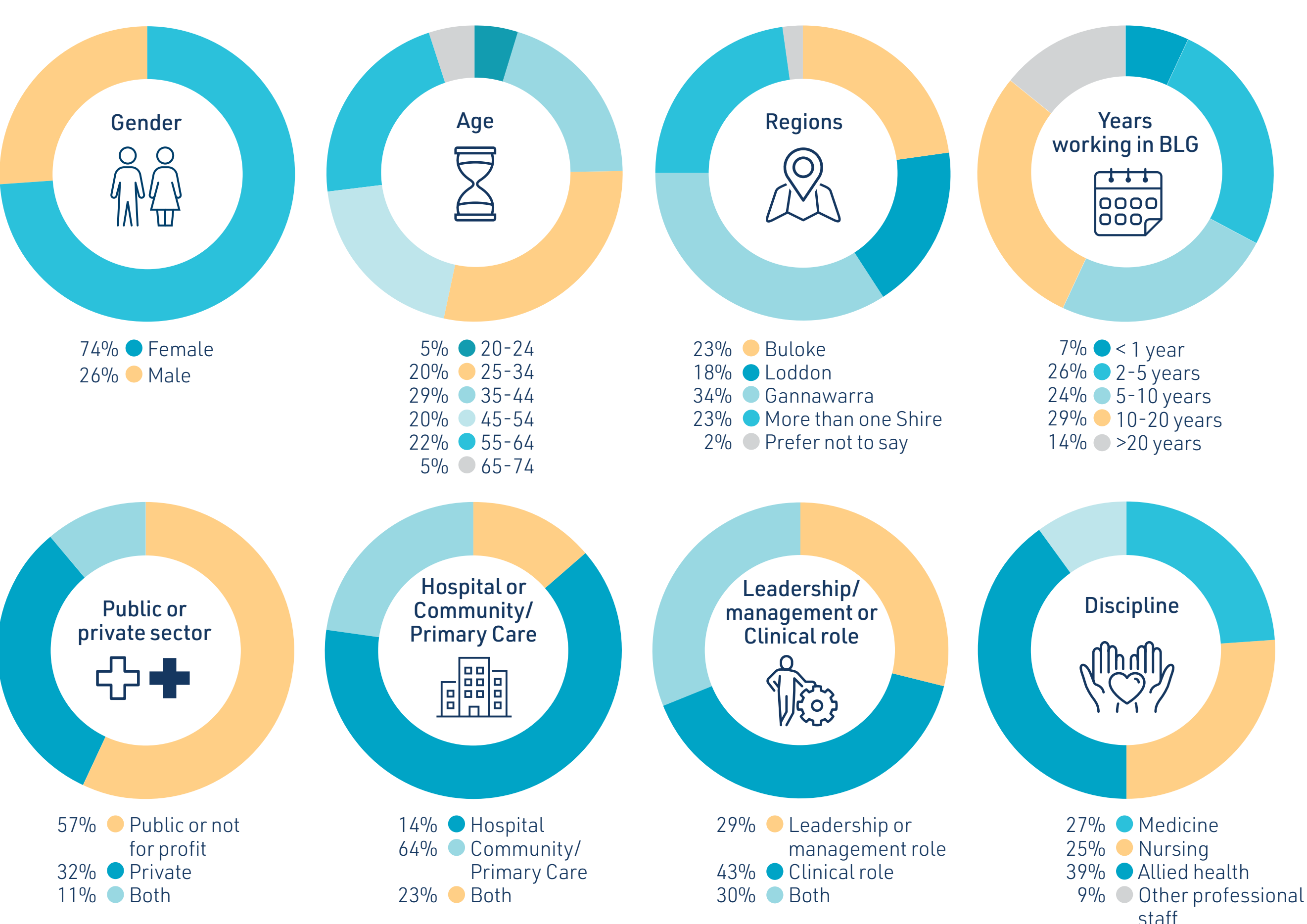
Co-design journey

The research was focused on getting local perspectives to inform healthcare models that are best suited to the BLG. The co-design was undertaken by Murray PHN and the Integrated Health Network Alliance using a research process with human research ethics approval from Monash University.

A strengths-based approach to co-design was used that focused on identifying and understanding regional assets, resources, workforce capacity, goals, motivations and aspirations.

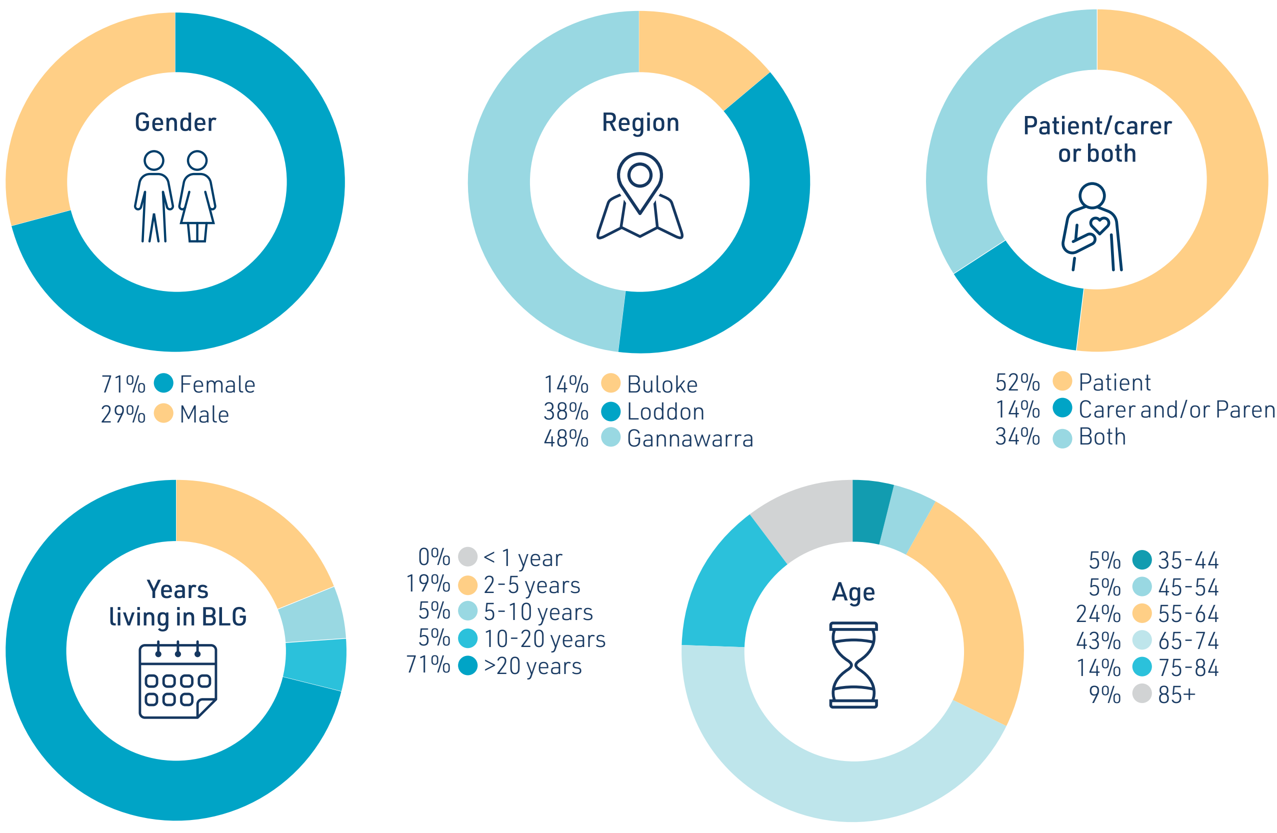
Co-design conversations with 44 health and medical professional stakeholders and 21 healthcare consumers and carers were held. This diverse group included CEOs, people in leadership and management, people with direct clinical service roles, GPs, registered and enrolled nurses, nurse practitioners, allied health professionals including physiotherapists, occupational therapists, speech pathologists, dieticians, professionals working in private practice and those in public hospitals, community health services and other health services in local councils, community leaders, community volunteers, board directors, retired health professionals, carers of people with disability, parents and families. The key characteristics of the co-design participants are presented below which describes age, gender, geographical region and other factors. People were also asked to describe their cultural background or familial ancestry; most people described being born in Australia and/or from British, European and white Caucasian origins. A smaller number of people described having Aboriginal and/or Torres Strait Islander cultural identity, or cultural ancestral backgrounds from African, Asian and South American continents.

