ACC and General Practice Connect

Roadshow Summary

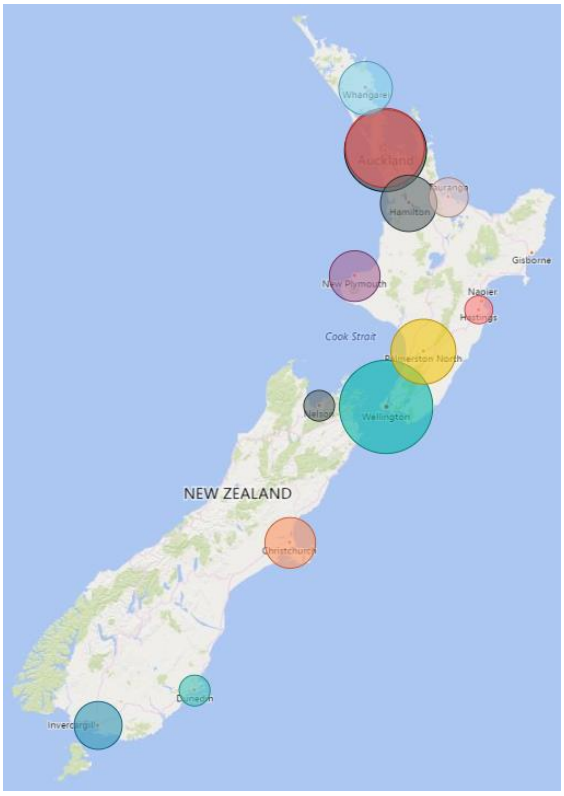
11 February – 05 March 2019

Contents

Roadshow locations

ACC held 17 workshops in 13 different locations throughout New Zealand between 11 February and 5 March 2019.

Week	Date	Session Time	Location
Week 1	11/02/2019	7:00 PM	Dunedin
	12/02/2019	7:00 PM	Invercargill
	13/02/2019	12:30 PM	Christchurch
	13/02/2019	7:00 PM	Christchurch
	14/02/2019	7:00 PM	Nelson
Week 2	18/02/2019	7:00 PM	Hastings
	19/02/2019	12:30 PM	Auckland South
	19/02/2019	7:00 PM	Auckland South
	20/02/2019	7:00 PM	Whangarei
	21/02/2019	12:30 PM	North Harbour
	21/02/2019	7:00 PM	North Harbour
Week 3	25/02/2019	7:00 PM	Palmerston North
	26/02/2019	7:00 PM	New Plymouth
	27/02/2019	7:00 PM	Hamilton
	28/02/2019	7:00 PM	Tauranga
Week 4	05/03/2019	12:30 PM	Wellington
	05/03/2019	7:00 PM	Wellington



Roadshow attendance

In total, 199 healthcare professionals attended the workshops.

The following graph breaks down the place of work recorded on the registration form:

The following breaks down attendees by role:

Roadshow discussion points

Key themes heard from our roadshow discussions:

- ACC needs to trust that you know the patient and what is best for them.
- To build a workable new model, ACC needs to collaborate with all interested parties.
- Lack of technology / integration has a significant impact on General Practice.
- Individual practitioners have different skill levels and capability, which needs to be recognised.
- ACC should consider the role Primary Healthcare Organisations (PHOs) can fulfil in training and education, but most practitioners would prefer the PHO not to be the contract holder with ACC for general practice services

Skills and Capability

- For Nurse Practitioners, there is no joint consultation with Practice Nurses. Nursing input is generally seen to be undervalued in the current regulatory model and teams are unable to take full advantage of the considerable skill and experience nurses offer.
- General practice is progressively being “deskilled” in acute care, as the current model does not cover the cost of managing simple treatments, e.g. suturing of lacerations. There is little incentive for General Practice teams to provide this care, so many patients are sent to emergency departments or after hours’ services.
- ACC should change its terminology around General Practice to focus more on the interdisciplinary nature of the wider General Practice team. Referring to practitioners, rather than GPs and Nurses to build sector confidence in ACC’s view of the General Practice team.
- We need to view the patient as a whole person with individual medical and social needs, not just a person with an injury. We need systems that take advantage of the General Practice team’s in-depth knowledge of the person in a high trust, low bureaucracy model.
- At times ACC questions clinical assessments and requires diagnostics, which may not be clinically indicated, e.g. a clinical diagnosis of fractured ribs after clear history of direct impact injury – ACC required the patient to be x-rayed to confirm this, which undermines confidence.
- The role General Practice teams often play in co-ordinating return to work or stay at work, and the need for ACC to better utilise the potential for General Practice to lead recovery.
- Nurses and General Practitioners want more training and education opportunities on identified topics. You suggested delivering this via video or online modules with the ability to earn CME points.
- PHOs were noted as adding a great deal of value to process around clinical quality, peer review, and education.
- There are differing levels of knowledge and skills amongst those in the same profession which should be recognised, i.e. General Practitioners with Special Interest, Nurse Prescribers.

