

Primary Health Care Advisory Council

Discussion Paper

**‘Service Models to meet the aims of the Primary Health Care Strategy
and deliver better, sooner, more convenient Primary Health Care’**

May 2009

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Section A: Summary document and feedback form

Purpose

This discussion paper sets out an approach for the delivery of patient/whānau centred primary health care in Aotearoa New Zealand through enhanced multi-disciplinary primary health care teams. It identifies a range of issues that will need to be addressed to progress this approach.

The Primary Health Care Advisory Council seeks your views on what's proposed and encourages you to share this paper with your colleagues. The feedback provided will help inform a final paper to the Ministry of Health (MoH) and District Health Boards (DHBs) on potential service models for primary health care.

About the Primary Health Care Advisory Council

The Primary Health Care Advisory Council (the Council) has been established to advise the Ministry of Health and DHBs on the further implementation of the Primary Health Care Strategy (PHCS). The Council asked a Working Group of its members (the Group) to provide advice on potential service models that could enhance the ability of the health care system to fulfill the aims of the PHCS and thus deliver better, sooner and more convenient primary health care (PHC) services. The Group consisted of representation from the Allied Health Professional Association's Forum, College of Nurses Aotearoa, New Zealand Nurses Organisation, NGO Working Group and the Royal New Zealand College of General Practitioners¹. This paper is the outcome of the work of that group.

Where to for Primary Health Care in Aotearoa New Zealand

There are many strengths within the current models of primary health care practice in Aotearoa New Zealand. Those strengths need to be acknowledged and built on. However, making more progress will require further changes in provider 'ways of working', accompanied by systems and policy support. Services must be integrated across PHC and between PHC and other parts of the health system including intermediary and secondary care, if they are to deliver on the rhetoric of the person/ whānau centred journey and deliver cost effective health care to fulfil the aims of the PHCS². Changes will need to continually balance the potential for improving health outcomes and the experiences of people/whānau using the services with the reality of funding and workforce constraints.

Key elements of a service model to enhance PHC

The Group's vision of the key elements of a service model for primary health care in 2012 is based **on a visible, expanded Primary Health Care Team (PHCT), utilising patient need stratification to align care with individual/family/whānau/community need**. This will mean

- Almost everyone will be able to identify their 'Health Care Home' which will provide access to a cohesive and 'visible' multidisciplinary PHCT. Every PHCT will be able to identify their population of influence (usually determined geographically or ethnically) – including those who are not enrolled. A 'visible' team means that all members of the team involved in providing services to a particular person/whānau will be identified by name, and the roles of various team members and the way the team works together will be clearly explained to service users.

¹ Further information about the processes of the group and overarching comments as context for this paper are outlined in Section B (Page 12).

² The primary health care context in Aotearoa New Zealand and the system drivers for these changes are outlined in Section C (Page 13).

- PHCTs will be multidisciplinary teams. Their exact constitution will depend on population and locality need but will include practitioners and staff to meet a broad range of health and social needs. They will be an expansion of most current approaches, which position a number of PHC providers outside the PHCT. Connections with allied health providers and health and disability Non-Government Organisations (NGOs) will be facilitated and there will be more effective utilisation of the skills of all team members.
- PHCTs may be co-located, for example in Integrated Family Health Centres³, or virtual. Whatever the physical setting and structure, relationship development and clinical networking will be visible and measurable, and all team members will understand and be able to articulate 'the glue' that holds the team together.
- Working as a team will take effort both initially and in an ongoing way. All PHCTs will have undertaken training in teamwork, and have resourced time and structural support to work effectively as a team. Undergraduate and postgraduate professional training for all those involved in PHCTs will incorporate knowledge and skills for team work.
- PHCTs will work in interdisciplinary environments. These will include systematic referral and communication pathways with health and disability NGOs and tangible relationships with other government organisations and NGOs in the community whose work impacts on the health of individuals and communities.
- Supported self-care will be a key goal of all interactions of the PHCT with those they serve. This will be supported by electronic and community based generic and condition-specific resources. To support independence from the system rather than dependence on it, engagement will encourage the person/whānau to remain well by being proactive about preventing health problems and provide support so that the person/whānau/community can independently manage their health⁴.

This service model will be responsive to person/whānau/community need. To do this the model proposes three levels of stratification that seek to integrate service delivery needs for promoting health, self-management, prevention, screening and management of long term conditions. The model incorporates the need for acute care and undifferentiated diagnosis at all levels across the health continuum; from those people who are well, through to those in palliative care. The boundaries between levels are often more blurred for people with multiple needs but accidents, injury and sudden onset conditions occur at all levels.

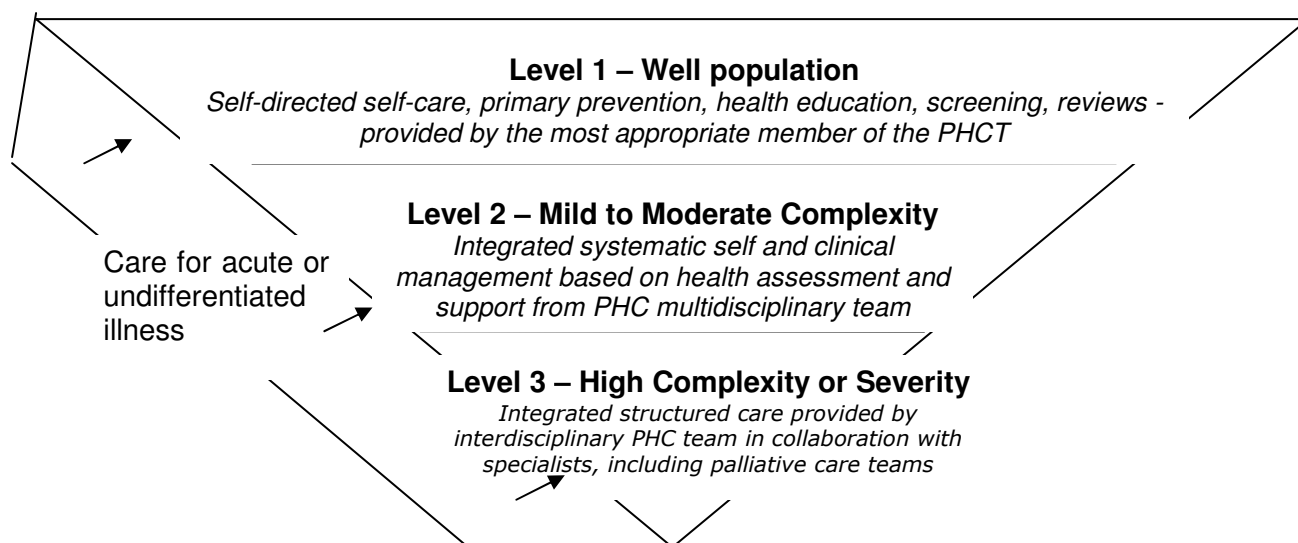
Providing stratified levels of care would enable better deployment of the PHC workforce aligned to individual/family/whānau/community need. It represents an important shift in the delivery of services so that more people receive an appropriate level of care from an appropriate health professional. This is a shift from much of current practice, which tends to treat all people who present to a general practice in a similar way, giving them an appointment for a presenting issue. Continuing in that model of practice will underserve people with higher levels of need and does not represent the most effective use of the practitioners available⁵. Figure 1 illustrates the three levels of care needed and how care for acute or undifferentiated illness is necessary at all levels.

³ Further comment about use of the word family in relation to names of health services is made on (Page 12)

⁴ Further information about the concept of the expanded PHCT is outlined in Section D (Page 17)

⁵ Further information about the stratified model of care and suggested workforce utilisation is outlined in Section E (Page 18)

Figure 1: Stratified levels of care for the PHCT



Effective information systems which support transfer of information between PHC providers and the wider health system will be vital to effective horizontal and vertical integration of services. Continued development of these systems will need to include further work to address privacy concerns relating to shared patient records.

Relationships with services on other levels of the care continuum

It is envisaged that more effective use of the PHC workforce will see services that are currently provided in secondary care settings being provided in the PHC environment. By 2020 it is anticipated that the majority of health problems will be dealt with in PHC settings with the need for only short term referrals into hospital based services for serious clinical problems, specialist interventions, care and procedures.

This model acknowledges that health services do not fall simply into the categories of primary and secondary care. Rather there is a continuum of care made up of 'a comprehensive arrangement of health services spanning all levels of intensity'⁶. Services such as District Nursing that can act as a rapidly responsive intermediary at the interface between acute/specialist services and primary health care, and nursing services for residents of older care facilities who are major recipients of primary health care services, are good examples of areas for greater integration with PHCTs.

Section I (Page 23) contains further comments about the relationships of PHCTs with services currently provided in secondary care settings.

Clinical governance and the PHCT

Effective clinical governance in PHC needs to involve clinical leadership that spans the full range of PHC practitioners involved in clinical care and the services provided. Those involved in various elements of governance, including clinical, managerial and community, need to jointly plan how services will be delivered by the PHCT and how success will be measured. This process will require a service user perspective. Measures need to be developed across the broad range of quality domains⁷, including access, equity, safety, effectiveness, and efficiency.

⁶ NZNO District Nursing Section (2009) A Framework for a quality DNS in NZ: a tool for service planning- summary document.

⁷ Ministry of Health (2003) Improving Quality (IQ): A systems approach for the New Zealand Health and Disability Sector. Wellington.