KEY CHARACTERISTICS OF HEALTHCARE PROFESSIONAL CO-DESIGN PARTICIPANTS



Total number of participants: 44. Total number of completed sociodemographic surveys 41 (93%)
*Where the sociodemographic survey was not returned the relevant information has been retrieved from the interview transcript to answer the question where available. Totals may not equal 100% due to rounding.

KEY CHARACTERISTICS OF HEALTHCARE CONSUMER AND CARER CO-DESIGN PARTICIPANTS



Totals may not equal 100% due to rounding. Total participants=21

Two initial priorities were proposed to stimulate discussion, which were general practitioner (GP) recruitment and retention and increasing access to primary care for people with chronic health conditions. Professional participants were also provided with a handout of potential systems strategies drawn from policy and evidence reviews as a discussion tool.

Insights drawn from a range of sources informed the co-design process including project governance meetings, community engagement through events, health services meetings and informal conversations. Preliminary findings were posted online for a period of review and feedback via an anonymous online survey. The proposed models were designed to be place-based, to incorporate community assets and draw from the experiences, perspectives and opinions of community members who participated in the co-design process, and to be evidence-informed using existing and new research, funding and policy opportunities.

The co-design findings are presented to inform a multi-level health system strategy, that builds sustainability into the building blocks of the health system, including leadership and governance, service planning and funding, workforce, data sharing and health information technologies and service delivery.

CO-DESIGN INPUTS AND GOVERNANCE

REGIONAL STAKEHOLDER GOVERNANCE

REGIONAL EXECUTIVE PANEL

COMMUNITY AND STAKEHOLDER ENGAGEMENT

MAPPING POLICY AND FUNDING LEVERS

SYSTEMS APPROACH WITH MULTIPLE INTERVENTIONS

- LEADERSHIP AND GOVERNANCE
- SERVICE PLANNING AND FUNDING
- WORKFORCE
- SERVICE DELIVERY
- DATA SHARING
- HEALTH INFORMATION TECHNOLOGIES

DYNAMIC CO-PLANNING

CO-DESIGN SERIES OF PILOT MODELS

IHN
Integrated Health Network Alliance

- Collaborative models
- Professional Networks
- Innovative Models of Care
- Shared care and service delivery
- Workforce Strategy

EVALUATION

REAL TIME KNOWLEDGE TRANSLATION

BULOKE LODDON GANNAWARRA HEALTH PRIORITIES

The over-arching shared priority of the two groups was the importance of healthcare accessibility and affordability across the continuum of care (primary to specialist/tertiary care and urgent care) and for specific community groups who experience barriers to care, including children and young people needing early intervention services for disability and/or mental illness, and care for older people particularly those who require supports to remain at home.

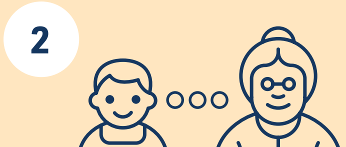
Healthcare accessibility and affordability across the continuum of care, from primary care to specialists and urgent care, and for specific community groups who experience healthcare barriers.

Co-design discussions with healthcare professionals, consumers and carers identified health priorities for the region.

PRIORITIES IDENTIFIED BY HEALTHCARE PROFESSIONALS

1 Healthcare accessibility and affordability "Healthcare close to home"

- Assistance with patient transport
- Improving access to GPs, allied health services and specialists
- Increasing healthcare affordability
- Assistance with complex care navigation



2 Health priority areas "Our young and our old"

- Mental health
- Early childhood intervention
- Aged care
- Chronic conditions

3 Other determinants of health

- Housing
- Health literacy
- Socioeconomic status
- Childcare, early childhood education and schools
- Declining populations
- Social and cultural participation

PRIORITIES IDENTIFIED BY HEALTHCARE CONSUMERS AND CARERS

1 Number of GPs, accessibility and continuity of care

2 Care of the ageing person

3 Timely emergency care

KEY SHARED PRIORITIES

"I think one of the biggest challenges I face is the severe shortage of specialist and certain allied health. It's really hard to get anybody to see a counsellor, and in the region, in the immediate vicinity, there's only one practice, they are very limited and when you take into consideration the number of people with mental health needs, you really need more of that. It's very hard to get a physiotherapist appointment. It could be a few weeks waiting to have a physiotherapist appointment." - GP

Consumers had specific concerns about access to timely emergency care, which was challenging because of travel distances to ambulance and emergency departments.

"I'm honestly more surprised that kids don't die out here. Because there's a lot of asthmatic kids... at the moment with the COVID epidemic, the way that the health system is so understaffed, or it just can't keep up." - Consumer

There were concerns that the inability to access early intervention services for children with developmental delays would result in long term social and educational outcomes.

"The children that tested within that mild-moderate severe area for their speech and language delays haven't been engaged with anyone previously... But then that flows on to being able to participate in kinder curriculum and social situations and things like that... if you don't have those solid foundations in that 3-4 year age group, you get to school and then you just keep falling behind." - Allied health professional

Mental health was the highest priority issue for healthcare providers, who said *"mental health underpins all other types of health. If your mental health is no good, then it's very difficult to focus on other types of health,"* nurse, and *"mental health is a growing and emerging issue,"* allied health professional. A general practitioner recommended that, *"extra mental health workers [are needed] with the rise in mental health problems, we've got one but it's not enough."* Mental health needs were also linked with the social isolation experienced by older people living at home on their own and young people experiencing stress and mental health challenges who were not able to access mental health services locally.