Relationships with ACC

- When interacting with ACC you would prefer a single point of contact, ideally someone who you get to know and trust. Many of you told us of the value added by previous relationship management roles such as the former GP Liaison role within ACC, which is no longer in place.
- ACC needs to trust that you know what is best for the patient.
- You highlighted ongoing frustrations in communicating with ACC – particularly the formality of communications and lack of any ongoing relationships that would build trust and confidence.

- There are preconceptions and/or a lack of trust when dealing with ACC arising from experiences with cover decisions, inconsistent communication around patient entitlements and care plans, and onerous administrative burden.
- ACC does not always work collaboratively with the wider health sector and does not sit cohesively as a part of the patient's overall journey.

Relationships with Others

- Collaboration needs to occur between all practitioners contributing to a patient's care, as well as with ACC to ensure the patient gets the best possible outcome.
- General Practice often lacks visibility of patient care and outcomes with other providers in the community, e.g. Physiotherapy. General Practice teams are often unaware a patient is being seen by allied health professionals, particularly if the patient presents there in the first instance. The option of building a requirement for patient progress reporting between providers into contracts was suggested. Options for leveraging existing systems enabling shared care records were also viewed positively. This is discussed further in the Interface section.
- ACC Accredited Employers and Third-Party Providers can be difficult to deal with.
- If PHOs are involved in an alternative way of working, ACC would get the best value from a relationship with PHOs around quality and education functions, rather than claims management.

Funding

- There is inequity in current schedule rates between General Practitioners, Nurse Practitioners, and Nurses, and no joint rate for Nurse Practitioners and Practice Nurses.
- Vocationally-registered General Practitioners are not paid the same as other specialists.
- The rate for copying clinical notes has not been updated for many years, and does not adequately remunerate the time, particularly for large requests.
- The fee-per-visit model does not always reflect the work involved and the way the care is provided.
  - Integrated ways of working could be adopted to enable a collaborative, patient-focused approach to service delivery in primary care, such as Health Care Home, Health Hub and Integrated Family Health Centres which are not supported by the current fee-per-visit model.
  - Increased resources and inputs required to manage complexity are not recognised.
  - Those with PTSD and patients with sensitive claims often need intensive management, which is not adequately remunerated.
  - There is limited flexibility when a patient presents with multiple or complex injuries in a single appointment needing to see multiple practitioners, with varying length of consults. Managing claiming for multiple injuries and multiple visits is challenging.
  - Telehealth (including phone contacts) is not an option under the current model.
  - The concept of more flexible funding, such as introducing funding for a "service" (similar to the Rural General Practice contract model of payment for time spent, regardless of clinician), rather than a fee-per-visit per practitioner "rate" was viewed positively.
- Capitation models were discussed as unfavourable options due to the variation in resources required to treat a variety of injuries.
- Particular interventions, such as wound care, are not adequately funded under the current model and there are no best practice guidelines around the use of particular dressings.

- You would like to see funding that recognises practitioners operating at the top of their scope, or with specialised skills and experience within their profession.
- We heard your concerns regarding PHO top slicing contracts and how ACC might get the best value from working with PHOs.

Interfacing systems and operations

- You are keen to see us explore models that would enable more secure and easier exchange of information via channels such as HL7 messaging.
- It can be difficult to get hold of Case Managers by phone and many are not keen to share their email addresses. Practitioners sometimes feel they are in an information vacuum.
- There is frustration with ACC requesting the same information multiple times, i.e. clinical notes. You would like us to explore use of systems like KonnectMed to enable electronic upload of clinical notes.
- General Practitioners are expected to sign off return to work for patients under the care of other community providers. Sign off for return to work should sit with the practitioner who is leading the care, with any return to work plans being shared across practitioners.
- ACC should make better use of its data to provide feedback on outcomes and the uptake of pathways as it becomes available.
- ACC's coding system to diagnose patients' needs an overhaul – we need a more consistent model that is easy to use.
- You gave us details of many issues with the ARC18:
  - There is a mandatory notes field on the form that does not display to ACC staff at all.
  - As a web-based form, if you are adding free text notes and close the page or go back, all the notes typed are lost.
  - No ability to "park" or save a form for later.
- It would be ideal if there were integrated health records that everyone could access. You suggested HealthOne as a good example of this in the health sector.
- You told us that ACC's systems do not account for public holidays, which can negatively impact on a patient's recovery when their claim is declined as no practitioners are available to provide information.
- ACC's website is difficult to navigate and its search function is lacking.

