SUBMISSION TO THE PRIMARY HEALTH CARE ADVISORY COUNCIL

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

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1. EXECUTIVE SUMMARY

The Primary Health Care Advisory Council is seeking feedback on its discussion document 'Service Models to meet the aims of the Primary Health Care Strategy and deliver better, sooner, more convenient Primary Health Care. The College of Nurses (Aotearoa) welcomes the opportunity to provide feedback on the discussion document and strongly supports the intent of the document particularly moves to more closely align nursing services with community need.

In particular, the College's submission to the Primary Health Care Advisory Council focuses on strongly supporting moves to increase the multi-disciplinary team functioning aligned to the model of patient stratification outlined in the document; supporting the need to ensure that funding is reviewed to support the intentions of the document; and supporting the increased role of nurse practitioners within primary health care and in older care facilities bridging to general practice.

Collated feedback represents a total of 42 submissions from individuals and groups (unspecified numbers) belonging to our organization (see appendix 1 for a breakdown of submitter type).

The verbatim words of some submissions are included in boxed areas

2. RECOMMENDATIONS

The College of Nurses (Aotearoa) principle recommendation is that funding is reviewed to ensure that the intentions of the document are supported.

3. BACKGROUND

3.1 The College of Nurses (Aotearoa)

The College of Nurses (Aotearoa), "the College", is a professional body of New Zealand nurses from all regions and specialities both within and outside of the District Health Board setting. It provides a voice for the nursing profession and professional commentary on issues that affect nurses, and also the health of the whole community.

4. SUBMISSION

The Primary Health Care Advisory Council seeks specific feedback in seven separate areas, and the College has provided comment under these specific headings. Additional general comments raised by our members are outlined following the specific feedback.

a. To what extent do you support the vision for an enhanced service model for primary health care based on a person/whanau centered approach and multidisciplinary teamwork?

The College supports a vision to enhance primary health care with a model that strengthens the voice of all the members of the primary health care team and is grounded in sound evidence. A multi-disciplinary service model that ensures a seamless transition between care levels is fully supported.

By definition, an interdisciplinary teamwork approach implies working in an interconnected collaborative manner. While the College supports a person/whanau centered approach, we consider that a **population-based approach** is also important. Caring for an enrolled population is an imperative of evidence-based primary health care and systematic analysis and audit of practice level data is likely to pinpoint inequalities in service delivery to individuals and groups.

Many nurse submissions felt the model as proposed was still based on a preventative medical model of disease prevention instead of the preferred prevention approach based on wellness. Nurses would choose to work towards wellness as an inherent benefit rather than behaviour change as a disease prevention strategy

b. Do you see the model of stratification as providing a means to better meet health care needs and improve utilisation of the workforce?

> "There is absolutely no need for all well people to see a general practitioner; screening and minor interruptions to wellness are the domain of registered nurses"

The College supports the model of patient stratification outlined in the discussion document. A more seamless but focused approach has the potential to enhance quality of care, particularly for those living with long-term conditions. It also allows for more collegial opportunities. The proposed model has the potential to enable health professionals to work with / care for the person/whanau in the context of their everyday lives. Registered nurses should be ideally placed to be the registered health care practitioner working within a MDT who could provide or coordinate the majority of care for long-term conditions systematically, largely focused on coordinated care in partnership with the person/whanau.

Yes, but realistic funding is needed for long term conditions and those with increased need. The funding needs to be realistic and proportionate to health promotion. This has been out of balance the last few years, with too much emphasis on health promotion and services for what is realistically a well population e.g. before school checks is a classic example of this. $100 for a well child check for a one off consultation versus $200 for managing someone with chronic conditions for a year….not in balance.

The College fully supports the proposal that nurse practitioners provide a much greater role at all levels and in all facets of primary health care service.

Both registered nurses and nurse practitioners working in residential care/primary health care for the older person could be better utilised throughout the three levels within a supportive primary health care team. In addition the College strongly supports a review of the current arrangements and service agreements, which support assessment and attendance by GPs in ARRC (age related residential care) settings. The College believes that more focused and integrated care could be provided by Nurse Practitioners (whose focus is care of older people) both directly into ARRC settings and across the continuum of care between primary, secondary and tertiary settings.