Healthcare professionals and consumers recommended that health service access needs to be supported through patient transport and care navigation.

"Sometimes it is difficult and takes a bit of time to find the right specialist to refer to and it might be issues like financial for example, many people are not able to pay to go see a specialist." - GP

Healthcare consumers also highlighted the importance of continuity of care and being able to access a professional and service who knows and understand your health needs. There was a shared understanding that as people age they need more healthcare, and that communities in the BLG have aging communities.

"I think it's the gap between probably losing your independence and getting into aged care, that in-between stage that's difficult. Because while you're independent you can drive to Bendigo or Swan Hill no problems. But once you lose your independence but you're not in aged care, it's just that gap." - Consumer

Healthcare professionals also described the importance of other determinants of community health including affordable housing, health literacy, access to childcare and schools supports and initiatives for improving population growth and social and cultural participation.

BULOKE LODDON GANNAWARRA HEALTH SYSTEM STRENGTHS AND CHALLENGES

The experiences of healthcare professionals, consumers and carers provide insights into regional health system strengths and challenges, which are critical for developing place-based models that are locally supported and maximise use of existing resources and strengths to address challenges and barriers.

PERSPECTIVES OF HEALTHCARE PROFESSIONALS

Strengths

1. Enjoy working with rural people and communities
2. Rural practice is innovative, interesting and engaging
3. Supportive workplaces

Challenges

1. Travel costs
2. Workforce shortages
3. Professional and social isolation
4. Poor access to specialists and allied health, and fewer healthcare providers
5. Community expectations
6. Community isolation and self-reliance

PERSPECTIVES OF HEALTHCARE CONSUMERS AND CARERS

Strengths

1. Local health practitioners who know the community
2. Models of care that suit the community
3. Local allied health services

Challenges

1. Healthcare workforce shortages and gaps
2. Limited infrastructure
3. Distance travelled for healthcare
4. Continuity of care and accessing multiple services

KEY SHARED STRENGTHS

The main strengths that were shared by healthcare professionals, consumers and carers are described in further detail below and which have informed the proposed models.

COMMITMENT TO RURAL COMMUNITIES

Health and medical professionals love providing care for rural communities, and healthcare consumers appreciate that healthcare professionals have in-depth understandings of local community contexts. The professionals who participated in the co-design expressed a genuine commitment to rural people and communities, which motivates them to work locally and give back to the communities in which they live.

"Country people and small communities... they are just honestly the best people to look after and they really appreciate what we do." - GP

"I like small communities. I like the community feel. I like the fact that you actually can see that you make a difference. And you get to see your patients again. You'll get to meet them wherever you go. It can be a curse or a blessing, but it is nice to think, I've had a hand in this person getting back to being able to do that." - Allied health professional

This commitment was echoed by professionals in leadership and management positions:

"We've got a really committed, passionate group of leaders across this BLG area, especially the Council, which I work closely with. We all have a shared vision. We're really committed to our to improving health for our community." - Leader/manager

Consumers also valued the commitment that health professionals demonstrated towards community health, one said, *"our GP was good. We really had a good relationship. He was great, he would call in whenever you needed. He'd use telehealth and he was more than happy to take advice (from specialists)."* Similarly, consumers noted the importance of local knowledge and programs, with one saying, *"these local nurses have a lot of local knowledge. I think that's important... it's certainly beneficial to the patients. That sense of reassurance, sense of familiarity."* Another consumer said, *"having that service 10 minutes from my house rather than 45 minutes... was a massive difference."*

RURAL COMMUNITIES ARE SPACES FOR INNOVATION AND SATISFYING CAREERS

Health and medical professionals working in the BLG value rural generalist practice, and that allows for diverse and enjoyable work roles. In many cases, a rural healthcare professional working in the BLG holds a number of concurrent service provider roles, for example, working across primary care, aged care, hospitals and council service provision of maternal and child health, including immunisation programs, while also serving in volunteer roles such as with sporting clubs.

The variety and challenge of rural practice is seen as a motivator and a driver for innovative practice models and ways of working, one GP described, *"no day looks the same as the other."* Senior GPs and nurses value the opportunities to up-skill, complete advanced scope training and/or credentialling and obtain a broad skill set.

"I do find rural general practice to be the true general practice, the real general practice, because you do feel the value of what you do here, by being able to get to know people, their families, their histories, and that being the hallmark or cornerstone of being a general practitioner is to really get to know the patient. It definitely helps manage their health better and is one of the main benefits of working long term in rural practice." - GP

"We also cover the hospital, which I find enjoyable because it gives you that continuity of care that you just don't get in a larger centre. You know it's not often that you can see someone in clinic, can admit them in hospital and then discharge them back to your care good or bad. But you do get to see the effects of your interventions, from a preventive point of view and how that impacts on inpatient management, which I find quite rewarding." - GP

Professionals in leadership and management roles expressed their appreciation for the rural generalist health professionals and the challenging work that they do:

"I admire what GPs do out here. I think it's much, much harder than trying to do the same thing in the larger centres. So I think the contribution that they make is huge." - Leader/manager

Healthcare consumers and carers who participated in the co-design process, similarly expressed their appreciation for rural healthcare professionals and their ability to tailor healthcare service models to community contexts and make positive remarks regarding local and regular travelling services. Primary care and allied health services were seen as assets for communities in maintaining good health and wellbeing.

"We have had some good providers over the years. If they're easy to access and professional. That really listen to you or prompt you with questions about your health and, you know, give you a referral where necessary. Those kinds of things." - Consumer

The innovative nature of rural generalists and working in small rural communities was described as under-appreciated or under-valued, especially in contrast to other specialists, which was seen as a myth to be dispelled, one leader said:

"There's a misconception that rural health is a bit sleepy. I think a lot of regional and metro hospitals, don't look at us as if we're skilled or well-trained and it's absolutely incorrect. Especially in rural health, when you have nurse practitioners and RIPRN nurses, nurses that are way more highly skilled than I've ever experienced in any other health facility." - Leader/manager

Supportive workplaces were identified as another reason for enjoying working in the region, which was attributed to leadership and management, multidisciplinary teams and other staff.

"I find all the health services very approachable and friendly. The CEOs are all very enthusiastic and so are the directors of nursing or directors of clinical services or whatever titles they might have. All the interactions I have with GPs are positive." - Leader/manager

"I love working here and I think It's a great organisation to work for. The management are fantastic and you know it's the most flexible workplace I've had." - Allied health professional

"A highly motivated team of people from the CEO all the way to reception... but that is also one of the things that made me want to continue to work here is the incredible support." - GP

KEY SHARED ISSUES

The main challenges that were shared by healthcare professionals, consumers and carers are

described in further detail below and which have informed the proposed models.