In considering further changes in health care systems, MoH, DHBs and Primary Health Organisations (PHOs) will need to carefully consider how new initiatives enhance the functioning of the PHCT and avoid creating new silos of PHC providers.

So what's holding us back?

'The future is already here; it's just not evenly distributed'⁸

There are 'beacons' of existing good practice in relation to multidisciplinary PHCTs within New Zealand and the Council would support processes to identify and learn from these. However it has also identified a number of current barriers to more widespread implementation of the enhanced service model for the PHCT proposed in this paper. In particular these barriers include:

- current funding arrangements and organisational structures, in particular;
 - complex and fragmented funding environment within PHC, between levels on the continuum of care, particularly between primary and secondary care, and between ACC and other PHC services. This environment provides limited flexibility for the PHC workforce to adopt new approaches to service delivery⁹
 - business/ownership model of service delivery with associated employer/employee issues
 - 80 ways of doing things through 80 PHOs and 21 DHBs
 - lack of critical mass and undeveloped infrastructure leading to fragmentation between DHBs, PHOs, allied health providers and health and disability NGOs.
- issues related to custom and practice of PHC providers, particularly current understandings and values related to roles and working as a team (this is further expanded on in the 'tensions' section below)
- delays and technological difficulties in instituting the shared electronic patient record and other technological tools
- variable person/whānau engagement in the development of PHC systems and processes.

Tensions

This discussion paper also acknowledges areas of tension in developing this enhanced service model. These include areas where differing views of Working Group members needed to be articulated, and/or where goals of the PHCS may be challenging to reconcile with current scope of practice descriptions for PHC practitioners. The tensions include;

- Point of entry and ongoing access to the PHCT
- Roles of individual team members and issues of accountability
- The nature of 'generalism' and how that is understood across disciplines
- Continuity and relationship with a team rather than an individual
- What will be the 'glue' that binds these PHCTs together
- The PHO / NGO tension
- Breadth of models of health that are the basis for service provision.

The Council invites reflection and comment on these tensions which are touched on below and are further expanded in subsequent sections of this discussion paper.

1. Entry or access to the PHCT and its members

How service users gain access to the PHCT needs to consider the perspectives of the person/whānau / and community, including the notion of choice. The model proposes that at first-point-of-

⁸ William Gibson, science fiction author, cited in Blue Sky Vision Consolidated Report, Kaiser Permanente 2003.

⁹ Ministry of Health (2008) Workforce Taskforce : Working Together for Better Primary Health Care: Overcoming barriers to workforce change and innovation, Wellington.

contact, people will have access to person/whānau centred comprehensive care, provided by the most appropriate provider for their needs. The way access is managed has implications for health and financial risk, equity and sustainability.

Potential paths include:

- entry via a triage generalist for everyone
- triage for first presentation of acute event or undifferentiated illness but self referral to any team member by those with ongoing illness who are self-managing
- self referral but with emphasis by the PHCT on the importance of coordination/navigation for people with more complex conditions (level 2 & 3)
- referral from a variety of health and social service workers in the community to the PHCT member they perceive is most appropriate for the need identified.

The acceptance or otherwise of the concept of a triage generalist for everyone will be key in defining the role for inclusion of allied health practitioners and health and disability NGO providers in the PHCT model. It is also linked to some of the barriers to access for groups not currently utilising PHC services proportional to their need (e.g. Māori, young people), and the notion of a comprehensive assessment as the basis for 'stratified care'. The concept of triage is also associated with the 'gateopener' role in descriptions of health systems, where good quality primary health care is seen to have a role in referring people on to services appropriate for their needs but minimising unnecessary use of specialist services.

An alternative to a triage generalist suggested by some members of the Group is that the PHCT as a collective is seen as the generalist first-point-of-contact. Within this approach, more 'specialist' members of the team would have easy paths of referral back to 'generalists' when they assess a condition as being outside their scope of practice. This 'intra-team' referral would be facilitated by co-location of practitioners and services, or could function through virtual integration. It would need to be supported by appropriate funding approaches which limit affordability barriers for those being referred. For effective teamwork centred around individuals/whānau it will be essential for PHCT members to understand each other's roles, scope of practice, responsibilities and contributions to PHC. As noted earlier, whether PHCTs are co-located or connected virtually, systematic referral and communication pathways will be required.

The Council is interested in your views about the potential paths for entry to the PHCT and the place or otherwise of the triage generalist role. Section F (Page 20) provides further background for this consideration of this issue.

2. Roles of individual team members and issues of accountability.

A more inclusive PHCT model (involving a wider range of health practitioners) raises key questions about the future role of the GP, Nurse Practitioners (NPs), nurses, and allied health professionals. For instance:

- Is the future role of the GP in primary health care going to be one of a 'specialist' to whom nurses, NPs, and allied health professionals will refer a selection of patients who are complex but not difficult enough to be sent to another class of physician?
- Or will the current role of the GP persist, and NPs, nurses, and allied health professionals extend the services available to patients by providing as part of the PHCT services in roles that at present are not widely recognised?
- Should there be a medically trained person in every PHCT, where workforce capacity allows?
- How do role definitions relate to leadership within the PHCT?

These kinds of questions have significant implications for professional training and development as well as for professional identity¹⁰.

There is a tension between wanting clear role definitions so that people can work effectively as a team, and the need for the health workforce of the future to be increasingly flexible and able to shift roles as needs dictate.

There is also a need for better collective understanding of issues around accountability, such as who carries the clinical risk (in the treatment of illness) medicolegally. All health professionals are fully accountable for their own clinical decision-making and care provided. Some members of the Group have expressed concern as to whether any ultimate accountability rests with the medical practitioner when care is collectively provided by a health care team. It would be helpful to understand what other models there are that could be drawn on to inform this discussion and to receive comments and suggestions regarding the development of collective clinical responsibility for team performance. The Council is also interested in your responses to more comprehensive roles for Nurse Practitioners, nurses, allied health professionals and other members of the PHCT in addition to GPs.

Section G (Page 21) provides further background to this issue.

3. The nature of ‘generalism’ and how that is understood across disciplines

General practitioners, nurse practitioners and many primary health care nurses would frequently identify themselves as ‘generalists’ and have a particular understanding of that term. However within other disciplines, some practitioners are also recognised as generalists while their colleagues are considered specialists (e.g. physiotherapy). This is important in relation to the concept of triage by a generalist noted earlier.

In general training and continuing professional education for those who aspire to be generalists has and maintains a broader scope than specialist areas of practice. However it is important to acknowledge that various levels of breadth and depth of training occur across all disciplines and offer benefits in different situations. As noted earlier, PHCT members understanding of each others scope of practice will be important in ensuring people/whānau receive the appropriate care they need. The strength of the multidisciplinary team is that the combined breadth and depth of the team is greater than any single practitioner.

It would be helpful for the Council to understand your perspectives on generalism and the role of the generalist in the multidisciplinary PHCT. Section G provides further background to this issue.

4. ‘Continuity’ and relationship with team rather than person

The importance of a relationship with a ‘primary care’ provider as potentially key to the benefits of a primary care led health system has been noted in the literature as an area that needs further exploration¹¹. Current evidence suggests a relationship with a person rather than a relationship with a place is important. Relationship with an ‘integrated and explicitly identified team’, which may have one or more locations, needs to be further explored. It has been suggested that relationship with the team could be encouraged by the registration of people with PHCTs rather than individual practitioners.

The Council is interested in your views about the role of the team in providing continuity of care. How would a team’s “collective responsibility” for continuity function? What are the advantages and disadvantages of registration with a team rather than an individual provider?

¹⁰ Charles-Jones H, Latimer J, May C (2003) Transforming general practice: the redistribution of medical work in primary care. *Sociology of Health and Illness* 25(1): 71 – 92

¹¹ Starfield B, Shi L, Mackinko J (2005) Contribution of primary care to health systems and health. *Millbank Quarterly* 83 (3): P 488

5. What will be the 'glue' that binds these PHCTs together?

Current primary health care teams are bound together by a range of factors. For instance kaupapa Māori providers are bound together by the desire for Māori health gain and whānau ora. Other providers might be bound together by a shared ethos, or history and financial incentives.

For expanded PHCTs to work effectively, they will need to define together what the glue will be that will hold them together. For example is their glue a shared vision for the way they can serve and improve the health of the people/whānau enrolled with them, contracts and/or financial incentives?

6. The PHO / NGO tension

The number of PHOs and their diverse ways of operating are currently significant barriers to increased engagement with them by NGOs, particularly national NGOs. In addition the difference between NGO funding models, often based on packages and/or components of care, and the PHO model based on enrolled populations is challenging to manage.

There is a need to understand what funding model would best support NGO/PHO collaboration and create improved links between PHCTs and NGO services.

Do NGOs need to have contracts through PHOs, as funding is seen to be a driver of the way people/organisations define relationships? Or is it that the ability to better communicate and collaborate with each other is being impeded by competitive funding models and service arrangements?

7. Tension between the breadth of models of health that are the basis for service provision

Many allied health disciplines and NGOs operate from a very broad model of health, with a strong focus on rehabilitation and/or social determinants of health. While these models are aligned with the vision of the PHC Strategy, they may be at odds with current service drivers in more traditional primary care teams. This is a potential source of tension in the development of expanded PHCTs, particularly in prioritising service development in a resource constrained environment.