In reviewing the proposed model of stratification, the College notes that it does not fully articulate the complexity that can occur at Levels 1 and 2 where people who might be assessed as being able to 'self manage' may not be able to do so. Ideally, the person in the primary health care team with the most appropriate skill set should provide care and this should occur within an interdisciplinary team framework.

It also needs to be noted that a stratified approach cannot be divorced from the everyday reality of people with long-term conditions becoming ill with acute conditions and needing a medical assessment (via a nurse practitioner or general practitioner) and the interdisciplinary input from allied health and others implicit in evidenced based long-term condition care.

The College is keen to see that concern for long-term conditions does not obscure the critical need for services to children and young people. In particular we are concerned to see school nurse roles appropriately resourced and carefully integrated into any PHC team.

c. 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?

8 years has already been wasted since the PHC strategy. The fundamental foundational barriers have never been addressed. Barriers alluded to in this document have been raised on countless occasions

Essentially the College believes that until foundational barriers (such as funding) are addressed there is reduced point in dissemination, as innovations tend to be exceptions based on high energy creative individuals. However with that in mind the following examples were provided:

- Use of drivers / developers of 'beacons' as consultants to assist in replication across other care contexts
- Use examples of good practice in undergraduate and postgraduate education programmes
- Undertake feasibility and/or evaluative research of practice innovations and disseminate results through publication
- Funded release time for practitioners from providers where interdisciplinary teams work well together to present their models to others, or enable practitioners to spend time in a 'beacon' setting
- Develop a webpage on the Ministry of Health's website including a guide for establishing primary health care teams
- Use 'champions' at each site who could act as mentors/local consultation experts
- Develop a primary health care database which could be shared
- Establish national networking opportunities such as national primary health care leaders group
- Establish a fund to identify benchmarks of quality practice, assess primary health care teams to those benchmarks and analyse the results. An action based ongoing research project would highlight high performing teams and publication would easily disseminate what works and what challenges still need innovation. The benchmarks could include examples of patient centredness, examples of relationships among staff and how they solve problems together.
- Case studies of successful New Zealand team approaches to build on the international research on the elements of teamwork[12]. New Zealand case study research will contextualise the findings of international research and identify the essential elements of interdisciplinary teamwork and the process necessary to implement these. Dissemination must occur once these essential components are established. Improved teamwork leads to innovation in clinical practice. If clinicians know and trust each other and are aware of each other's roles and skills they are more likely to support new initiatives.

Example of existing model of 'good practice'

The Faculty of Health and Environmental Science has just launched the National Centre for Interprofessional Education and Collaborative Practice (NCIPECP). This centre will foster educational practice, research and clinical practice to improve Interprofessional working for health professionals in New Zealand. This centre is already establishing links with the PHC environment and will continue to do so.
Within this centre AUT University has a clinic on the Akoranga campus called Akoranga Integrated Health (AIH). This clinic has just started a project that models many of the

[1] Poulton, BC., West, BC. 1994. Primary health care team effectiveness: Developing a constituency approach. *Health and Social Care in the Community*, 2:77-84.

[2] Poulton, BC., West, BC. Measuring the effect of teamworking in primary health care. In: Hearnshaw, HM (ed). *Audit for Teams in Primary Care*. Leicester, University of Leicester: pp 7-12.

concepts in this document. The project is centred on people with mild to moderate osteoarthritis of the knee and hip. These people enter the project via a single assessment triage undertaken by a Nurse practitioner. Following the generic holistic assessment the person's priorities of care are discussed with an Interprofessional team and undergraduate students from a range of disciplines (Physiotherapy, Occupational Therapy, Podiatry, Nursing, and Psychology). Once the treatment is planned and discussed with the person, and then a student 'navigator' is appointed to the person. This navigator may be the main treatment provider but their role is to stay with the person while they undertake other aspects of their care. In this way the students not only get to see where their disciplines fit into the care plan but also see how the other disciplines interact.

