Models of care

This issues guide is linked to the vignette 'Can Zane work a 40 hour week?'

Patient pathway, clinical decision rules, service model or resource allocation model?

'Models of care' is a phrase commonly used in contemporary Primary Mental Health Care (PMHC). In practice 'model of care' is an ambiguous term. It is used to mean: a patient pathway to and through services; clinical decision rules about what treatments to offer to whom, when and by whom; a model for conceptualising and organising services; and a high-level model for allocating service resources at population level. When you use the term 'model of care' to support any aspect of your planning or provision, ensure you articulate, record and periodically check the sense in which you are using it.

Form follows function

In all models of care, and in whatever sense the term is used, there are implicit structure and process elements that make up the *form* of the service provision. For example, in stepped care the steps are a structural aspect, and the routine progress assessment leads to a process of 'self-correcting' movement up and down the steps).

One of the principles of this Toolkit is that *form follows function.*[1] When planning we often think about structure too early, and then develop processes that fit with the structure. We strongly recommend that when using the idea of any model of care, it is best to prioritise function and refer back to it frequently when developing/modifying processes and structures. At least be clear which of function or form (structure/process) is dominating in any application of the idea of stepped care.

[1] Grumbach, K., *Redesign of the Health Care Delivery System: A Bauhaus "Form Follows Function" Approach.* JAMA, 2009. **302**(21): p. 2363-2364.

Models of care in contemporary New Zealand Primary Mental Health Care

Stepped care is the model currently receiving most attention in the policy context and there is pressure to move towards its more widespread adoption.[2] However the majority of the mild to moderate mental health needs of patients are currently met by the GP or practice nurse in the context of existing consultation times and alongside the competing demands of other health issues being brought into the consultation. This model which might be thought of as 'business as usual' contains elements of stepped care, when services are available or the patient's situation becomes more acute. For those who can afford it, business as usual includes referral to private providers of generic counselling, specific psychological treatment and psychiatric consultation. Another model is 'high intensity' care, which is more often seen in Kaupapa Māori PMHC. In this model, work may include the whānau, may occur away from the consulting room setting, and may allow for more frequent or a greater number of face to face sessions.

Within the stepped care model as currently interpreted in the New Zealand setting, there is considerable variety. For example, in many of the Ministry funded Primary Mental Health Initiatives, following an initial diagnosis of 'mild to moderate 'mental disorder, the GP can manage the problem within the existing consultation framework, may apply to the PHO for funded extended GP consultation time, or move up a step (or two) and refer through the mental health coordinator for counselling or clinical psychology time. In other settings the steps are more proscribed with treatment pathways determined by a mental health assessment tool ranking, providing access to stepped care which provides access to clinical psychologist input after a course of drug treatment. These variations on stepped care appear different again from some Kaupapa Māori or Pasifika models where the steps involve initial engagement with community development workers who may then refer directly to psychologists or psychiatrists with specific cultural expertise.

[2] Ministry of Health. 2009. Towards optimal primary mental health care in the new primary care environment: a draft guidance paper. Wellington: Ministry of Health.

Moving from one model to another

Moving between models of care is best undertaken as a process of planned evolution. This can be challenging when compelling drivers of change (such as new funding allocations) are imposed from outside without regard to where you are in your process. Nevertheless it is important to have a medium to long term plan that you are working to. There is a series of important steps to ensure you can make a successful transition.

Steps for evolving a new model of care

1. Define and characterise your current model(s) of care
2. Define and characterise the model you are evolving towards

In these steps you will need to consider the domains listed in Box 1 below, some of which are listed in the Ministry of Health's guidance on moving to stepped care:[3]

3. Identify the five major steps in moving to the new model of care

This may include stopping some aspects of services, reconfiguring some and developing some new services or service components.

4. Identify, classify and manage your key relationships in relation to these major steps *(see Specific Issues Guide: Relationships and communication- create link).*
5. Develop a timeline

To develop the timeline identify the end point and work back. Then identify known internal and external related or unrelated issues that will impinge on the timeline. Adjust the timeline.

6. Identify the resources required, including personnel and funds.
7. Develop the milestones under each major step, and the tasks associated with each milestone. This will include relationship management.

[3] Ministry of Health. 2009. Towards optimal primary mental health care in the new primary care environment: a draft guidance paper. Wellington: Ministry of Health.

Box 1: Domains to be considered when characterising the model you are evolving towards

1) How personalised is the care?
2) What are the inclusion/exclusion criteria and how are these operationalised?
3) What is the service user pathway?
4) What is the process for monitoring clinical outcomes?
5) What is the process for reviewing clinical management?
6) What is the process/mechanism for ensuring the needs of vulnerable groups are met?
7) How does the model ensure appropriate adaptation to local need while staying consistent with the need for regional and national consistency?
8) How does care provision coordinate between primary, secondary and social sectors?
9) Is the model supported by an appropriate IT platform?
10) What resources are dedicated to workforce capacity and capability?
11) How are DHB/PHO/social sector organisations supporting/undermining the model?
12) What are the funding mechanisms and do these support your model of care aspirations?
13) What processes are in place to monitor and improve service performance and quality?

Not a panacea

It is important to remember that any model of care is a device that is used to shape services. No model of care can be a fully defining feature of service provision. For example, there are instances where stepped care may not serve some aspects of service requirements or resource allocation, such as underpinning values-based decisions. An example of this is where you may wish to prioritise service access for some population groups to make equity of outcomes more likely.

'Can Zane work a 40 hour week?'

(click here to go back to guide)

Zane (Kai Tahu, Ngati Toa, Rangitane) is a nurse employed by the PHO to set up a new Kaupapa Māori primary mental health service for people with mild to moderate mental health problems. He has worked in services around the country over the years in both inpatient services and community mental health teams. The PHO role gave Zane and his wife an opportunity to return with their young children to his local area, where his Scottish great-great-grandfather farmed, and re-connect with whānau.

Zane has observed how fragmented and uncoordinated services may mean substandard care for tangata whaiora and has made a personal commitment to providing more holistic, integrated care. He has taken a whānau-centred approach, meaning in practice that most assessments are done at the patient's home and may involve several visits so that a connection can be established with whānau and he can gain an understanding of the full story around the problem. Most of the referrals are for problems in the moderate to severe spectrum, with frequent substance use and physical comorbidity. He also fields requests to see other whānau members, even though they do not have referrals and the cases have not been triaged.

Zane has submitted a request to employ another staff member to work fulltime in his service, as the joint management and clinical role means he is regularly working 50-55 hours per week, and a waiting list is building. The PHO is running two parallel service models: Māori are entitled to extended GP consultations, medication and/or up to four sessions of brief talking therapy in the mainstream service, or extended GP consultations and medication/and or the Kaupapa Māori service. About a fifth of Māori patients using PMHC use the mainstream service and 2% of Pakeha patients use the Kaupapa Māori service.

Zane is about to attend a budgeting meeting with other service managers and Planning and Funding. He is concerned because Māori make up only 9% of the local population and his request will mean he is asking for 25% of the staffing budget for PMHC in his locality. Planning and Funding take Treaty obligations seriously and acknowledge that Zane's work situation is untenable in the long term.

Questions to consider:

How does Zane

1. Argue that the model of care he is providing is good value for money?
2. Support equitable distribution of primary mental health care across the DHB catchment area?