For the changes needed both in practitioner behaviour and systems to become embedded and sustained, they will need to be driven by PHC contract key performance indicators (KPIs) that are constructed in conjunction with the sector and the professional bodies making up the PHCT. Indicators are needed that reflect the commitment to team work and whatever models underlie service provision.

Further background to issues about the settings for service delivery of PHCTs, relationships with services currently provided in secondary care settings, clinical governance, and sustainable change are outlined in Sections H –J and L.

Enablers for moving beyond identified barriers and tensions

The solutions and enablers for moving beyond identified barriers and tensions are seen to fall into two distinct categories: *Practitioner Behaviour Changes* and *Systems and Policy Changes*

Key enablers for *Practitioner Behaviour Changes* are seen to be

- Ensuring that each PHCT member understands other members' roles
- Collaborative working across professional organisations
- Provision of funded time for team development
- Provision of professional development for all staff
- Strengthening of clinical leadership and governance, involving all disciplines working in PHCTs.

Key enablers for *Systems and Policy Changes* are seen to be

- Review and revision of the current funding model of PHOs. Funding shapes behaviour and incentives need to be clearly aligned to supporting the development of integrated care and teamwork
- Progress on the movement of services currently provided in secondary care settings to PHC settings where appropriate
- Consolidation of funding and planning functions for the PHC sector, including relationships with ACC funding
- Increased systems support for allied health providers and health and disability NGOs.

Other important enablers that require national level coordination and action are

- Progress on the institution of technological tools and
- Person/whānau engagement.

Next steps – Proposed Actions

The Group has identified a range of proposed actions to advance work on this service model. The proposed plan attaches specific actions to the enablers identified above, and identifies who could be responsible for progressing the work, including associated timeframes. These details can be found in Section K on Page 24. Your feedback is sought on whether these are the most important actions, and if so how they should they be prioritised.

Conclusions

The PHCAC Working Group believes that the model of primary health care set out in this paper will better meet the health needs of individuals and communities, and utilise resources more cost effectively. This model needs:

- Identifiable and visible, skilled multidisciplinary PHCTs with clear role clarity
- System support for teamwork and collaboration
- Multidisciplinary clinical leadership that makes best use of available resources and technological tools to assure safety and quality
- Person/whānau-centred delivery approach that supports self-care and meets cultural needs
- Involvement of service users in planning
- Sustainable funding streams which support more effective models of care utilising the skills of all team members appropriately.

This service model could be delivered in a number of settings but to achieve its implementation, a collection of actions is needed. These include support for changes in the custom and practice of health care providers; review of current funding arrangements and organisational structures across the PHC sector and along the Primary/Intermediary/Secondary continuum; progress on development of the shared electronic patient record and other technological tools; and increased engagement of service users and communities.

Have your say - feedback on this discussion paper

This paper sets out a range of issues and questions about the future of service delivery of primary health care in Aotearoa New Zealand and the Council is keen to hear your views on what's proposed. While comments are welcomed on any aspect of the paper, the Council is particularly interested in your views on the key discussion points / questions noted below.

Discussion points

- To what extent do you support the vision for an enhanced service model for primary health care based on a person/whānau centred approach and multidisciplinary teamwork?
- Do you see the model of stratification as providing a means to better meet health care needs and improve utilisation of the workforce?
- The paper proposes more widespread implementation of multi-disciplinary Primary Health Care Teams (PHCT) and notes there are beacons of existing good practice in place. How might these best practice examples be consistently identified and learned from? How might these 'learnings' be more widely disseminated?
- The paper sets out a number of barriers that are 'holding us back' from achieving widespread PHCT approaches. Are there barriers that are not reflected in this paper? To what extent do you consider the various barriers impact on your ability to progress PHCT approaches?
- The paper touches on a number of tensions that exist within the wider primary health care sector and between various organisations, providers and practitioners. Are there tensions that are not reflected? To what extent do these tensions impact on your ability to adopt PHCT approaches?
- The paper identifies key enablers for moving beyond the identified barriers. To what extent do you consider that these enablers will help address the barriers and tensions noted in the paper? In particular how might funding be reconfigured to ensure that the roles of all members within the multidisciplinary PHCT are supported and that new services developed do not lead to fragmentation of care? What might this mean for business models?
- A set of actions is proposed to advance the service model approach outlined in the paper (Section K). Are these the most important actions? Are there certain actions that need to be prioritised?

Please send your feedback to your Council representative **by Friday 29th of May**. Your feedback will help inform a revised paper for consideration by the Council. A final paper will be sent to the Ministry of Health and DHBs to inform their work on primary health care implementation.

If you have any queries about the Primary Health Care Advisory Council please see

<http://www.moh.govt.nz/moh.nsf/indexmh/phcs-advisory-council>

Section B: Working Group Processes and Overarching Comments

The Council's Terms of Reference acknowledge that exploration of issues by the Council to determine a consensus position will not always reach a single view and that differing views need to be noted. This discussion paper acknowledges several current areas of tension in developing this enhanced service model, areas where differing views of Group members needed to be articulated, and/or where goals of the PHCS may be challenging to reconcile with current scope of practice descriptions for PHC practitioners.

This paper represents the views of Working Group members and it is acknowledged that although the group has attempted to take a person/whānau user view of the PHCT, this paper summarises provider interpretations of that view and has not yet had input from consumers and community members themselves. Gathering their input and more formal consultation with Māori and Pacific colleagues, is an important next step in progressing this discussion.

The enhanced service model described in this discussion paper is differentiated from a 'multidisciplinary Integrated Family Health Centre (IFHC)'. The enhanced service model is seen to be the 'how' of service delivery, whereas an IFHC is one potential site for this delivery. In addition, the Group would like to recommend review of the use of the word 'family' in relation to developing PHC services. The use of 'family' can be problematic for encouraging access by various groups within the community who do not see themselves as included by that term. This is a particular issue in developing services to better meet adolescent health needs but can also be a barrier for those living in relationships or settings that do not fit into traditional ideas of 'family'. Potential alternatives include 'Integrated Community Health Centre/Service', 'Integrated Health and Wellbeing Centre' or 'Integrated Health Care Home'.

This paper has a strong focus on horizontal integration between individuals and organisations involved in the delivery of PHC with limited attention to vertical integration with secondary health care services. However many of the prerequisites for effective horizontal integration will facilitate effective vertical integration.

While the term 'person/whānau' may be clumsy at times, it is used in this document in place of 'patient' to highlight the fact that PHC goes beyond treatment services to broader concerns related to health where people frequently do not consider themselves as 'patients'.

In this document PHC refers to care that incorporates primary care (first-point-of-contact, comprehensive and coordinated health care services) but also aims for much more than an absence of disease and highlights the importance of equity, partnership with communities and attention to social and environmental determinants of health alongside health care services. This type of care requires the contributions of a broad multidisciplinary team, along with collaboration with individuals and organisations beyond traditional 'health care' settings.¹²

Members of the Working Group

Jan Milne, NZ Dietetic Association, for Allied Health Professional Association's Forum

Karen McLeay, NZ Society of Physiotherapists Inc, for Allied Health Professional Association's Forum

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Dr Jo Scott-Jones, Royal New Zealand College of General Practitioners

Jackie Edmond, Family Planning NZ, for the NGO Working Group

¹² Neuwelt P, Matheson D, Arroll B, Dowell A et al (2009) Putting population health into practice through primary health care. *New Zealand Medical Journal* 122 (1290): 98 – 104

Section C: Primary Health Care Context in Aotearoa New Zealand and System Drivers for Change.

The PHCS envisioned that co-ordination of care across service areas with a collaborative multidisciplinary approach would be an important means of improving the health of the population and reducing health inequalities.

It is clear from the literature that

- PHC makes a considerable contribution towards improving health outcomes, in a cost effective manner¹³
- high quality PHC systems internationally are characterised by comprehensive access to appropriate services, continuity of care and person/whānau-centered care¹⁴.

What has happened so far and what still needs addressing?

Implementation of the PHCS allowed a variety of services to develop across geographical areas some of which are innovative and community responsive and some of which have changed little from traditional models of care. DHBs have made a variable response to the needs of PHC in their regions – some have not changed their functional relationships at all, whereas others have adopted locality based PHC strategies and encouraged PHOs to be active in the development of PHC services, particularly the development of services to improve access initiatives and health promotion activities.

Health and disability NGOs have been left 'out of the loop' in the provision of new models of PHC delivery, many struggling to cope with relationships with 80 PHOs and 21 DHBs¹⁵.

The contribution of allied health remains underdeveloped. There is poor understanding within existing PHC structures of the value that could be added to care for people/whānau through collaboration with allied health practitioners. Resourcing and integration issues have hampered access to the allied health workforce¹⁶.

Feedback from consumers notes that PHC fees have reduced and service utilisation is increasing¹⁷, and although there have been considerable improvements in health outcomes under the PHCS¹⁸, further improvements are needed in terms of:

- mechanisms to ensure consistency of high quality care across practices¹⁹
- better horizontal integration between PHC providers and better vertical integration of care between primary and secondary, private and public systems, including better referral mechanisms and information flows
- better understanding of what people should expect from services²⁰.

