

## Models of Care Policy Framework

### Introduction

NZNO provides professional leadership, advice and support to members in a range of areas relevant to nursing practice. The majority of practising registered and enrolled nurses are members of NZNO (approximately 35,000/49,261 (Nursing Council of New Zealand [Nursing Council], 2012a)), as well as a significant number of students (approximately 3700). NZNO is committed to the representation of all members and the promotion of nursing and midwifery, undertaking significant activity across a range of sectors to ensure the nursing perspective is heard. This document focuses specifically on the regulated nursing workforce – registered and enrolled nurses, and nurse practitioners.

In 2011, NZNO developed a vision for nursing that outlined a future direction for nursing in a range of areas including health sector models of care (Clendon, 2011). The vision stated:

*Innovative and flexible models of care that are person-centred will be developed and evaluated by nurses. Technology, enhanced communication, and new treatment modalities will be utilised to ensure that models of care are appropriate, cost effective and meet the needs of all people. People will be consulted about the models that best meet their needs and nurses will work collaboratively with other health professionals to meet these needs. The principles of whakawhanaungatanga, manaakitanga, rangatiratanga, and wairuatanga<sup>1</sup> will continue to guide professional nursing practice...(p.12)*

One of NZNO's goals following completion of the vision project was to develop specific policy frameworks for each section of the vision. This document outlines NZNO's policy framework on models of care. The policy framework identifies key strategies to guide the organisation's direction in advancing the vision up to and beyond 2020. The policy framework will be reviewed as new information and evidence comes to light.

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<sup>1</sup> See glossary on page 15 for a list of definitions.

## Purpose

The purpose of this document is to:

- > articulate NZNO's commitment to developing effective models of care that include nurses;
- > outline NZNO's vision for models of care based on international and local evidence; and
- > provide steps on how this vision can be achieved.

## Background

The term 'models of care' has seen increasing usage over the past five years, both in nursing and in health generally. Policy documents frequently refer to 'changing models of care' or 'new models of care'. These new models of care are destined to change the face of health care in Aotearoa New Zealand and provide a means of addressing the changing health needs of New Zealanders. But what are models of care, and how are new and changing models of care likely to impact on nursing? A shared understanding of the term will assist nurses and other health professionals define models of care in a way that is relevant to their work.

'Models of care' is a multifaceted concept with no single definition. In essence however, a model of care describes the way in which services are designed and delivered and should:

- have a theoretical basis;
- be underpinned by evidence;
- incorporate defined standards and principles;
- include a framework that provides a structure for implementation and evaluation (Queensland Health, 2000; Davidson, Halcomb, Hickman, Phillips, & Graham, 2006).

The NZNO 'Beyond 2020: a vision for nursing' project (Clendon, 2011) defined both narrower and broader models of care currently in evidence in Aotearoa New Zealand, providing examples of both. Clendon explains the need for future models to focus on the relational aspects of care and whānau ora approaches as a means of moving health care beyond the primarily medical model to meet the changing needs of patients into the future. NZNO also supports models such as those proposed by the Canadian Nurses Association (CNA) which argues for models to place individuals, families and communities first, implement primary health care for all, pay attention to Canadians at risk of falling behind, and invest strategically to improve the factors that determine health (National Expert Commission, 2012). In addition, the CNA recommend the need for ensuring health in all policies, safety and quality in health care, preparing providers educationally and utilising technology to its fullest.

In a rapidly evolving health environment, characterised by growing health inequalities, and an increasingly diverse and ageing population there is near unanimous recognition that current models may not meet future health need and that new approaches are needed. The challenge is in identifying new, evidence-based models, and coordinating the various approaches, ideas, and interventions including any required changes to funding mechanisms, to ensure a cohesive platform for implementation is in place.