PATIENT TRANSPORT

Communities across the region require more accessible patient transport options, especially for older people and people who have difficulty travelling long distances, who can no longer drive, who need to travel to access allied health or specialist appointments, including families with a child with disability. The long travel distances, lack of transport options and increasing petrol costs were described to limit people's healthcare options resulting in deferred care or choosing not to attend.

"I don't know how to fix that... but we really need to be looking into travel, you know even for our some of our patients that can't afford it. I had a patient who came back from Bendigo, who lives locally and was meant to come across here and see me but couldn't afford the fuel. So she was left for a week or more. We finally did a visit over there and she was in poor condition and I felt like we'd failed her. So how we can't fix that?" - Nurse

Similarly, an allied health professional said:

"I do think a lot is put off or ignored because they're just used to having no access or they're used to going, 'OK, so do we travel to Swan Hill, Bendigo, Horsham, or do we just not worry about it and see how things play out?" -Allied health professional

Existing community transport options were identified within communities across the region through health services, community services and shire councils, however, both professionals and consumers identified many gaps in this service provision that means people can't access the services that they need. Gaps such as costs, complex booking systems, high demand, service unavailability and other restrictions travel distance or pensioner status can make people ineligible. Many communities in this region do not have a same day return public transport connection to regional or metropolitan centres.

Service providers in regional centres who travel to small rural communities to provide services have expressed concern with the sustainability of these outreach services, given funding limitations and high service demands. Private providers who offer these important services appear to do it out of their commitment to communities, not because it is a financially sustainable model. *"Because if I don't go there, all of those kids will get nothing."* - Allied health professional

A low or no cost service that provides transport between small rural communities and the larger regional centres, is needed.

"We need help to transport people to or from Bendigo or Swan Hill, some sort of service that can take them to get the scan or to get a procedure or an appointment that will be a huge help for a lot of people here. I have people saying I didn't get this test because I couldn't find anyone that could take me there." - GP

Recommendations for supporting patient transport include providing fuel vouchers for patients to drive themselves or give to a friend who can assist to take them to an appointment, as well as increasing flexibility around eligibility for transport services and transport reimbursement programs such as reducing threshold of travel distance for eligibility.

AGED CARE

There was a shared understanding that as people living in BLG communities age, they will need more healthcare and other supports to remain living at home and close to family and friends.

Both professionals and consumers agreed that more support services were needed in communities to allow older people to stay living in their own homes for longer, for services including community and district nursing services and social and transitional supports.. One nurse said, *"the majority of our population is aged and the majority of our population want to stay in their homes."* The importance of services and resources for older people was expressed by a consumer, *"we've got an ageing population but it's that aged care in the home. And it's all very well to say, ageing in the home, but it's really difficult without service providers."* and a CEO said, *"to ensure that our district nursing is well resourced and that people can be cared for safely at home."*

The importance of local services for older people was a key point of emphasis;

"They're getting older. They don't manage those journeys, they can't drive to Melbourne or even to drive to Bendigo... they're stressed, they're not feeling well or they just get anxious about it." - Consumer.

It was noted that older people have longer stays in hospital because of the lack of transitional supports or available beds, which contributes to rising healthcare costs.

There is also a lack of private services for older people due to inadequate funding, so even if older people have packages to pay for services there aren't existing services to provide what they need locally, *"we don't have any private aged care services here, like, where are they going to come from? Nobody is going to come from Bendigo to give Betty a shower."* - Nurse. Advanced care planning and palliative care were identified as specific aged care needs.

HEALTH SYSTEM NAVIGATION

The health system in Buloke, Loddon and Gannawarra, like other rural regions, is complex and challenging to navigate for healthcare professionals and consumers and carers, and it takes healthcare professionals more time to locate specialists and other services for referral and linkage.

People have difficulty accessing health services they need, including GPs, allied health and specialists. Across the region, access varies and is inconsistent making it hard for professionals and communities to keep track of and stay up-to-date, this was emphasised by consumers, *"we don't know what's available from the hospital."* and, *"I find it gobsmacking that I've lived here for five years and I don't know what's available."*

There are long waiting lists for services, people have limited options due to small number of providers and experience difficulties and barriers due to funding complexities. For example, in some places a family can access allied health services locally if they have National Disability Insurance Scheme (NDIS) funding but would be ineligible if they don't have NDIS funding and can't privately pay for themselves.

Assistance with complex care navigation for people with chronic conditions was identified as a priority, given the challenges that people experience relating to moving between primary care and acute care; accessing specialists and visiting services; using both in-person care and telehealth; and accessing care in a range of different geographic locations including, regional and metropolitan centres including Swan Hill, Echuca, Bendigo, Mildura, Horsham, Bendigo, Ballarat and Melbourne.

Navigation is made more challenging by frequent changes to visiting services and service providers, and strain and pressure caused by workforce shortages that can lead to cancelled service visits, longer waiting lists or travel distances, reductions or limits to service provision availability or eligibility. It is very hard for communities and GPs and other healthcare providers to know what services are available under what conditions, especially in the context of workforce shortages and service disruptions. An allied health professional said, *"I think a barrier is too, the families just don't have capacity to source their own healthcare. Like advocate for themselves, or even understand the system".* These issues also make it difficult for health professionals to communicate and collaborate with each other, one consumer observed, *"the services don't talk to each other up here. That's why they're not doing too well. I think all these services need to talk to each other to be able to help the towns. It's like an octopus and you need to all the arms to stretch out to each service and talk to each other."* - Consumer

WORKFORCE SHORTAGES

Workforce shortages were identified as a major sustainability barrier and ongoing risk, summed up by a CEO, *"we've got an overstretched workforce".* Workforce shortages create difficulties with accessing GPs, allied health and specialists. Workforce shortages are multi-faceted and complex issues with multiple intersecting implications and outcomes, *"it's a snowballing effect. Not having adequate staffing numbers means that the staff that you have are put under strain and then they leave and that puts more strain."* - GP

Providers expressed concerns for aging GPs and difficulties or improbabilities of replacing them, especially in privately owned clinics in small rural towns. In some clinics and towns, this risk has already been realised, and they no longer have a regular full-time GP employed and are reliant on expensive locum models or have to limit service provision.

Senior managerial/leadership staff are also called in to cover clinical shifts and provide direct service provision. Senior staff are covering multiple jobs at once, holding the system together through stoicism and good will. The lack of experienced and senior staff also creates issues for training up junior staff and providing supervision and support for career development on site.

Overall, shortages are placing additional pressure on existing health workforce, impacting the ability of providers to have the right skill mix during shifts to provide optimal care and maintain safety, and people are having to do longer shifts to maintain standards of care.