¹³ Starfield B, Shi L, Mackinko J (2005) Contribution of primary care to health systems and health. *Milbank Quarterly*, vol.83, no.3, 457-502

¹⁴ World Health Organisation (2008). *The World Health Report 2008 : Primary care, now more than ever.*

¹⁵ Health & Disability Sector NGO Working Group (2005). *Non Government Organisations (NGOs) and the Primary Health Care Strategy.* NGO Working Group: Wellington.

¹⁶ Allied Health Innovations in Primary Health: A report to the Allied Health Workforce Strategy Group, February 2009, DHBNZ

¹⁷ Ministry of Health (2007) *Evaluation of the Primary Health Care Strategy: Practice Data Analysis 2001-2005* <http://www.victoria.ac.nz/hsrc/reports/primary-index.aspx>

¹⁸ Ministry of Health (2008) . *Portrait of Health. Key results of the 2006/2007 New Zealand health survey.*

¹⁹ Ministry of Health (2008). *Report to the Minister of Health from the Workforce Taskforce. Working Together for Better Primary Health Care; Overcoming Barriers to workforce change and innovation.* Wellington

²⁰ [http://www.nhc.health.govt.nz/moh.nsf/pagescm/666/\\$File/meeting-needs-chronic-conditions-feb07.doc](http://www.nhc.health.govt.nz/moh.nsf/pagescm/666/$File/meeting-needs-chronic-conditions-feb07.doc)

Wider systems drivers

Improving sustainability and improving performance are identified as key goals for long-term systems planning in the New Zealand health sector. It is clear from demographic data that health care demands are going to put increasing pressure on the health system.

In line with international trends²¹, long-term conditions in New Zealand are the leading cause of hospital admissions and account for 70% of health funding and 80% of all deaths²². The majority of people with long-term conditions receive most of their health care within PHC services. The National Health Committee Report (2007)²³ describes people (with long-term conditions in particular)

- having to use a broad range of services repeatedly and frequently
- wanting more time with health practitioners
- suffering from poor communication mechanisms
- requesting assistance with access and co-ordination of services
- needing better linkages between health services.

There is also growing concern about the sustainability of the PHC workforce, with a recent workforce report²⁴ urging PHC workforce adaptation with an emphasis on multidisciplinary team integration.

In November 2008, an International Masterclass visit by MoH and sector leaders to selected healthcare organisations in North America and United Kingdom was aimed at focusing on the design of overall health systems and service delivery structures and in particular new models of care²⁵. They observed that

- most healthcare systems are undergoing change, and that the most appropriate structure for a system depends on the system's goals, values and beliefs – 'form follows function'.
- health organisations are being consolidated for efficiency reasons, and shared service agencies providing lower cost back-room functions through standardisation
- organisational structures supporting primary care are geographically configured to allow alignment of personal health with population health, and of primary care with social and community care.

All systems are emphasising the importance of clinical leadership and engagement in service planning and review. 'Clinical networks' are emerging as important mechanisms to promote consistency and quality of service²⁶.

There is a need for, and move towards, redistribution of services between levels in the health system and between professional groups²⁷. Investment focus is shifting 'upstream' from secondary to primary care and from treatment to prevention and self care, and a more planned approach to PHC.

²¹ World Health Organisation (2002) Innovative care for chronic conditions: building blocks for action. WHO, Geneva

²² Rea H, Kenealy T, Wellingham J, Moffitt A et al (2007) Chronic Care Management evolves towards Integrated Care in Counties Manukau, New Zealand. NZMJ Vol 120 No 1252

²³ National Advisory Committee on Health and Disability (2007). Meeting the needs of people with Chronic Conditions. Wellington: Ministry of Health

²⁴ DHBNZ Future Workforce 2005-2010 http://www.dhbnz.org.nz/Site/Future_Workforce/Default.aspx

²⁵ Ministry of Health (2009) System Design and New Models of Care. Report of the New Zealand International Masterclass 2008. Wellington: Ministry of Health

²⁶ Scottish Executive, NHS (2007) Strengthening the role of managed clinical networks. Edinburgh; Stanton P (2006) The role of an NHS Board in assuring the quality of clinically governed care and the duty of trust to patients. Clinical Governance 11(1): 39 - 49

²⁷ Arcus K, Stephenson P, Roth T (2009) Health sector challenges and trends in service design responses. Unpublished DRAFT Wellington: Synergia & Ministry of Health

Where to for PHC in Aotearoa New Zealand?

It has been suggested that no single organisational model can meet all the anticipated effects of PHC: effectiveness; quality; access; continuity, productivity; and responsiveness. In presenting to the Council in November 2008, Smith²⁸ suggested that two models stand out as meeting most of the desired effects:

- the integrated community model
- the professional co-ordination model.

It is notable that effective information systems and transfer of information between different providers in PHC and wider systems represented a core feature of the preferred models in many analyses²⁹.

Smith noted that others have identified the tension between

- co-ordinated professional models whose strengths include responsiveness, and
- community-oriented models whose strengths include equitable access to services.

The Working Group believes the future for PHC in Aotearoa lies in working through the tensions presented by these two approaches to a model that combines the best of both - a population and person/whānau-centred approach that is provided by an identifiable and 'visible'³⁰ multidisciplinary team working in an interdisciplinary environment and includes

- health promotion
- primary prevention
- individual/family, person/whānau treatment and support.

The enhanced service model as outlined in this paper, builds on strengths of the current general practice model of care:

- people already identify their general practice as the place to go for primary care
- the development of functioning teams in the general practice setting has been facilitated by Cornerstone accreditation^{31, 32}
- PHO enrolment provides an effective and structured community database that in combination with the shared electronic patient record makes a solid foundation for an identifiable extended multidisciplinary team associated with care for a particular population³³
- the PHCS, through PHOs, provides a community integrated model of support systems to general practice and in some areas they have extended their function into wider community providers and health care activities.

However the current arrangements position a number of PHC providers outside the PHCT, for example maternity, well child service providers, district nursing and public health nursing services, allied health practitioners and health and disability NGOs. Moving to a broader PHCT expands current primary care approaches to include and facilitate connections with these other PHC providers. The shared electronic patient record is an important enabler of this process.

²⁸ Smith J et al (2008) Developing models of integrated primary health care: what does the evidence tell us? Unpublished draft.

²⁹ Ibid

³⁰ Safran, D (2003) Defining the future of primary care: What can we learn from patients? *Annals of Internal Medicine* 138: 248 - 255

³¹ CORNERSTONE (RNZCGPs) is a combined quality improvement and quality assurance process which uses a set of measurements collated in the publication *Aiming for Excellence*.

³² There is some work underway to have these and Te Wana accreditation (HealthCare Aotearoa) processes occur in parallel to reduce compliance effort. Standards New Zealand produces asset of Health and Disability standards and has suggested that there would be value in working together to identify other standards which may be common across various parts of the health sector.

³³ Pullon, S (2008) What is the place of general practice within primary health care? *NZFP* 35 (5)

The collective term 'Allied Health Practitioner' includes a wide variety of practitioners who may be self-employed, work under DHB secondary care structures or for NGOs. As noted there is poor understanding within existing PHC structures of the value that could be added to care for people/whānau through collaboration with allied health practitioners. It is vital going forward that value is realised in PHCTs.

Health and disability NGO challenges related to funding, contracting and relationships with 21 DHBs and 80 PHOs have been articulated in various surveys and documents since the implementation of the PHCS. The differences between PHOs throughout the country not only impacts on collaboration between local and national NGOs at the local level, but also on ability to share care, and avoid duplication which often leads to fragmentation of service provision.

These challenges mean different interfaces and relationships with NGOs will operate at the level of the PHCT. Just as systematic referral and communication pathways are required between primary and secondary care, so appropriate infrastructure and processes are also required for referral and communication between the PHCT and NGOs. This is particularly important where person/whānau care is spread between practitioners in PHCTs and the NGOs. Later comments relating to the need for PHCT members to understand and acknowledge the skills and knowledge of each other's roles, responsibilities and contributions to PHC, also apply to the NGO relationship.

Further connections with ACC, MSD, Housing New Zealand, local authorities and community organisations who influence the social determinants of health, are also a feature of PHC³⁴ and can best be facilitated through PHO level engagement and governance.

PHCTs need to take a person/whānau-centred approach to achieve common understanding, shared responsibility and agreement on management of health conditions³⁵. Development of new approaches to health care should include consumers in the planning stage as evidence shows that people who are better informed, more engaged and able to participate in their own health care are more likely to adopt improved health related behaviours and have enhanced health outcomes.³⁶ People/whānau who use services also have an important role to play in influencing system changes so that services are focused on the needs of those they serve, rather than provider's needs.

³⁴ Neuwelt P, Matheson D, Arroll B, Dowell A et al (2009) Putting population health into practice through primary health care. *New Zealand Medical Journal* 122 (1290): 98 - 104

³⁵ Wilson, H (2008) Becoming patient centred. *NZFP*, Volume 35, (3); Holman H & Lorig K (2000) Patients as Partners in managing chronic disease. *BMJ* Volume (320); Harris M F, & Zwar N (207) Care of patients with chronic disease : the challenge for general practice. *Medical Journal of Australia*, Volume 187 (2)

³⁶ Bodenheimer, T (2005) Helping Patients Improve their health-related behaviours: What system changes do we need? *Disease Management*, Volume 8 (5)

Section D: The Visible Multidisciplinary Primary Health Care Team

PHCTs envisaged in this paper will be multidisciplinary and include general practitioners, nurse practitioners, primary healthcare nurses, midwives, health care assistants, allied health practitioners³⁷, community health workers, cultural support staff and practice managers. This list of PHCT members is neither exhaustive nor prescriptive and may well include other practitioners, depending on population and locality need, but does indicate the breadth of those who need to form the core of these teams.