Patient Centricity

- ACC need to take a holistic view of the patient and treat the whole person, not just an injury.
- ACC need to empower General Practice teams to manage people with complex needs. The current model does not enable flexible management of more complex cases, particularly around sensitive claims and those with PTSD.
- ACC's consumer workshops need to capture the views of individual patients and not focus on organisations. Patients with the most critical feedback may be reluctant to engage and may "suffer in silence". It's important to provide opportunities for them to share their experiences.
- Practices see and know the patients, so are best placed to know what would help them achieve the best outcome.
- A great deal of goodwill exists in the system with practitioners going above and beyond for their patients. Our way of working needs to be supportive.

- The current regulatory model requires face-to-face visits for all interactions, which means patients must be brought into clinic for funding to be accessed by the practice. This does not value the patient's or practitioner's time, creates challenges for patients who may have transport and social issues, and generates an unnecessary financial burden with patient co-payment for appointments.

New Models

- A number of initiatives and models underway within the heath sector (that have proven to add value) were mentioned as possible options for ACC to consider. Physiotherapists embedded within schools, return-to-work programmes for those with chronic health conditions and utilising Green Prescription were all mentioned as examples of approaches that dovetail with injury management and prevention in primary care.
- There was discussion on how bundled payments or packages of care could work and the associated risks. These approaches could work well for wounds and non-complex injuries, but may not be so effective for more complex cases, such as a spinal injury.
- Overall practitioners were supportive of a bigger role for General Practice teams in injury prevention.
- Injury prevention at a population level could be achieved in a similar way to the current falls prevention approach, although the use of DHBs for delivery was questioned.

Project Specific

- You asked us to be a bit clearer about what we are asking – the topic feels a bit high level and "woolly" at this stage.
- You don't want a new model that will add to administrative burden.
- The project needs to ensure it delivers to its full potential, so should not rush through the process. However, it should consider delivering quick wins to alleviate some of the more pressing issues.
- There were differing opinions on PHOs and the role they should play, ranging between exclusion from the process to a leadership role. Generally, a mixed model where PHOs would deliver education and quality, with claims and funding for services remaining directly between ACC and practices seemed acceptable.
- One size may not fit all. Regional demographics, infrastructure and market differences are important and need to be considered.
- The new solution should allow for the implementation of the HTI pathway in all regions.
- Practitioners in primary care are under pressure with increasing workloads, driven by a push for more services to be provided in the community rather than hospital, and an aging General Practice workforce. Everyone is time poor and ACC needs to consider that when involving clinicians in this work.
- It is important that ACC includes all relevant professional bodies in this process alongside medical bodies, including NPNZ and the Practice Nurse College within NZNO, and allied health professions.

Feedback cards

Out of the 199 attendees, 30 feedback cards were completed (15% of total attendees).

We have also received additional feedback through www.shapeyouracc.co.nz and a few emails directly to GPConnect@acc.co.nz.

Of the feedback received;

- 21% related to current funding models. Either:
  - inequity of funding in contracts v regulations, where contracts pay more for the same service.
  - Nurse v General Practitioner funding differences, where the same service can be delivered via either practitioner (sometimes a Nurse would be more appropriate) but a General Practitioner would be paid more.
  - The amount paid is not reflective of the service delivered.

- 14% was about communication and collaboration:
  - Communication is both a barrier to change and the way to manage that barrier.
  - Better communication between ACC and everyone involved in the patient's recovery was highlighted. ACC should keep everyone informed when communicating with the patient.
  - ACC needs to work with all parties to deliver a successful solution.
  - Sometimes individuals are overpowered by larger organisations so ACC needs to work in a way that enables everyone to contribute.

- 8% ensuring the solution is patient centric.

- 7% said there need to be changes made to ACC's website, integration between systems and some sort of secure communication rather than email.

- 5% wanted ACC to acknowledge the skills of individual professionals;
  - That they have the right skills to deliver service.
  - There should be a difference between a recent graduate and someone who is a vocationally-registered GP.

All feedback captured in the cards has been incorporated in the roadshow feedback section.