Workforce shortages extend beyond health and medical professionals to administrators, cleaning, maintenance and childcare, which impact on maintaining health system sustainability and require a whole-of-system approach. For example, difficulties accessing builders and tradespeople for home modifications recommended by occupational therapists cause delays in implementing care plans.

"Workforce of all service types. Doesn't matter if you are a cleaner or you work in a hotel or maintenance or you're a doctor. Workforce is our biggest challenge." - CEO

There is an identified need for local workforce development and strengthening, for place-based workforce development pathways i.e. "grow your own", in addition to workforce recruitment strategies through domestic and international pathways. Historically there are reports of major difficulties in recruiting workforce from overseas due to systemic complexities of immigration and inadequate supports from workforce agencies and government departments.

Workforce training pipelines are not providing sufficient workforce for sustainability, with one leader/manager saying, *"recruitment for the training pipelines that leak like a sieve."* New workforce coming through have different expectations for workload and work shifts.

"They've gone to jobs with better hours. So Monday to Friday, with weekends off. They don't want to work 12 hour shifts. You know, a lot of our staff are doing 12 hour double shifts now. And people have young children and they don't want to do that anymore." - Nurse

Attractive employment packages with appropriate reimbursement are part of the solution.
"I shouldn't have to compromise on paying nurses less. You want those skilled nurses and you want them to be renumerated properly, the same with your reception staff and your practice manager." - GP

Key elements of ideal employment packages were identified by health and medical professionals to include reimbursement commensurate with work demands, flexible work arrangements, support for settlement, secure childcare and housing arrangements. This was further reinforced by healthcare consumers who said, *"if you're going to try and get GPs in your area and they've got children, you've got to be able to provide childcare for them."*, *"Now there's no accommodation in (our town)."*, *"They don't come up here because there's no accommodation."*, *"Midwife wants to come back to (our town) but can't get a house."*

Some providers are using open and rolling recruitment models and are still not successful. Competition between providers and with regional centres for workforce creates further problems. Inability to recruit workforce impacts on a range of health and social outcomes for communities.

"In Donald, there's some kids at the early childhood centre who really need kinder inclusion support workers and they have funding for them but they can't find anyone to do it." - Allied health professional.

Difficulties recruiting suitable workforce has various flow on effects within health services. Providers are unable to recruit senior and experienced staff and are more likely to recruit new graduates with less experience. This results in lack of career development and progression pathways for allied health professionals. Workforce shortages also impact on a service's capacity to offer work experience and student placements, which in turn creates difficulties in recruiting new workforce. It is very difficult to backfill clinical staff to take on other work or projects that might be required by government e.g. for surge response.

SUSTAINABILITY BARRIERS, ENABLERS AND RESOURCES

The barriers, enablers and resources for sustaining healthcare in the BLG region were identified and described by professionals, and mapped to the health system building blocks for targeting including in the proposed models.

	Barriers	Enablers	Key resources
Leadership and governance	• Competition, not collaboration • Exclusion from key partnerships	• Local leadership • Regional workforce strategy • Translational research	• Existing partnership and governance structure for BLG health and wellbeing services • Existing professional networks and committees • Highly skilled and knowledgeable, committed local leaders already engaged in local and regional partnership and service development activities • Relationships with universities for training pathways and translational research
Service planning and funding	• Market failure and inadequate funding models, and unreasonable administrative burdens and targets	• Collaborative planning • Block funding • Public/private partnerships	• Buildings and infrastructure in communities across the BLG for health service provision and co-located community service hubs • Innovative place-based service models developed in the BLG and surrounding regions that can be further strengthen and scaled up • Relevant funding opportunities that can be targeted to bring more services to the BLG • Existing funding sources for primary healthcare programs including through Murray PHN • Funding and other supports for general practice staff through Murray PHN and professional associations

	Barriers	Enablers	Key resources
Workforce	• Pressure and strain on rural GPs • Workforce shortages	• Access to schools and childcare • Support for families and partners • Community inclusion and belonging • Affordable housing • Attractive employment package • Accessible and high-quality postgraduate education • Professional networks • 'Grow your own' workforce development and training pathways	• Existing and new policy initiatives that provide incentives and other workforce supports including recruitment packages, locum leave cover, funding for professional development, and other rural practice incentives • New policy and funding levers becoming available through commonwealth and state government healthcare reforms and workforce strategies • Resources to support professional networking through Murray PHN
Data sharing and health information technologies	• Difficulties using telehealth • Over-reliance on telehealth	• Business management and accreditation supports for GPs • Shared/regional healthcare policies and standards • Telehealth infrastructure • Shared/regional data and information sharing systems	• New telehealth infrastructure available at many health services funded through COVID response
Service delivery	• Travel costs and long travel distances	• Co-located services • Innovative models • Advanced/full scope roles – Rural generalist GP, nurse practitioner, RIPRN nurse, allied health generalist, allied health assistants, key worker model • Patient transport	• Existing co-located service models supported by service agreements and partnerships • Existing innovative, place-based models that can be further scaled up and strengthened

Proposed sustainable rural health models

The following strategies and models for sustainable rural health were proposed by healthcare professionals, consumers and carers and will inform the design of the pilot models to be trialled in the region.

HEALTHCARE PROFESSIONAL IDEAS FOR BUILDING SUSTAINABLE RURAL HEALTHCARE

Allied health assistants	Grow the allied health assistant workforce by embedding training pathways and service provision models.
Care coordinator	Employ local care coordinators who can assist providers with locating appropriate services for referral and help community members to navigate the complex regional health and community service system.
Regional casual nursing workforce pool	Create a casual nursing workforce pool that is used in addition to agency nursing staff, which ensures appropriate staffing for safety and quality, reduces administrative burdens of finding and orienting new staff, and creates new recruitment opportunities.
GP rotational relief	Employ a GP on salary for rotational relief, which reduces costs of employing GP locums, which are increasingly expensive and hard to find.
Build capacity of local community leaders	Up-skill local leaders to provide assistance and support roles that address health service gaps, e.g. developmental screening by pre-school teachers via micro-credentialing.
Attractive GP employment package	Employ GPs on salary to increase recruitment and retention given the significant difficulties of maintaining viable private GP practices in the region. An attractive package is needed with renumeration to represent the significant value GPs provide to communities, which includes family supports.
Local and regional health integration	Strengthen local and regional healthcare integration, for example by establishing community hubs with GPs, nurses and allied health, and a regional healthcare network using existing and developing models
Blended funded roles	Implement and evaluate blended funded roles that create substantive, full-time positions supported by multiple funding sources with a single employer and contract, developed through relational commissioning.
Patient transport and/or mobile clinics	Explore options for funded patient transport and mobile clinics where this can increase access to primary care services for people with limited community mobility or no access to transport.
Sustainable Urgent Care Centres (UCCs)	UCCs in the region are supported by My Emergency Doctor and private GPs but the model is not sustainable. Need to better use and further develop advanced scope roles for UCC staffing e.g. RIPRN, nurse practitioners and community paramedicine.
Nurse practitioner and advanced scope nursing roles	Better use existing nurse practitioner workforce in the region that is not working to full scope by creating a viable employment model in both primary care and urgent care, with embedded training pathways.
Rural Generalist (RG) training and employment pathways	Explore options for RG training and employment pathways which could include leadership and management, and teaching and research roles.
Attractive allied health career pathways	Create advanced and full scope allied health roles and employment pathways e.g. allied health rural generalist pathways, which have value for primary care and public/ private partnerships, and that can be developed and implemented in partnership with regional centres.
Regional business support and mentoring for private general practice clinics	Enhance place-based supports for private general practice clinics that increase business management and accreditation supports through regional networking and skill sharing.