Members of the PHCT may have different employers and/or employment arrangements but the ultimate aim is to meet the health needs of the person/whānau and communities, improve quality of care and the journey through the health care system. PHCTs may be co-located or virtual, but relationship development and clinical networking will be visible and measurable whatever the structure.

Systematic referral and communication pathways between PHCTs and health and disability NGOs (who provide a wide range of services, encompassing clinical services, social support, alternative therapies, alongside health promotion and public education) will also be key to the effectiveness of PHCTs.

The interdisciplinary environment the PHCT works within will vary from region to region, but will need to include tangible relationships with the Accident Compensation Corporation (ACC), Ministry for Social Development (MSD), Housing New Zealand, local authorities, community organisations, thus providing a cohesive network, centred on the person/whānau need.

Clinical leadership in PHCTs, PHOs, DHBs and the Ministry of Health (MoH) will need to work to ensure that people/whānau remain at the heart of the health care system which will be driven by person/whānau outcome measures, including quality and safety of care provided. Equity and cultural perspectives on quality will be important considerations for PHCTs, and providers will be equipped to provide culturally responsive and appropriate care.

Supported self-care will be a key goal of all interactions of the PHCT with those they serve. Both individual and group support, generic and condition-specific will be available face-to-face in local communities, along with on-line support and resources specific to the context of Aotearoa New Zealand. As the model encourages independence from the system rather than dependence on it, engagement will encourage the person/whānau to remain well by being proactive about preventing health problems and provide support so that the person/whānau/community may manage their health independently.

The Working Group envisage that by 2012 community development will be a growing strategy for driving initiatives in PHC and through community-led initiatives, effective change in engagement with the promotion of health and preventative health care will be developing. Population health initiatives will seamlessly flow from national organisations and across providers and communities due to the integrated nature of PHCTs.

³⁷ Allied health describes a wide variety of practitioners, including but not limited to pharmacists, physiotherapists, occupational therapists, social workers, optometrists, psychotherapists, audiologists, clinical psychologists, dental practitioners, dietitians, counselors, podiatrists, speech-language therapists, chiropractors, osteopaths and drug and alcohol clinicians

Section E: Proposed Stratified Care Model

In addition to expanding the PHCT to include allied health practitioners and health and disability NGOs, there is benefit in deploying the workforce in a way that more closely aligns to levels of person/whānau need. One way of doing this is to utilise patient need stratification.

People with significant long term conditions, accessing services, have said that they want a sense of connection to services which goes beyond making appointments when a problem arises. They express a need for information, assistance with planning, navigating appointments and referrals, interpreting information and results and to gain a sense of ownership and realistic expectation of living with their illness. They also identify the need to receive services which specifically accommodate their particular personal context and circumstances. Above all they value having sufficient time spent with them to enable prolonged communication. This can present a challenge to current service delivery patterns and is the reason for examining the process of patient stratification outlined herein.³⁸

Patient stratification must be based on comprehensive assessment of clients to determine the level of need. Using data derived from patient registers and analysis of enrolled patient health needs, PHCTs could organize service delivery better to meet categories of individual person/whānau needs.³⁹

The stratification proposed in this enhanced service model seeks to integrate service delivery needs for health promotion, self-management, prevention, screening and management of long-term conditions. The following three level model is proposed to provide culturally responsive quality focused health care aligned to the needs of the individual/family/whānau/community. The model incorporates the need for acute care and undifferentiated diagnosis, at all levels from those people who are well, through those with chronic conditions to those in palliative care. Screening for conditions other than those already diagnosed would also be offered at all levels, where indicated and appropriate. The boundaries between levels are often more blurred for people with multiple needs but accidents, injury and sudden onset conditions occur at all levels.

The concept of stratification aligns with various international models of chronic care management. Common areas of consideration in those models include self-management, disease or care management, and case management or care co-ordination. It is also linked to the different stages of the long-term conditions continuum in the work of the Ministry of Health's Long-Term Conditions programme.

The ultimate aim of the model is to provide integrated structured care in a timely fashion by trained and skilled healthcare practitioners to meet the needs of people/whānau and communities and deliver better health outcomes. It includes the wider needs of families/whānau and the critical work of prevention and promoting health.

Level One – Well Population

This part of the enrolled population is well much of the time, but requires contact with a health service for assistance with management of some conditions from time to time. Routine preventative services are promoted including, immunisation, Well Child checks and other risk assessments. Services should focus on promoting shared responsibility and self care to maintain health and well-being. An expansion of services at this level will require additional workforce, team working skills and training and support networks for all members of the PHCT.

³⁸ Carryer, JB, Snell, H, Hunt, B., Perry, V. Blakey, J (2008) Long-term conditions care in General Practice settings: Patient perspectives. *New Zealand Family Physician*. 35(5), 319-323

³⁹ Bodenheimer, T (2008) Transforming Practice: *The New England Journal of Medicine*, 359: 2086-2089.

The PHCT approach includes health education and the promotion of health, a range of lifestyle/allied health services e.g. dieticians, smoking cessation, physical activity etc, and will be accessed by referral as indicated by person/whānau led needs assessment. Links to health promotion in the wider community will be primarily through links with PHO level initiatives.

Workforce deployment: First contact 'presenting problems' and preventative services can be managed and offered by general practitioners, nurse practitioners, PHC nurses and allied health practitioners when working within a multidisciplinary team (see further discussion regarding entry point to the PHCT).

The practicalities of achieving new models of deployment are currently constrained by workforce shortages throughout the PHC sector.

Level 2 - Mild to Moderate Complexity

These populations have identified health impacts from one or more conditions and require systematic care that is person/whānau centred. They need ready access to a comprehensive service including allied health practitioners.

Workforce deployment: An appropriate registered health care practitioner working within a multidisciplinary team could provide or co-ordinate the majority of care for long term conditions systematically, largely focused on co-ordinated care in partnership with the person/whānau. There is scope for better utilisation of the skills of registered PHC nurses in providing structured care, and in the navigator/coordinator role. However unplanned visits for these conditions and for acute conditions need to be accommodated. Involvement of general practitioners or nurse practitioners will be required at times, as will involvement of secondary care services, community based allied health services and health and disability NGOs.

All care at this level is underpinned by comprehensive assessment, which considers wider family, social and spiritual support networks. Planned integration with broader social services including transport, housing, employment and education is essential at this level.

Level 3 – High Complexity or Severity

These are patients with multiple co-morbidities affecting their quality of life. Successful care is dependent on high level functioning of the PHCT with access to mobile and community based staff and other specialists. Supported integrated care will be required including pain management, palliative and end of life care.

Workforce deployment: The PHCT will provide care for this group, their carers/whānau with the use of the whole interdisciplinary environment including a wide variety of other services across health and social service networks.

Many residents of older care facilities will be part of Level 2 & 3 populations, especially those confined to hospital level care. They could benefit from direct on site care provided by nurse practitioners whose scope of practice is care of older people and who are part of or well connected to local PHCTs. As such increased assessment and intervention could be delivered without recourse to hospital admission and the presence of a nurse practitioner would provide a valuable source of teaching for residential care staff.

Section F: First-point-of-contact with the PHCT

In the model proposed, it is important that at first-point-of-contact with their PHCT, people will have access to person/whānau centred comprehensive care, provided by the most appropriate provider for their needs.

The concept of usual entry into the PHCT structure through first-point-of-contact with a 'triage generalist' needs further discussion. The acceptance or otherwise of this concept will be key in defining the role and funding models for the inclusion of allied health practitioners and NGO providers in the PHCT model, and is linked to the concept of stratified care. Entry through a '*triage generalist*' may also be a barrier to access for people who have traditionally not accessed PHC services in proportion to their need (e.g. young people/Māori/more diverse groups) and may not enter into the PHCT structure at all. Key issues identified are that:

International literature supports the concept that first contact with PHC improves outcomes and efficiency (in relation to cost) compared to direct access to 'specialist' care⁴⁰. However much of this research relates to *primary medical care versus specialist medical care*, rather than considering the role of non-medical specialists for example.

The Working Group also notes that people may wish to choose who they access within the PHCT, at least in the first instance, and that currently there are a number of options for entry into the PHC system – ACC, Family planning, Plunket, general practitioner, work based nurses as well as numerous private and complementary services. The exercise of personal choice is frequently moderated by affordability – young people and those socially disadvantaged are obliged to access allied health practitioners via general practice and onward referral because of inability to pay for such services. It will therefore be important to understand person/whānau/community perspectives on the 'gate opener' role.

The importance of a relationship with a 'primary care' provider as potentially key to the benefits of a primary care led system has been noted in the literature as an area that needs further exploration⁴¹. Current evidence suggests relationship with a person rather than with a place is important, but relationship with an 'integrated and explicit PHCT' needs to be further explored.

The role definition of the 'trained primary care generalist' also needs clarification. The Working Group recommends that a separate piece of work is undertaken, in collaboration with representatives from the broad range of disciplines that will make up the PHCT, to better understand the concepts of generalism and specialism in relation to PHC. However it is the belief of some Group members that this generalist would normally have medical or nursing training, while others would see themselves as a generalist in their role as allied health worker.