This project and the centre may be of interest to the advisory council as we feel it enacts many of the key principles of the PHCTs strategy but more importantly trains students as to how to work in an Inter professional way.

d. 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 College has identified several additional barriers, which currently prevent the achievement of widespread PHCT approaches.

Funding arrangements and organisational structures
The College considers that the principal barrier for most primary health care professionals is the current funding structures and the private business model of general practice. All those making a submission raised, in one way or another, the issue of funding structures and processes.

The obvious omission is the fact that most primary care/general practices are owned by GPs and are operated as small businesses. Just like any other owner/operator of a small business, there is an understandable reluctance (and even resentment) to 'kowtow" to what is perceived to be outside interference in how their business is run. Independent owner operator businesses rightfully assume self-determination, accountability and control over how the business – in this case health care- is managed. There is currently a perceived renewed determination on the part of primary health care/general practice small business owners to hold on to and to maintain their independence within the wider health care system. This approach would appear to be supported by NZMA, IPAs and to a lesser extent the RNZCGPs (and the current National Govt's support of clinical leadership/decision making).

Current arrangements (especially GP employment of practice nurses) do not encourage or enable all health professionals in primary health care to work to their full potential. For example, there is great potential for registered nurses and nurse practitioners to expand their roles in primary health care, particularly working with people living with long-term conditions. However, the current PHO/General Practice funding and delivery models place restrictions on practice innovations. Despite the rhetoric of "new ways of working" and "right person for the job", funding structures

have directly limited or impeded such moves. One nurse-owned practice submitted that they have:

> *"...been told privately that they miss out on a lot of funding [they are] entitled to because no-one tells [them they are] entitled e.g. there is $26 available to pay per smear. When the practice does the smear, the GP [at another location] claims the $26 regardless."*

Information technology barriers
Additional information technology barriers exist relating to the lack of a consistent primary health care electronic patient management system and multiple providers of software. Although a free market economy, New Zealand lacks a uniform system inhibiting the various systems interfacing with each other between practices and between sectors.

Lack of integration between primary and secondary providers
This fragments patient care, particularly in relation to those with long-term conditions, and communication between the professionals in different sectors is poor. There are small numbers of excellent examples of integration occurring including clinical nurse specialists and/or medical specialists running clinics in primary health care where primary care professionals are mentored into enhanced roles. There are significant examples of wasteful duplication and also concerns expressed by submitters about capacity and appropriate expertise in the primary sector.

> "As a mobile community based nurse (PHO employed) for people with long term conditions I am not allowed to see the notes of my patients who attend care plus funded visits to their General Practice"

Professional development opportunities at postgraduate level
There are time constraints on fulltime doctors and nurses, time and funding constraints for employed doctors and nurses (especially for inter-professional courses not supported by Clinical Training Agency funds).
Shared professional development opportunities are important as they provide doctors and nurses with an opportunity to learn together which in turn facilitates teamwork in clinical practice.

Lack of appropriate utilisation of allied health professionals in primary health care
For example, funding and other barriers restrict the use of community pharmacists who could have a far greater role in an interdisciplinary team (particularly in the care of those with long-term conditions). Dieticians, physiotherapists, social workers, psychologists and counsellors currently do not have an established primary health care role.

Lack of understanding among patients of concepts of moving towards team based care[3]
Patients do not necessarily understand the increasing roles of nurses and there needs to be a concerted effort by primary health care professionals to explain how this new approach works. This approach must take into account the overarching principles of primary health care: first-contact, holistic, health orientated, longitudinal, life span. Some submitters noted that the MoH has not utilised many opportunities to role model the increased role of nurses; frequently referring only to doctors only in public pronouncements about various services.

Slow development of self-management approaches
Self-management approaches have been slow to develop in primary health care. Shared training of the different disciplines would facilitate uniform partnering approaches with patients.