HEALTHCARE CONSUMERS AND CARERS IDEAS FOR BUILDING SUSTAINABLE RURAL HEALTHCARE

Accessible transport for people to attend healthcare appointments	Transport that is accessible for people with disability and older people who can no longer drive themselves, can't drive temporarily due to illness, or do not feel safe driving long distances.
Bulk billed services for people who can't afford to pay	Maintaining bulk billed doctor services is important for community access.
Accessible childcare	Childcare is essential for workforce recruitment and retention including GPs. There also needs to be childcare options available for shift workers.
Effective communication between service providers	Enhance communication between services and service providers for shared care and referrals.
Support to navigate health services	Support people with multiple conditions to access healthcare from multiple providers and geographic locations. More help for people to learn how to navigate healthcare services locally and regionally, and to understand what services and resources are available to them.
Clear and up-to-date information on local health services	Provide information to communities that details the locally available services, in ways that are easy to understand and that are kept up-to-date.
Accommodation for attracting new healthcare professionals to town	Communities need accommodation options to attract healthcare professionals to live and work in the region including short- and long-term rentals and houses for sale. Older people in the region are interested in down-sizing and selling their houses but there are not enough suitable options for sale.
Reliable internet access across the region	Poor mobile internet coverage impacts on peoples ability to confidently and effectively access telehealth, which is essential for accessing specialists and preventing unnecessary travel.
Supports for older people to remain living at home and in their own communities	There is a gap in service provision for older people who are living independently at home, and who require supports to prevent deterioration and premature entry to residential aged care facilities, which could be located in another town away from family, friends and professional supports. Health and social supports are needed for older people to remain living at home and in their own communities for as long as possible, and to support people during this transition period, including support for people to navigate My Aged Care.
Mental health promotion for young people	Young people often need to travel to regional centres for mental healthcare which creates a barrier to care. Mental health promotion programs focused on prevention and education could help to improve local supports for young people at risk of mental ill-health.
Support for GPs to stay in communities over the long term	Continuity of care from a regular and known GP is important for maintaining health and wellbeing. More needs to be done to support GPs to stay working in communities over the long term.

Recommendations

KEY PRINCIPLES

The following set of key principles have been refined through the co-design process. The principles provide a framework for making decisions about the design and development of the pilot models. The principles target sustainability in each of the multiple building blocks of the health system. The framework is grounded in a strong foundation of place-based and evidence-informed knowledge, and aims to target the quintuple aims of healthcare to maximise effectiveness, efficiency, equity and professional and consumer experience.

QUINTUPLE AIMS

1 Consumer experience 2 Provider experience
3 Service cost/value 4 Health outcomes 5 Equity and access

LEADERSHIP AND GOVERNANCE

Cross-sector executive leadership with shared vision and commitment

SERVICE PLANNING AND FUNDING

Co-planned and networked services for a defined region.

Dynamic funding models and relational commissioning

WORKFORCE

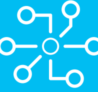
Strengths-based regional workforce strategy with capacity building and training pathways embedded in all healthcare models.

Cross-sector partnerships for workforce supports, prioritising childcare and housing

SERVICE DELIVERY

Innovative rural healthcare models with advanced scope practice roles and team-based care.

Telehealth and outreach clinics providing healthcare close to home



DATA SHARING

Real-time data sharing for healthcare delivery and planning

HEALTH INFORMATION TECHNOLOGIES

Optimal use of health technologies for shared care and consumer access

PLACE-BASED

Co-design with healthcare professionals and consumers

EVIDENCE-INFORMED

Informed by current research, policy and frameworks

PROPOSED MODELS

Overall, the co-design findings have been used to create three have been used to create three intersecting streams of work with a series of proposed models and strategies. The models apply the design principles using a systems perspective, and are interrelated and overlapping to target all health system building blocks for sustainability.

The proposed models are described below, with descriptions of existing work underway, which can be incorporated into implementation plans and suggestions for additional initiatives and exemplar models to explore.

1 WORKFORCE ADVOCACY, RECRUITMENT AND STRENGTHENING

- Strengths-based regional workforce strategy
- BLG Practice Managers Cluster
- Loddon Mallee Nurse Practitioner Network
- GP supervision capacity building

2 INTEGRATED PRIMARY CARE SERVICES

- Integrated rural primary care hubs
- Telehealth optimised primary care clinics
- Digitally integrated health networks

3 INNOVATIVE EMPLOYMENT MODELS AND MODELS OF CARE

- Nurse Practitioner Rural Outreach Model
- BLG Integrated Care Network

INTEGRATED HEALTH NETWORK

Leadership and governance
Service planning and funding
Workforce
Service delivery
Data sharing and health ICT

STREAM 1. WORKFORCE ADVOCACY, RECRUITMENT AND STRENGTHENING

A shared, regional Buloke, Loddon and Gannawarra workforce strategy is needed that includes a clear and comprehensive plan for advocacy, recruitment and workforce strengthening. This work can be led by the Buloke Loddon Gannawarra Health & Wellbeing Executive Network (BLG Executive Network), which is an executive level partnership with representation from health and community services across the region which is well placed for this collaboration, strategy development and implementation. A shared, regional workforce strategy would create opportunities for pooling resources across services for workforce advocacy, recruitment, retention and professional development. This partnership approach would also nurture the reciprocity and respect that exists between stakeholders in the region.

The development of a regional workforce strategy would recognise and respond to the accumulating pressure and strain on the health workforce caused by enduring workforce shortages. There is also a need to protect, value, strengthen and retain the highly skilled workforce that is currently employed, including providing them with professional development and career pathways.

It is recommended that a five year plan is developed for the BLG, that is focused on three key pillars – advocate, recruit, and strengthen. The plan needs to incorporate priority objectives and targets that build the regions' strengths, opportunities and resilience, rather than a needs-based, deficit lens that reinforces narratives of disadvantage. A marketing and communication plan needs to be incorporated to ensure the strategy is widely promoted to community and governments, and to increase engagement and ownership.