## Current Context

### Regulation and standards

Registered and enrolled nurses and nurse practitioners (nurses) are regulated under the Health Practitioners Competence Assurance Act (2003) and are accountable for ensuring all health services they provide are consistent with their education and assessed competence, are within their scope of practice, meet legislative requirements, and are supported by appropriate resourcing. Nurses are also responsible for ensuring that professional standards of nursing practice, such as those outlined in the *Standards of Professional Nursing Practice* (NZNO, 2012) and the Nursing Council of New Zealand's *Code of Conduct for Nurses* (Nursing Council, 2012b) are upheld.

### Regulated nursing workforce

The regulated nursing workforce comprises registered and enrolled nurses, and nurse practitioners. This workforce is supported in its delivery of nursing services by health care assistants (caregivers, practice assistants, kaimahi hauora etc). Nursing remains a predominantly female occupation (93 per cent of the workforce) with New Zealand European ethnicity (68 per cent) being the most commonly identified group among Aotearoa/New Zealand nurses (Nursing Council, 2012a). This gender and ethnic mix does not reflect the composition of the general population or the population groups that more commonly access health care. In particular, Māori men and women make up approximately 15 per cent of the population and have poorer health status than any other group in New Zealand (Ministry of Health, 2012), yet only seven per cent of nurses identify as Māori (Nursing Council, 2012a). Although this figure has increased from 2.7 per cent in 2002 (Nursing Council, 2004) and numbers of Māori health professionals are also increasing with latest census figures showing numbers of Māori working in health care and social assistance increasing from 8.5 per cent to 10 per cent since 2006 (Statistics New Zealand, 2013), action is still required to improve numbers of Māori nurses in the workforce. Pasifika people are similarly underrepresented in nursing, as are men (Nursing Council, 2012a).

Workforce planning for nursing to date has been limited. It has been suggested that a shortage of up to 15,000 nurses will occur by 2035 (Nursing Council, 2013), yet little work has yet been undertaken to consider ways in which this will be addressed. There is significant work being undertaken to improve access to first year of practice placements for new graduate nurses (Online. Available: <http://www.health.govt.nz/our-work/nursing/nursing-initiatives/recruitment-new-graduate-registered-nurses> 27 November 2013). However in the 2013/14 year one in three new graduates were still having difficulty finding jobs (<http://www.stuff.co.nz/national/education/8901561/Nurse-graduates-struggle-to-find-jobs>). This is compounded by the older nursing workforce remaining in, or returning to nursing roles as an outcome of the global financial crisis (North, Leung, & Lee, in press). In order to ensure models of care meet the needs of the population of New Zealand, strategic planning in terms of nursing workforce development is an obvious priority.

### Existing models of care and the evidence to support them

Examples of models of care in nursing include nurse-led clinics, family centred care, the 'recovery model', case management, the restorative model in older adult care, and pre-admission clinics. Broader models of care across the health sector include primary health care as an over-riding approach to health care, general practice, whānau ora, the provision of health care in hospitals or in homes, and the provision of specialist health services in major centres. While there are endless possible approaches to

health service delivery, the following elements appear to be common to those models identified in the literature as most successful:

Models should;

- > be interdisciplinary (where each team member recognises and respects the knowledge and skills other health professionals are able to bring to the care of a patient);
- > involve collaborative teamwork (with the right person providing the right care at the right time at the right place to the right person);
- > be patient-centred;
- > consult and engage end users, clinicians, managers, and key stakeholders throughout the development and application of any model;
- > be robustly evaluated; and
- > have strong organisational commitment

(Cooper et al., 2012; Germain & Cummings, 2010; King et al., 2011; Kruis, et al., 2013; Mead & Bower, 2000; Munn, Tufanaru, & Aromataris, 2013; Petri, 2010; Reeves, et al., 2013; Schmied et al., 2010; Smith, Allwright, & O'Dowd, 2007; Wong & Cummings, 2007; WHO, 2008; Zwarenstein, Goldman, & Reeves, 2009).