Care in residential care facilities is poorly addressed[45]
Currently residential care facilities (for older adults and those with disability) are marginally linked with primary health care facilities and are not being ideally served. There is considerable scope for nurse practitioners to provide itinerant consultancy and direct clinical care for these people. As already noted elsewhere The College believes that more focused and integrated care could be provided by Nurse Practitioners (whose focus is care of older people) both directly into ARRC settings and across the continuum of care between primary, secondary and tertiary settings.

Impact of barriers on ability to progress PHCT approaches

"My role as an interprofessional postgraduate primary health care educator.
1. Funding barriers affect my work as a primary health care educator using interprofessional approaches
2. Funding streams prohibit interdisciplinary team work
3. Teamwork is poorly understood and lack of NZ evidence is limiting dissemination of effective approaches and in turn limiting innovative approaches (which would enhance nurses roles in PHC delivery)."

"The barriers mentioned [in the discussion document] are all identifiable at the 'coal face' of the PHC sector. From a general practice perspective I am employed by a GP – who owns a business that happens to provide health care! Whilst I appreciate my employer for "allowing" me to work to my full potential within his clinic (such as facilitating nurse led clinics) – I am acutely aware of the limitations of my practice. I can effectively do all the clinical requirements for an acute patient with an ACC related injury – yet a Dr must sign the piece of paper to make this care "legitimate". I

[3] Safran, D. 2003. Defining the future of primary health care: what can we learn from patients? *Ann Int Med*, 138: 248-55.
[4] Gaffy, J., Grande, M., Campbell, J. 2008. Case management for elderly patients at risk of hospital admission: a team approach. *Primary Health Care Research and Development*, 9:7-13.
[5] Hudson, AJ., Moore, LJ. 2006. A new way of caring for older people in the community. *Nursing Standard*, 20(46):41-7.

can provide all the care that is required to undertake a cervical smear yet I cannot refer a woman to Specialist care if I note a suspect lesion.

"Unfortunately, the culture of business and patch protection that has dominated the PHC system has ensured a continuous supply of barriers to release the potential of nurses. I am 35yrs old – and considering the average age of practice nurses is 54yrs – I can confidently say that I am part of the future of nursing. I am committed to the principles of the PHCS and the PHC Nursing Strategy ... the current PHC system, however, is not!!

e. The paper touches on a number of tensions that exist within the wider primary health care sector and between various organizations, 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 College considers that the tensions noted are legitimate. The proposed model requires a fundamental shift in thinking from all players, people/whanau/communities as well as health professionals. Further tensions identified are outlined below.

- There is a lack of understanding of the pathways into primary care. Richard Bohmer's work articulated at a Primary Focus conference about 3 years ago usefully described standard and non-standard routes, worked out in advance with patients who have long-term conditions. This enables patients to be seen by nurses or doctors or nurses and doctors depending on health care need. Pathways need to be flexible according to situation and patients must understand how they work
- Accountability is still not well understood by many nurses and doctors. Nurses in primary care frequently say that certain aspects of work are not in their scope of practice (even though the work is generalist primary health care nursing) and doctors feel they must be solely accountable for a patients care. This talking past each other can only be resolved through situation level team discussion.
- Patients who will want to consult with their preferred clinician may not accept community health homes. Patients identify with individuals not groups.[6]
- The tension between Maori and other ethnic service providers and organizations and mainstream providers/funders expectations. Often contractual requirements do not reflect the realities of providing health services for those other than the majority consumers. A cultural component should therefore be explicit in the tensions.

[6] Safran, D. 2003. Defining the future of primary health care: what can we learn from patients? *Ann Int Med*, 138:248-55.

To what extent do these tensions impact on your ability to adopt PHCT approaches?

"The tension between Primary and secondary care has a daily impact on my ability to provide care to patients. On any given day I can spend up to 20% of my clinical time chasing lab reports/A+E charts/pharmacy enquiries and battling the processes involved with identifying referral processes to various services. The system between PHC and "outside agencies – including the DHB" is fragmented and at times stressful to navigate."