Advocate	An advocacy strategy is needed that focuses on the resources needed for health workforce recruitment and retention, which are primarily housing and childcare. Advocacy should use cross sector partnerships in the BLG to target multiple avenues for lobbying and influence. With key messages reinforcing the need for more equitable distribution of workforce resources for the BLG region, and there are opportunities to advocate for this in upcoming state and commonwealth government policy reforms.
Recruit	Recruitment should focus on 'grow your own' strategies of local training pathways and student placements, as well as a marketing campaign for domestic and international workforce recruitment. The key messages should relate to the BLG 'region of choice' qualities and showcase the innovative and diverse rural practice opportunities in the region and attractive employment packages and models, for example RIPRN nurse positions (Rural and Isolated Practice Registered Nurses) and other positions to be developed through Stream 2. Integrated primary care services and Stream 3. Innovative employment models and models of care.
Strengthen	Workforce retention and strengthening should include professional training and development, networking and peer support strategies. There is an opportunity to map out attractive career pathways that include advanced training opportunities across the continuum of care, which could be developed and implemented in partnership (and not in competition) with regional centres. This strategy needs to incorporate supports tailored for early, mid and later career stage supports for end-to-end careers in the BLG. Professional development and education needs to be made more accessible for rural practitioners by providing financial reimbursement for accommodation, childcare and travel, and backfill supports to help organisations to relieve staff, to optimise uptake and participation. Setting up professional networks will enhance peer support and provide a foundation for shared care. Support to apply for existing funding and grants for workforce strengthening is needed.

CURRENT MODELS ALIGNED TO THIS STREAM:

- **North Central LLEN and Regional Development Australia work towards early childhood education and childcare advocacy:** "Creating Viable Childcare Services in Rural Areas" (September 2022): bit.ly/3lols5B
- **Supervision roadmap for rural generalist training in Victoria:** Applying the Supervision roadmap for rural generalist training in Victoria would enhance GP supervision capacity in the region which would have a number of workforce benefits including increased capacity to recruit GP registrars and nurse practitioner candidates, a stronger pipeline for rural medical students and GP trainees. See: gpsupervisorsaustralia.org.au/product/supervision-roadmap-rural-generalist-training-in-victoria/
- **Swan Hill District Health model of general practitioner supervision and strengthening the regional workforce pipeline:** has developed a model and guidelines to encourage an environment for facilitating alternate and high quality forms of supervision of medical doctors and building local supervision capacity to retain doctors in the region. See: youtu.be/lV2jNYaaF5c
- **BLG practice managers cluster:** a Murray PHN initiative to support general practice managers in the BLG region to connect and network through quarterly meetings. This initiative has potential to provide mechanisms for connecting practice managers with accreditation and business supports needed for improving practice sustainability.
- **Loddon Mallee Nurse Practitioner Network:** re-activation of this practice network by Murray PHN will provide peer support for rural and regional nurse practitioners and help to promote nurse practitioner training pathways to potential candidates.
- **Wimmera Development Association:** is leading innovative solutions to the housing crisis including short term options for newcomers and students or trainees https://www.wda.org.au/infrastructure/infrastructure/housing

RECOMMENDED ADDITIONAL MODELS TO EXPLORE:

- ***Exemplar model: Attract, Connect and Stay:*** *a community development based initiative developed in rural Australia, that supports communities to lead the development of workforce recruitment plans with a focus on community inclusion and belonging. Communities in the BLG regions could adopt this initiative for a whole-of-community plan for workforce recruitment. Funding is required to employ a settlement worker, however education materials and expert advice is provided free-of-charge. Establishment funding could be sought for a trial, however commitment from a sustainable funding source is recommended. See attractconnectstay.com.au/*
- ***Exemplar model: Grampians Health workforce housing project:*** *"Planning with Councils for housing" (January 2023): grampianshealth.org.au/2023/01/horsham-healthcare-staff-accommodation-project/*
- **Allied health rural generalist pathway:** AHRG training positions bit.ly/3yHlCIm and AHRG accreditation council: bit.ly/3yLAWUk
- **Student housing:** work with service providers and training schools in the region to apply for funding to build/lease student housing locally that could be shared by BLG services and clinical placement providers. Regional Health Infrastructure Fund – has previously awarded funding for accommodation at Boort, Inglewood and Sea Lake: vhba.vic.gov.au/health/regional-facilities/regional-health-infrastructure-fund
- **Advanced nurse training scholarships:** previously funded through Murray PHN, would be valuable for providing nursing advanced practice development pathways and maintaining urgent care service access across the region.
- **Nurse practitioner and medical training scholarships commonwealth government initiative:** medical graduates and nurse practitioner graduates will be incentivised to work in non-metropolitan areas by discounting the amount of Higher Education Loan Program (HELP) debt to be repaid from 1 January 2022 health.gov.au/our-work/help-for-rural-doctors-and-nurse-practitioners

STREAM 2. INTEGRATED PRIMARY CARE SERVICES

There is scope and opportunity to further integrate rural health services across the BLG, by bringing together existing health services within communities into varying levels of service delivery and partnership arrangements.

The integration of health services will depend on an effective workforce strategy (Stream 1) and attractive employment models and models of care (Stream 3) for sustainable staffing.

Integrating local services will provide opportunities for building local rural health teams for shared care and peer support.

Local services are likely to include a mix of public, not-for-profit, private service providers and local, travelling and telehealth providers. There could be varying levels of integration from co-location, to consortia or amalgamation.

Integration may create opportunities for pooling funding at the local level to improve value for money, for example combining funds from different sources to create more attractive employment positions, e.g. full time positions or conjoint positions with dual funding streams. For example, an allied health assistant might be employed for a community who provides services funded by the hospital and by a private provider.

This proposed work stream aims to make optimal use of existing funding streams to maximise service provision for communities. A single established site would also be a drawcard for attracting new funding. Integrated primary care services in small rural communities could adopt key worker, transdisciplinary and/or rural generalist employment models where clinical staff can train and obtain advanced skills that are needed in the community, which might usually sit outside their scope of practice.

At the regional level, integrated local services can be linked up to create a hub and spoke network across the region, enabling health professionals greater employment and work diversity opportunities, where healthcare professionals can work across hubs and take up opportunities for job sharing, supervision, mentoring, and hands-on up-skilling. These regional health networks would also increase supervision capacity across the network to strengthen workforce development and supports, and training pipelines locally and regionally.

Integration would further foster spirit of collaboration in the BLG, ensuring inclusive approaches with cross sector and private/public partnerships, and for workforce recruitment development and funding.

A locally integrated health service "hub" would remove silos or boundaries between services in communities, with opportunity to improve after hours access through collaborative initiatives. Integration with virtual services would also improve access to after hours care and help to mitigate service demand, using the new Victorian Virtual Emergency Department.