## Principles of models of care

Recent qualitative research by Clendon (2013) exploring nurse perceptions of models of care identified a set of core principles against which to measure development, implementation and evaluation of models of care from a nursing perspective. These principles form the basis of the policy recommendations in this document and are as follows:

- > maintaining the person at the centre of health care;
- > facilitating cultural competence (including cultural safety), biculturalism and a commitment to te Tiriti o Waitangi;
- > enabling Māori-centred approaches to models of care
- > ensuring the provision of accessible, quality, evidence-based health care;
- > providing mechanisms for enabling interdisciplinary practice;
- > clarifying roles and responsibilities between health professionals;
- > enabling the provision of nurse-led care;
- > facilitating nurse leadership and authority across the sector;
- > ensuring health professionals have appropriate education and skills to sustain change;
- > developing effective communication strategies throughout the sector;
- > focusing on primary health care as an overriding approach to health improvement;
- > maintaining a healthy awareness of the risks associated with the business model (where the business model is broadly defined as an approach to health care that integrates business ownership, targets, productivity, and fiscal prudence).

Further information on the research underpinning this policy document is available at [www.nzno.org.nz/resources/nzno\\_publications](http://www.nzno.org.nz/resources/nzno_publications).

# Policy statements

## A primary health care approach to health

NZNO supports an approach to healthcare that is founded on the premise of primary health care in all settings.

### Rationale

A primary health care approach to health care encompasses the following principles: achieving equitable social circumstances and equal access to health care for all; achieving community empowerment through public participation in all aspects of life; the promotion of healthy social and structural conditions for good health (the social determinants of health); cultural sensitivity and cultural safety; health literacy; intersectoral collaboration; health promotion and illness prevention (McMurray & Clendon, 2011). A primary health care approach should not be limited to community settings and is not just about first point of contact care, but is an approach that should be used in all settings to support patients and their families to lead healthy lives. This approach is supported strongly in the literature with the World Health Organisation originally proposing primary health care as key to improving population health with the signing of the Declaration of Alma Ata in 1978. In 2008, the World Health Organisation reiterated the importance of primary health care as an overriding strategy and approach to improving health (WHO, 2008). The Canadian Nurses Association (CNA) also supports models that are founded on a primary health care approach (National Expert Commission, 2012).

Feedback from nurse: *A primary health model of care is more likely to be helpful to the teenager who drinks and smokes and consumes excessive caffeinated beverages, engages in unprotected sex and is in hospital with appendicitis than the medical model.*

### Action points

#### Members

- > learn how a primary health care approach to practice can be incorporated into every day nursing practise;
- > take steps individually and within the workplace to implement a primary health care approach to practice.

#### NZNO

- > Advocate for a primary health care approach in all health care delivery settings.

#### Education providers

- > Develop curricula that are based on a primary health care approach to health care delivery.

#### District Health Boards and other employers

- > Embed a primary health care approach to health care delivery in all settings e.g. broaden acute care practitioners health care focus to encompass assessment of

- the social determinants of health, preventative screening and intervention, and appropriate referral and support;
- > direct staff to assess patients and their family whānau utilising a primary health care approach and monitor to ensure this is happening;
  - > ensure sufficient funding and staffing is present to enable appropriate support to be offered to patients and their family whānau.

Ministry of Health

- > Focus policy on primary health care as the core approach to health care in Aotearoa New Zealand.

## Person-centred health care

NZNO supports models of care that are person-centred and responsive to patient needs, with funding that is specific to the individual (and their family whānau where relevant).

### Rationale

Person-centred health care involves creating a culture that accepts people for who they are and where they are at in their life. Person-centred health care is about including the patient in their own care, respecting a person's ability to make decisions about the care they receive, and ensuring care is respectful and responsive to individual preferences. Person-centred health care can be as simple as sitting and listening to a person and focusing on their needs rather than focusing on the tasks that need to be done, or as complex as involving them in a quality improvement process. Models of care should be designed *with* patients, not designed *for* patients.