An alternative suggested by some members of the Group is that the PHCT as a collective is seen as the generalist first-point-of-contact within which more 'specialist' members of the team have easy paths of referral back to 'generalists' when they assess a condition as being outside their scope of practice. This 'intra-team' referral would be facilitated by co-location of PHC practitioners and services, and funding that does not introduce affordability barriers for those being referred. However whether co-located or virtual, systematic referral and communication pathways are required, with a clear need for PHCT members to understand

⁴⁰ Gunn J, Naccarella L, Palmer V, Kokanovic R, et al (2007) What is the place of generalism in 2020 in the primary care team? Canberra: Australian Primary Health Care Research Institute; Starfield B, Shi L, Mackinko J (2005) Contribution of primary care to health systems and health. *Milbank Quarterly* 83 (3): 457 - 502

⁴¹ Starfield B, Shi L, Mackinko J (2005) Contribution of primary care to health systems and health. *Milbank Quarterly* 83 (3): P 488

their own limitations and acknowledge the skills and knowledge of each other's roles, responsibilities and contributions to PHC.

Section G: Roles of PHCT members and issues of accountability

There is a need for clear definition of the respective roles PHCT members play as part of securing and maintaining the sustainability of PHC and PHC services. Current role descriptions based on documentation from professional organisations (where available) and/or as identified by Group members are outlined at Appendix One. It can be argued that current role descriptions are written in the context of assumptions related to historical roles rather than on empirical evidence that such roles are the most effective model of service.

There is also a tension between wanting clear role definitions so that people can work effectively as a team, and the need for the health workforce of the future to be increasingly flexible and able to shift roles as needs dictate.

The Group highlights the need for continued work to reconcile the current role descriptions as outlined with the new ways of working envisaged for the PHCT. It is important to acknowledge that redefinition of roles is a complex process, that has significant implications for professional training and development as well as for professional identity.⁴² As noted these implications are particularly apparent regarding the future role of the GP, Nurse Practitioners (NPs) and nurses. For example loss of direct patient contact for simple issues would profoundly affect the development of the doctor-patient relationship, which GPs identify as an important process in then identifying and helping people with more complex issues.

It is important to separate clinical accountability and coordination functions for PHC practitioners. Every health professional is accountable for the care they give and for following up on the care they ask others to complete. However, particularly for people with long-term conditions, it is important that there is an identifiable, clinically qualified practitioner who takes responsibility for ensuring that care is linked and continuous. Some members of the Group felt it is important that a medically trained practitioner is a member of each PHCT and as noted in the summary document, how the role of that person relates to the notion of carrying clinical risk for the PHCT is a matter for further discussion.

Electronic systems are a tool to support this holistic care but strong clinical governance (discussed further on page 23) with appropriate auditing and review is needed to ensure such tools do support quality care provision and appropriate follow-up and coordination of care.

⁴² Charles-Jones H, Latimer J, May C (2003) Transforming general practice: the redistribution of medical work in primary care. *Sociology of Health and Illness* 25(1): 71 – 92

Section H: Settings for service delivery for the enhanced service model

The three levels of the enhanced service model described in this paper will need to be flexible and delivered in a variety of service delivery settings, with a variety of governance and management forms. The specific environments/geographical location will have a significant impact on the key features of collaboration and multidisciplinary teamwork. Some current service models include:

- virtual PHCTs where relationships exist between different providers and may include sharing of patient information. Examples include rural health care delivery (e.g. West Coast)
- co-located practices where a range of providers are available to people/whānau in one location. Examples include
 - settings with systems to support integration and multidisciplinary teamwork
 - settings where co-location facilitates referral between healthcare practitioners but other integrative systems are lacking.(Note that co-location of providers can facilitate but does not equate to the model of PHCT service delivery proposed in this paper).
- organisations where different providers have formed one business entity and provide a range of services
- the Health Care Aotearoa model of community driven and governed PHC services in which multidisciplinary teamwork is a key feature.

Overseas examples include:

- local, integrated 'community health and wellbeing centers/service'⁴³ which in the Aotearoa New Zealand setting could come under the PHO umbrella
- local multi-sectoral 'community development networks'⁴⁴.

Two key settings for the future are seen to be

- the proposed IFHC
- virtual PHCTs where care is customised and matrixed around the needs of the person/whānau seeking care/support and facilitated by processes that support integration and shared electronic systems.

Key requirements for delivering this enhanced service model of care include:

- good quality team work between PHC practitioners with specific attention to:
 - workforce development to ensure that all team members understand each others' role and how best to integrate their contribution to person/whānau care
 - clear goals and processes to evaluate progress
 - protected ring-fenced non-patient contact time to meet for open communication about respective roles, tasks, clinical outcomes and continuing education
 - processes in place to underpin safety of participation.
- more work to better adapt services to person/whānau needs
- skilled and sufficient PHC workforce, including addressing shortages across the breadth of PHC practitioners
- continuing professional development for all PHCT members
- electronic patient health records which make information widely available to the full range of providers in a PHCT within agreed privacy and security protocols
- funding and business models that support interdisciplinary practice.

⁴³ Examples of these can be found at :

<http://new.wales.gov.uk/topics/housingandcommunity/regeneration/socialenterprise/newsletter/0607winter/ystalyfera/?lang=en>

⁴⁴ http://www.dhcs.act.gov.au/engagement/publications/community_development_network

Section I: Relationship with secondary care services

Changes in technology and medical practice mean that general practice now cares for increasing numbers of people, while the utilisation of secondary services declines. In this context, the interaction between the models for PHC and hospital-based services are increasingly important to ensure that effective and efficient relationships and communication processes are focused on the needs of the person/whānau and provide continuity of care.

More effective use of the PHC workforce will see multidisciplinary PHCTs providing specialist assessments across a number of disciplines and undertaking a wider range of minor surgery and post operative care to meet the health needs of their population. This will require delegated funding to PHOs and other providers. This will not only release hospital specialist time but also achieve better, sooner, more convenient healthcare for the PHCTs populations.

It is estimated that one in five patients on hospital waiting lists is waiting to see a hospital specialist for access to diagnostic tests. Wider access by PHCTs to diagnostic procedures would allow better utilisation of hospital resources and free up the waiting lists for patients who really do need to see a hospital specialist. For those who do require subsequent referral, it would also mean they will have already had the relevant tests when they first see the hospital specialist.

Improved co-ordination of electronic communication will ensure that the interface between PHCTs and secondary services better serves the interests of people/whānau. A comprehensive policy requiring compatibility between secondary healthcare provider information systems, which encourages uptake of existing standards, would ensure prompt advice of patient discharges back into primary care or even direct access to specialist appointments.

Section J: Clinical Governance in the context of a broader PHCT

Clinical governance has been defined as the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish⁴⁵. Clinical leadership is a component of that system, and effective clinical leaders cannot operate in isolation but must reflect the context in which they operate.

In the context of PHC, clinical leadership needs to span the full range of PHC practitioners involved in the services provided. This also includes the range of allied health practitioners who will be involved in providing care in the PHCT. Quality of service delivery and clinical excellence need to be supported systematically in all areas of PHC delivery. This includes all processes / procedures related to 'clinical care' provided to service users (as opposed to business and financial processes).

In PHC clinical governance needs to sit alongside corporate and community governance to ensure increasing alignment of financial, managerial and clinical responsibilities in all decision making.

⁴⁵ In Good Hands, Ministerial Task Group on Clinical Leadership 2009; modified from Scally, Donaldson 1998

Section K: Barriers and Enablers

A. Practitioner Behaviour Changes

Key enablers are seen to be

- Ensuring that each PHCT member understands other members' role
- Collaborative work across professional organisations
- Provision of funded time for team development
- Provision of professional development for all staff
- Strengthening of clinical leadership and governance, involving all disciplines working in PHCTs

Specific Enablers	Action needed	By Whom	By when
1. Ensure that all PHCT members understand and acknowledge the role and skills of each other, and their respective responsibilities and contributions to PHC.	Identification and development of education processes that involve shared team-based learning and development of skills for team work, both for <ul style="list-style-type: none"> ○ those already working in PHC ○ in training programmes for professions who will potentially work in PHCTs. 	Policy makers and pre and post graduation educators across all disciplines. Workshops at professional Association Conferences	Joint meetings and concept development by Dec 2010 Implementation of pilot programmes 2011.
2. Collaborative work across professional organisations	High level conference to facilitate inter-professional collaboration between professional organisations involved to agree core values and set parameters for role development. Definition of the knowledge and skills for different roles ⁴⁶ across the continuum of care, e.g. from assistant to advanced practitioner ⁴⁷	Joint Colleges/Professional Associations and stakeholders	By August 2010
3. Recognition of the development of teamwork within the model of care as part of regular work processes	Arrangements between employers and employees recognise the need for protected time for teamwork, including meeting regularly to review collective service provision in addition to clinical case review. Establishment of an overarching structure to provide continuing support, research, and education for teamwork amongst the PHCT.	DHB/PHO contracts Policy makers and fundholders, MOH DHBNZ, PHOs	Implementation by August 2010

⁴⁶ including identification of specific role/task matching but also support for the use of generic skills of practitioners to encourage flexibility of roles

⁴⁷ Current examples include NZNC GP involvement in NP panels, shared vision conference presentations, involving NPs in peer groups