Integrated services would improve access to allied health professionals on site or via a regional health network with easier liaison and referral. They will also provide the vehicle for developing and approving shared, regional healthcare policies and standards, so clinicians are not dealing with different policies and standards within or between local and regional services. Digitally integrated health systems will be explored to find the best shared/regional data and information sharing systems for the hubs. Telehealth infrastructure will be used for shared care, connecting consumers to care, and for networking and professional development.

Local integrated primary care services provide continuity of care for communities, even if workforce changes over time, as a single point of access and entry for the healthcare system. With optimal use of local workforce capacity and better use existing resources for contingency planning workforce shortages and the need for surge response.

Consolidated and integrated human resources and administration supports across sites can reduce costs and ensure workforce gaps are filled

The hubs would provide attractive sites for placements and research.

CURRENT MODELS ALIGNED TO THIS STREAM:

- **Victorian Virtual Emergency Department:** public health service to treat non-life-threatening emergencies accessible by professionals, urgent care centres, residential aged care facilities, and direct by the public: vved.org.au/
- **Royal Flying Doctor Services specialist access via telehealth:** access to specialists via telehealth funded through the RFDS at locations in the BLG including Cohuna, Kerang, Boort, Birchip, Wycheproof, Charlton, Donald, Wedderburn and Inglewood. This service includes addiction specialists and psychiatrists (child and adolescent and adult); noting it is not a crisis service. See: locations map here

RECOMMEDED MODELS ALIGNED TO THIS STREAM:

- **RACCHO or PRIM-HS model:** rural area community controlled health organisations (RACCHOs) proposed by the National Rural Health Alliance in a pre-budget submission (2022), is modelled off of Aboriginal Community Controlled Health Organisations and aligns with the principles for sustainable rural health. A RACCHO is proposed as a not-for-profit organisation funded by government in areas for critical workforce shortage and market failure, for delivery of place-based multidisciplinary primary and secondary care by rural health teams networked locally and regionally, underpinned by block funding from the Commonwealth Government and operated with salary-based employment models. A number of schemes are serviced, i.e NDIS and Department of Veteran's Affairs, with acknowledgement that rural based care costs more to deliver and activity-based funding is not conducive for sustainability. The Labor Government committed to trialling the model in Murrumbidgee region as a pre-election promise. See: ruralhealth.org.au/primary-care-rural-integrated-multidisciplinary-health-services
- **BLG Integrated Care Network:** networking services for shared care and secondary consultation and skill sharing/education, to improve coordination with regional centres. Networking professionals across the region (horizontal integration) and with professionals in regional centres (vertical integration) for shared care, with secondary benefits of skill sharing and professional development. The Network could create opportunities for multidisciplinary relationship building including private practitioners and professionals cross sector i.e. aged care, disability and education.

  Exemplar model: ECHO model (Extension for Community Healthcare Outcomes): *rolled out in the USA using a hub and spoke model of networking rural and regional sites for tele-medicine and tele-education (1). The model could have a focus on mental health (with Bendigo, Swan Hill, and Mildura), and/or a have a focus on older people with complex conditions to remain living at home (cancer, palliative care and life limiting conditions) to align with community priorities and existing levers.*

STREAM 3. INNOVATIVE EMPLOYMENT MODELS AND MODELS OF CARE

Attractive employment models are needed to recruit and retain staff, and these need to be competitive in comparison to positions available in nearby regional centres. Innovative healthcare models will act as a draw card by creating roles and places where people want to work.

Health workforce in the BLG value interesting and diverse roles and supportive workplaces, and this must be embedded in employment positions and models of care. Rural generalist models, for example, could meet this expectation while also providing the range of services that are needed by small rural communities across the region. Workforce will be more satisfied and engaged when they can work to their full potential. Feasible and sustainable models are needed that can be maintained over the long term and provide continuity for communities. There needs to a focus on creating salary models, which are the preference of the next generation of GPs.

Employment models and models of care need to also include attractive non-clinical roles that provide essential support for professionals and consumers. This includes traditional human resources positions, but also emerging and non-traditional roles like care navigators and/or social prescribers, that can help people navigate the health system and access resources needed to attend appointments including transport, childcare, and to connect with social activities or groups.

Advocating for funding models that incorporate additional costs required for delivering programs in rural contexts and have sufficient flexibility needed to develop place-based models. Where outreach and mobile clinic models are used to reduce barriers to care relating to transport and fuel costs, there needs to be a focus on clinician safety and wellbeing.

CURRENT MODELS ALIGNED TO THIS STREAM:

- **Nurse practitioner rural outreach model:** nurse practitioners in rural primary care are generally underemployed and under used and this was an existing issue for the BLG region. There are also registered and other advanced scope nurses in the region who are interested in advanced training but have limited employment pathways. Support is needed for GPs, to ensure communities maintain timely access to primary care, which in turn reduces demand on urgent care.

  In this trial model of care, a nurse practitioner provides primary care clinics in rural communities with the support of a care coordinator to increase health care accessibility. Care coordinators assist providers with locating appropriate services for referral and help community members navigate the complex regional health and community service sector need to be employed and embedded.

  Assistance to find and book transport, support for other issues including social connection, health promotion, access to transport, clear and up-to-date information on health services. This model also acts as a pipeline for local workforce development. The care coordinator positions will provide a training and development pathway for allied health assistants and other vocationally trained support and care staff.

RECOMMEDED ADDITIONAL MODELS TO EXPLORE:

- **Health assistant model:** building health assistant workforce provides local 'grow your own 'career paths for community members providing opportunities for training and career development without having to leave town. Provides workforce for health services and cross sector, including private NDIS and aged care providers. Also creates the beginning of career paths into health and medical workforce roles.

  Exemplar model: Reach Out Rural Learning Hub at Alpine Health: Alpine Health RTO delivers Certificate III in Individual Support (RORHL) Ageing, Home & Community to key rural health partners including Mallee Track Health and Community Service to grow the health and aged care assistance workforce including nursing assistants: alpineinstitute.vic.edu.au/rural-learning-hubs

- **Regional/local casual GP and nursing workforce pool:** creating a casual nursing workforce pool that is used in addition to agency nursing staff, which ensures appropriate staffing for safety and quality, reduces administrative burdens of finding and orienting new staff, and creates new recruitment opportunities. Employ a GP on salary for rotational relief that reduces costs of employing a locum, which is increasingly expensive and inaccessible, and could be a GP registrar and use the Murrumbidgee Single Employer Model.

  Exemplar model: Murrumbidgee Single Employer model: trainee rural GPs are employed by single employer in the Murrumbidgee region and complete all of their GP registrar rural generalist training without changing employers for rotations between rural hospitals and primary care for up to four years. Special 19(2) exemption to allow GP services to attract MBS rebates: mlhd.health.nsw.gov.au/careers/medical-services-careers/murrumbidgee-rural-generalist-training-pathway-(mr

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