"1. Barriers inhibit the different disciplines to study together and to forge effective relationships.
2. Change affects both nurses and doctors. Nurses perceive there are barriers to their practice, in particular to undertaking nurse led initiatives. Sometimes there are real barriers but sometimes not. Doctors perceive changes to their traditional roles which will alter the way they work."

f. 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?

The College considers that the enablers noted on page 9 of the discussion document for practitioner behaviour change are a good platform to start from, however are not comprehensive enough. The essential elements of effective team function identified by the Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada Project[7] could be useful and includes the following principles:

- Care providers having a shared vision, values and philosophy
- They cultivate trust and mutual support
- Effective communication between team members
- Education and professional development to enable members to work in collaboration effectively
- A shared understanding of member roles and responsibilities
- Flexibility for each provider to practice to full extent of their abilities
- Adequate resourcing.

A difficulty with making change in any organization is the willingness among key players – ie owners/employers and the ways that incentives are utilised to encourage change.

"In our experience, change in general practice is very dependent on the employer – in this case GPs being the drivers – or not – for change. For clinical governance and wider changes to be successful this must be one of the first barriers to be addressed, utilising a variety of proven successful incentives."

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[7] Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada. 2005. (accessed at http://www.elcp.ca/en/resources/pdfs/enhancing-interdiscipli.)

"The development of PHCTs will require protected time to build the trust and respect which underpins effective team-work – the existing business model does not allow this to happen as meetings / team building exercises are viewed as 'un-productive time.' Team building should work from a cultural competency framework e.g. Whare Tapa Wha"

Contracts will need to be flexible in terms of who provides the service and KPIs need to be appropriate for the service being provided. For example, Maori provider KPIs would be different from mainstream KPIs because of the nature of the service and the cultural needs of the clients.

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?

Funding is currently focused on the primary provider of care being that of the GP. Yet medicine is not always necessarily the service that the patient requires. The College considers that a review of the way in which funding is disbursed for first-line health services in primary health care is long overdue to enable nurses and nurse practitioners to **independently access funds.** The College supports these nursing services being embedded preferably in a community owned primary health care service with a strong governance structure or if needs be, in a private business where the interdisciplinary team (plus community and lay members) are represented on the governance board.

g. A set of actions is proposed to advance the service model approach in the paper. Are these the most important actions? Are there certain actions that need to be prioritised?

The College supports the set of actions proposed to advance the service model approach in the paper and notes that this will require additional funding to be ring fenced if these processes are to occur.

Additional specific points to note are outlined below.

Practitioner behaviour changes:

- Prioritising time for team meetings in primary health care is an urgent imperative. It is currently resisted as it is time when money could be made and patients could be seen.

Systems and policy changes:

- Funding arrangements need to be reviewed and changed, however it is unclear whether funding via a stratified pathway will be effective given the complexity of health care and health care seeking behaviour. Funding patient needs rather than professional roles will facilitate many other enablers to occur however retaining the current funding model will halt many other enablers.

- In some places, the formation of MSOs has reduced the load from small PHOs and improved structure and processes around finances and quality assurance
- The allied health and NGO voices need strengthening at all levels and this must be accompanied by policy changes.
- Integrated Family Health Centres (IFHCs) that are either government/DHB or PHO owned) would appear to hold one answer (in the short term) to the proposed changes as described in this discussion paper

Additional general comments

Language and terminology
The College notes that the terms multidisciplinary, interdisciplinary and interprofessional are used interchangeably throughout the document and each term has a different meaning and implies different ways of working. These terms need to be clarified and defined.

In addition, appendix 1 of the document includes definitions of scopes of practice. The GP definition discusses being able to manage "uncertainty and undifferentiated complaints in presenting complaints". This is the language used on page 4 of the document when delineating the Stratified Model. The next page describes the nurse practitioner role according to the definition provided by the Nursing Council, however goes on to imply that the nurse practitioner role is not as 'full' as the GP – refer bullet point 7 where a nurse practitioner is contrasted to the GP as being less than a generalist. This could be important language that has the potential to impact on the PHC nurse practitioner role. The GP definition goes on to state that the GP should be the centre of the team and have ultimate responsibility. However, the College would argue the patient as being at the centre of the team. The approach currently outlined is no longer valid given that the licensed health care providers practice under their own accountability under the Health Practitioners Competence Assurance Act (2003).