⁴⁸ e.g. team work is a prerequisite for the Cornerstone and Te Wana processes

Specific Enablers	Action needed	By Whom	By when
	<p>Pilots supported by research exploring best models of practice for interprofessional working</p> <p>Support for accreditation processes that strengthen and develop team work.⁴⁸</p>		
4. Provision of professional development opportunities for all staff.	Review funding arrangements for professional development with a view to increasing access to include a wider spectrum of health professions and staff in NGOs	Policy makers	Review to be completed by August 2010
5. Strengthening of clinical leadership and governance, involving all disciplines working in PHCTs	<p>Review of current clinical governance arrangements in PHC settings to identify and build on examples of interdisciplinary practice</p> <p>Bringing together of the various accreditation processes and identification of standards which may be common across various parts of the health sector.</p> <p>Exploration of options for 'joint venture' type arrangements with DHB secondary care services to support clinical supervision for practitioners where there are smaller numbers in PHC (e.g. some of allied health disciplines)</p>	<p>MOH DHB NZ PHOs</p> <p>Relevant organisations HDANZ and colleges.</p>	<p>Review by December 2009, Promotion of good practice by April 2010</p> <p>Review and recommendations by Dec 2010</p>

B. Systems and Policy changes

Key enablers are seen to be

- Review and revision of the current funding model of PHOs
- Progress on the movement of service currently provided in secondary care to PHC settings where appropriate
- Consolidation of funding and planning functions for the PHC sector
- Increased systems support for allied health providers and NGOs

Specific Enablers	Action needed	By whom	By when
1. Review and revision of the current funding model of PHOs	<p>Funding of patient need stratified care (rather than professional roles) ensuring there are clear expectations that the team decides on allocation of funding (not one provider) with requirements to be responsive to PHO population health approaches.</p> <p>Flexibility for NGO's and allied health teams to take on contracts for patient need stratified care in PHC as part of PHCT service delivery</p>	MOH DHB PHOs NGOs professional bodies and colleges	Negotiations by end of Dec 2011

Specific Enablers	Action needed	By whom	By when
	Exploration of further movements to salaried models of general practice accompanied by performance incentives		
2. Progress on the movement of services provided in secondary care settings to the PHC environment	<p>Identification of the services provided in secondary care settings which could be moved to primary health care environments</p> <p>Processes/systems to move funding and infrastructure with identified services, without undermining intermediary care services</p>	MOH PHOs DHB	Ongoing
3. Consolidation of funding and planning functions for PHC	<p>Consideration of geographical consolidation of PHO functions / alliances of PHOs to facilitate relationships and contracting with NGOs and allied health providers</p> <p>Greater support for collaborative ventures between PHOs and sharing of documentation and planning processes between the PHO's and DHBs</p> <p>Consideration of greater alignment between how the PHCT is funded through MoH, DHBs, and PHOs, and how they are funded by ACC</p> <p>Targeted funds for spread of innovation in priority areas (e.g. applied research to support evaluation of initiatives)</p>	<p>MOH and PHOs</p> <p>PHOs and DHBs</p> <p>MoH/ACC</p> <p>MOH</p>	<p>Review of current structures by Dec 2009.</p> <p>Proposals for change implementation by Dec 2010.</p> <p>Ongoing</p> <p>Ongoing</p>
4. Increased systems support for allied health providers and NGOs	<p>Allied health representation in the Ministry of Health so that the allied health voice is consistently 'at the table'</p> <p>Consistent recognition of the allied health overarching body alongside other professional bodies.</p>		

Other enablers

Other important enablers that require national level coordination and action are

- Progress on the institution of technological tools and
- Person/whānau engagement.

Specific Enablers	Action needed	By Whom	By when
1. Progress on the institution of technological tools	<p>Shared electronic health record available at all access points and transferable nationally in accordance with current legal and professional requirements</p> <p>Consistent involvement of allied health and NGOs in work to progress shared electronic records acknowledging that currently their client health records sit outside the PHO related PHC records</p> <p>Systems to support telephone and email contact between people/whānau and members of the PHCT to reduce the need for clinic visits</p> <p>Telehealth connection of generalists with specialists, available to all disciplines in all areas of the country</p>	HISAC	
2. Person/whānau engagement	<p>National and local communication with communities so that it is clear that</p> <ul style="list-style-type: none"> ○ the model of care expects to work with them to support self care ○ the drivers point to independence of the 'system' rather than dependency on it ○ continuity of care is highly valued, by making the PHCT explicit and all of its members 'visible' <p>Continued community positions in governance</p> <p>Encourage registration of people with PHCT rather than individual practitioners.</p> <p>Dissemination of education amongst DHBs, PHOs, and health professionals of the concept of community development and practical examples of how this benefits outcomes</p>	<p>MOH PHOs DHBs</p> <p>DHBs and PHOs</p> <p>Joint community and education conference, community champions</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Conference by Dec 2010</p>
3. Improved options for transport to support patient, PHCT members and specialist mobility	<p>Exploration of IT alternatives to travel – Telehealth and video conferencing, where not appropriate supported travel to centers for learning and for patient treatment.</p>	MOH DHBs PHOs	Ongoing

Section L: Facilitating sustainable change

The practitioner behaviour changes needed require structural and systems support if they are to progress, become embedded and sustained. The changes needed both in practitioner behaviour and systems and policy need to be driven by PHC contract key performance indicators (KPIs) that are constructed in conjunction with the sector and the professional bodies making up the PHCT. Indicators are needed that reflect the commitment to team work (e.g. capture information about the effectiveness of referrals and time spent in collaborative activities). Appendix Two describes nine principles that should guide the development of models that involve change in behaviour.

Adopting a systematic and evidence-based approach to facilitating change has been identified as important in developing models that involve change in behaviour. Pilots accompanied by careful monitoring and feedback from evaluation are also seen to be useful⁴⁹. Systems analysis tools involving self-audit (e.g. Cornerstone, Te Wana, HDANZ), significant event audits (SEA)⁵⁰ can be utilised not only for assessment but also as a vehicle for change and may facilitate improved productivity⁵¹.

Measuring 'success'

As noted earlier (Section C) improving sustainability and performance are key goals in current health sector planning. Measuring performance and sustainability in PHC will necessitate extending the current work that is focused primarily on services delivered by general practice teams (e.g. PPP). Domains such as financial, clinical and service-related may be viewed as important aspects of performance of a PHCT⁵². While historically measures of 'productivity' in health care have related to numbers of patients/clients seen⁵³, the broader work of a PHCT will need to be reflected in person/whānau outcomes using holistic models such as Te Whare Tapa Whā, encompassing physical, mental/emotional, spiritual and social domains.⁵⁴

Regular person/whānau satisfaction surveys could be extended/partially replaced by measures of 'enablement'⁵⁵, a key goal of supported self care. In addition measures of relative time spent on clinical and non clinical workload⁵⁶ would be useful in capturing broader aspects of 'productivity' in a PHCT, along with measures of community involvement/impact that community has on the behavior of a PHCT⁵⁷.

⁴⁹ Ibid

⁵⁰ Royal College of General Practitioners (1995) Significant event auditing: a study of the feasibility and potential of case based auditing in primary care. Occasional paper no. 70

⁵¹ McCarthy EL (2002) Physician office productivity improvement through operations analysis and process redesign. *J Ambulatory Care Manage.* 25(4):37-52

⁵² The Government Social Research Unit in the UK in a "Practical Guide: An overview of behaviour change models and their uses" – further details necessary. See further Appendix Two.

⁵³ e.g. Garg ML, Boero JF, Christiansen RG, Booher CG (1991) Primary care teaching physicians' losses of productivity and revenue at three ambulatory-care centers. *Acad Med.* 66(6):348-53

⁵⁴ Durie M (1998) *Whaiora. Māori health development* (2nd Ed). Auckland: Oxford University Press

⁵⁵ Howie J, Heaney D, Maxwell M, Walker J (1998) A comparison of a patient enablement instrument (PEI) against two established satisfaction scales as an outcome measure of primary care consultations. *Family Practice* 15: 165 - 171

⁵⁶ Kearnes DR (1992) A productivity tool to evaluate NP practice: monitoring clinical time spent in reimbursable, patient-related activities. *Nurse Pract.* 17(4):50-2

⁵⁷ Although written for organisations at the level of the PHO, Neuwelt's community participation tool may be useful (Neuwelt P (2007) *Community participation toolkit: A resource for Primary Health organisations.* Wellington: Steele Roberts.)

Incentivising of good results across these broader domains for PHCTs needs consideration.

Appendix One

Primary Health Care Team Members' Role Definitions

The role descriptions below are based on current documentation from professional organisations (where available) and/or as identified by Group members. As noted in the body of this paper, it can be argued that current role descriptions are written in the context of assumptions related to historical roles rather than on empirical evidence that such roles are the most effective model of service, and the Group highlights the need for continued work to reconcile the current role descriptions as outlined with the new ways of working envisaged for the PHCT.

There is also a tension between wanting clear role definitions so that people can work effectively as a team and value each other's contributions, and the need for the health workforce of the future to be increasingly flexible and able to shift roles as needs dictate.

General Practitioners

1. The scope of general practice as defined by the Medical Council of New Zealand⁵⁸ is 'an academic and scientific discipline with its own educational content, research, evidence base and clinical activity, and a clinical speciality orientated to primary care. It is personal, family, and community orientated comprehensive primary care that includes diagnosis, continues over time, is anticipatory as well as responsive'.
2. A vocationally registered general practitioner is a medical practitioner who after 6 years undergraduate study, and at least two years as a house surgeon, has successfully completed the three year vocational training programme (GPEP), including passing the PRIMEX exam and Fellowship assessment visit, entitling them to apply to the Medical Council of New Zealand for vocational registration as a general practitioner.
3. General practitioners deliver generalist medical care by purposefully engaging with patients as people over time, developing professional-person/whānau relationships as an important framework for health care delivery. This holistic approach places value on knowing the individual as a whole person and recognises the context of that individual within home, family, and community. Consideration of family and community extend generalist care beyond the individual to groups, or small populations, of people, beyond individual health problem to health education and the promotion of health and health maintenance at a community level.
4. General Practitioners deal with uncertainty and undifferentiated presenting complaints, they can recognise and manage conditions that arise both commonly and rarely within a person or population. GPs deal with the complexity of co-morbidities present for any individual, providing interventionist care with regard to their skill level and the effect of that care upon each aspect of that person's life and medical conditions.

⁵⁸ Medical Council of New Zealand. Vocational scopes of practice. Accessed 06/04/09 from <http://www.mcnz.org.nz/Registration/Howtobecomearegistereddctor/Vocationalscope/Vocationalscopeofpractice/tabid/142/Default.aspx>

5. The New Zealand Medical Association believes that within the medical care team, the medical practitioner (in this instance the General Practitioner) should remain at the centre of the team and has ultimate responsibility for the care of the patient⁵⁹. While acknowledging the important skills and knowledge that General Practitioners bring to the PHCT, this expectation causes considerable concern for several members of the Group and is an issue that requires ongoing dialogue in relation to the functioning of the PHCT.

Nurse Practitioners

6. The scope of practice for a Nurse Practitioner as defined by the Nursing Council of New Zealand⁶⁰ is:
 - a. 'Nurse Practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practise both independently and in collaboration with other health care professionals to promote health, prevent disease and to diagnose, assess and manage people's health needs.
 - b. They provide a wide range of assessment and treatment interventions, including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests and administering therapies for the management of potential or actual health needs. They work in partnership with individuals, families, whānau and communities across a range of settings.
 - c. Nurse Practitioners may choose to prescribe medicines within their specific area of practice.
 - d. Nurse Practitioners also demonstrate leadership as consultants, educators, managers and researchers and actively participate in professional activities, and in local and national policy development'.
7. A nurse practitioner is a registered nurse with at least four years postgraduate experience and a masters degree in which extensive additional education has been provided in the areas of pharmacology, pathophysiology, clinical assessment and diagnostic reasoning and the use of evidence. Nurse practitioners can diagnose, order laboratory tests and some may prescribe without supervision or standing orders. A nurse practitioner is thus able to provide front line care in the general practice setting in the particular aspect of primary care they have specialised in, alongside the general practitioners who have the full range of generalist medical skills.
8. In practice as in the normal process of professional collaborative relationships, general practitioners and nurse practitioners working alongside each other will utilise each other's specific expertise to ensure the best service for people/whānau by appropriate referral to each other.
9. There are currently only 17 nurse practitioners working in the area of primary health, 8 of whom have prescribing rights⁶¹. There are also many nurses who have completed the required qualifications and might complete the registration process if employment opportunities in primary health care teams were clearer.

⁵⁹ New Zealand Medical Association (2008) The changing nature of the medical team, new roles and role substitution: Position statement.

⁶⁰ Nursing Council of New Zealand (2005). Scopes of practice. Accessed 06/04/09 from <http://www.nursingcouncil.org.nz/standardsrn.pdf>

⁶¹ http://www.dhbnz.org.nz/Site/Future_Workforce/Nursing-Midwifery/Nursing-Projects/Nurse-Practitioner/Default.aspx

Accessed 3.2.09

Registered Nurses

10. The scope of practice for a Registered Nurse as defined by the Nursing Council of New Zealand⁶² is:
 - a. 'Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. They practice independently and in collaboration with other health professionals, perform general nursing functions and delegate to and direct enrolled nurses and nurse assistants.
 - b. They provide comprehensive nursing assessment to develop, implement and evaluate an integrated plan of health care, and provide nursing interventions that require substantial scientific and professional knowledge and skills. This occurs in a range of settings in partnership with individuals, families, whānau and communities.
 - c. Registered Nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience.
 - d. Registered Nurses may also use this expertise to manage, teach, evaluate and research nursing practice. There will be conditions placed on the scope of practice of some Registered Nurses according to their qualifications or experience limiting them to a specific area of practice'.
11. Registered nurses can fulfil the role of the prime carer for people who will most benefit from structured care, those who need time spent talking and listening. They can provide easier access to a wide range of services, extend their practice through use of protocols and standing orders and provide assistance with managing living and navigating life with a long term condition.

Health Care Assistant

12. Health Care Assistants can provide a supportive role (which are yet to be fully developed in the New Zealand context) to clinicians working in the PHCT delivering basic level care to the patient, changing linen, ordering stock, filing records, data collection and input into IT systems and many other tasks that currently occupy clinical time could be well provided by the health care assistant in supporting roles.

Allied Health Providers⁶³

13. An allied health practitioner has a distinct, specialised body of knowledge and skills and is appropriately qualified as defined in s12 (2)(a-e) of the Health Practitioners Competence Assurance Act 2003.
14. Allied health professionals provide services and engage in activities which include prevention, assessment / evaluation, identification / diagnosis, treatment, rehabilitation / habilitation, advocacy, promotion of health and wellbeing, prescription (optometry), education and research.
15. Allied Health Practitioners include pharmacists, physiotherapists, occupational therapists, social workers, optometrists, psychotherapists, audiologists, psychologists, dental practitioners, dieticians, counsellors, podiatrists, speech-language therapists, chiropractors, osteopaths and drug and alcohol clinicians, but this list is not exhaustive.

⁶³ Allied Health Professional Associations Forum. Information Site. Accessed 20/03/09 from http://www.ahpaf.wellington.net.nz/Information_Site.html

Midwives⁶⁴

16. The scope of practice for a midwife as defined by the New Zealand College of Midwives is:
 - a. The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.
 - b. The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral midwives provide midwifery care in collaboration with other health professionals.
 - c. Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being.
 - d. The midwife may practice in any setting and remains responsible and accountable for the care she provides.

Community Health Workers⁶⁵

17. Community Health Workers support people/whānau to engage with health services, assessing social barriers to health, and being catalysts for lifestyle changes using health promotion and education skills. They can help people/whānau set specific and achievable goals around identified health issues and any social needs and assist when required with liaison to statutory and community helping agencies (e.g. Work and Income Housing New Zealand Corporation, Family Budgeting Services, Citizens Advice Bureau and other community organisations) to maximise available support for people and their families.

Cultural Support Workers⁶⁶

18. Cultural support workers uphold cultural safety and best practice by advising and guiding staff on culturally appropriate interventions with people/whānau. They have a role in liaising with medical staff, patients/whānau to ensure clarity of information and effective communication between all parties.

Practice/Business Manager

19. A practice/business manager takes care of the business side of a practice allowing the health professionals to concentrate on person/whānau care. He/she is responsible for managing staff, finance and medical records, developing the practice's business strategy and making sure that business processes run smoothly. Duties vary according to the size of the business but would usually include taking the lead on the practice budget, recruiting, training and managing administrative staff, dealing with accounts and budgets, paying wages and making sure the practice meets its financial targets, organising duty rosters, management of reception and appointments

⁶⁴ New Zealand College of Midwives. Scope of practice of the midwife. Accessed 18/03/09 from <http://www.midwife.org.nz/index.cfm/1,178,html>

⁶⁵ Based on Community Health Worker job description for a primary health care organisation in South Auckland; and Riripeti Haretuku (2000) Maori Community Health Workers. Accessed 20/03/09 from <http://www.ngangaru.co.nz/uploads/File/Maori%20Community%20Health%20Workers%20Presentation.ppt#8>

⁶⁶ Based on job description for Māori cultural support workers in South Auckland

systems, and being an important link for quality initiatives. The practice manager will usually be a key point of liaison with external organisations such as local DHBs, PHOs, NGOs and social services.

Appendix Two:

Principles for behavioural change models

The Government Social Research Unit in the United Kingdom in a *“Practical Guide: An overview of behaviour change models and their uses”* describe nine principles that should guide planners in developing models that involve change in behaviour.

The Nine Principles are:

- 1. Identify the audience groups and the target behaviour.**
 - If faced with a complex behaviour break it down into its component behaviours and/or adopt a systems thinking approach
- 2. Identify relevant behavioural models**
 - use both individual- and societal level models. Draw up a shortlist of influencing factors
- 3. Select the key influencing factors to work on**
 - use these to design objectives in a draft strategy for the intervention
- 4. Identify effective intervention techniques**
 - which have worked in the past on the influencing factors selected
- 5. Engage the target audience for the intervention**
 - in order to understand the target behaviour and the factors influencing it from their perspective
- 6. Develop a prototype intervention**
 - based on the learning from working with the actors. Cross-check this against appropriate policy frameworks and assessment tools
- 7. Pilot the intervention and monitor continuously**
- 8. Evaluate impacts and processes**
- 9. Feedback learning from the evaluation**