Role of education
While the document provides a good general summary of the current situation and barriers to moving forward, the document fails to address the role of education. Key to the intent of the document is the ability of health professionals to work together in a multidisciplinary way, however at present, there are no mechanisms in place to teach health professionals to work in this manner. While the document does state that all PHCTs will have training in teamwork, we consider that there is significant work to be done via Tertiary education providers working with health care providers to ensure that students not only understand the primary health care environment before they enter it, but also to be trained to work and learn in an inter-professional way. There is no mention within the document of how the links with the education of the health providers and the PHC environment will occur.

A large submission to the College was presented by a group of senior nurses working in secondary care but providing services across the continuum and into the

community. The College believes these verbatim comments offer a critical perspective on the prospects for transition of services to the current model of General Practice.

We disagree with the second enabler for systems and policy changes and do not support the progression of the movement of services currently provided in specialist and acute settings to the PHC settings for reasons articulated in the executive summary above. These include: the reality of limited specialist resource, the interdependencies of specialist services that are required to deliver and effectively function, the ability of acute and specialist services to respond rapidly to acute patient need (severity of illness). Anecdotal typical views expressed about migrating services are:
➡ What is the evidence that this works? ➡ PCTs are a mess in the UK, being rolled up because they cost too much? How can New Zealand afford it? ➡ Whose needs are being served in this, not mine? ➡ Are we cattle fodder to break the general practice model? ➡ No training or autonomy, and I'm not being part of it. ➡ Primary care is suffering from GP shortage so who is the team to join? ➡ General practice is private enterprise so who is the team and who I am I working for? ➡ How do you work with a "corner diary" model? ➡ Practice Nurses are well known to speak of being disempowered and deskilled so who wants to join them! ➡ There is no leadership. ➡ How do you keep up specialist skills when you are a one man or two 'man' band and there are no role models? ➡ Who will pay my time to meet with the MDT when they won't pay for my mandatory training to do my job? ➡ I don't have access to the full patient record because that is at the General Practice and I work in the PHO who doesn't have them, so I'm at risk in my practice. ➡ How can I alter medicines with no framework, yet its core to my work? ➡ Terms and conditions are only piggy backed off specialist services so these won't exist, so relativities can't be argued? ➡ There is no clinical room for me to see my patients? ➡ Fifty Nurse Practitioners in seven years and still no easy way of getting work.

5. CONCLUSION

The College considers that the document presents a good overview of the current situation and the barriers to making greater gains in the area of Primary Health Care. We wish to draw PHCAC attention to the document Investing in Health (2003, 2007) which pre empted many of the issues raised in this document and represents issues which both NZNO and the College of Nurses see as critically important to realising the vision of the strategy

We wish to conclude with 5 key points:

- Until funding mechanisms are reviewed properly, the intended gains to ensure proper population health and seamless care for patients will not be fully realised.
- The private business model of general practice is a significant challenge to the vision of this document.
- Whilst services are largely medically led or directed they will remain focused on illness management of patients rather than wellness promotion for populations. This is compounded by largely medical control of funding utilisation.
- The role of Nurse Practitioners remains underutilised and this is unacceptable given current unmet need in many aspects of service delivery especially primary health care and residential care
- Any transfer of services to primary health care settings must recognise capacity, space, sharing of information and the need for appropriate knowledge and skill.

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APPENDIX 1

Contributors

Type of contributor	Number
Educational institution	5
Plunket	1
Senior Lecturer in Primary Health Care	1
Senior Lecturer (Nursing)	1
Nurse Practitioner	4
Defence Force	1
Individual (Registered Nurse)	14
Individual (Primary Health Care Nurse)	8
Individual (School Nurse)	1
Groups of nurses (number unspecified)	4
Iwi Provider nurses (number unspecified)	1