*Example: When a nurse at Auckland City Hospital's oncology day stay unit found out that one of his patients was scheduled to receive chemotherapy on her wedding anniversary, he asked the woman and her husband what song they'd first danced to on their wedding day. It was 'Save the last dance for me'. The next day, on completion of the patient's six hour infusion, the song began to play.*

Person-centred health care (also known as patient-centred care) is widely understood to contribute to improved patient-reported outcomes, improved communication, greater satisfaction with care, and improved biomedical outcomes (Cooper et al., 2012; Jayadevappa & Chhatre, 2011; Wilson, 2008). It is characterised by a number of key dimensions that differ from the biomedical model including the incorporation of a bio-psychosocial perspective; seeing the 'patient-as-person'; sharing power and responsibility; therapeutic engagement between professional and patient with the goal of alleviating vulnerabilities; and acknowledgement of the 'professional as person' component of the patient-professional relationship (Hobbs, 2009; Mead & Bower, 2000).

## Recommended actions

### Members

- > Understand what patient-centred care entails and implement this into everyday practice.

### NZNO

- > Advocate for patient-centred approaches to models of care in policy documents, statements, and in practice;
- > advocate for improved measurement and understanding of patient health needs, including mental health and its effect on physical health and vice versa.

### Education providers

- > Focus nurse education on the person, relational care, and other elements relevant to person and whānau-centred care;
- > strengthen the teaching and integration of mental health across the curriculum.

### District Health Boards and other employers

- > Ensure development and implementation of new models are person-focused;
- > ensure development of new models occurs in collaboration with nurses, other health care professionals and recipients of care.

### Ministry of Health

- > Develop funding mechanisms that enable funding to be person-centred – consideration could be given to roll out of individualised funding to those with chronic long term conditions such as that occurring in the disability sector (e.g. Manawanui individualised funding support: <http://www.incharge.org.nz>).

## Quality in health care

NZNO supports models of care that are built on collective feedback and evidence, and are underpinned by quality and safety.

## Rationale

Quality care is inextricably linked with patient outcomes and is achieved when patients, providers, health professionals and systems work in harmony to ensure optimal health outcomes at all stages of a patient's journey through the health system. In New Zealand, the Health Quality and Safety Commission (HQSC) oversees quality of care in the health sector and is mandated by legislation to regularly publish a set of quality indicators (HQSC, 2012). The Triple Aim outcomes summarise the goals of the New Zealand health sector: improved quality, safety and experience of health care; improved health and equity for all populations; and best value from public health system resources (HQSC, 2012). Achieving quality is a continuous process and nurses have a core role at all levels – system, individual and community.

## Action points

### Members

- > Make quality and safety an everyday priority as an individual and throughout the workplace;
- > Integrate evidence-based practice into your own practise.

### NZNO

- > Advocate for models of care built on evidence and underpinned by quality in policy documents and statements;
- > advocate for nurse engagement with development of new or evolving models of care;
- > advocate for appropriate engagement where new or evolving models of care include change of employer or conditions of work.

### Education providers

- > Enable students to understand quality and its links to nursing practice;
- > continue to build student understanding of evidence-based practice and how this applies to models of care and health system delivery as well as individual care.

### District Health Boards and other employers

- > Ensure models of care are evidence-based, with built in mechanisms for ensuring quality;
- > ensure new models of care are robustly evaluated and that this is built into implementation plans.

### Ministry of Health

- > Ensure an evaluation component is built into all new models of care and is properly resourced.

## Interdisciplinary practice

NZNO strongly supports interdisciplinary practice as a core element of care provision.

## Rationale

Interdisciplinary practice (also known as interdisciplinary or interprofessional collaboration) is described as an interpersonal process characterised by healthcare professionals from multiple disciplines with shared objectives, decision-making, responsibility, and power working together to solve patient care problems (Petri, 2010). Each professional brings to a practice setting knowledge grounded within their own discipline but with sufficient knowledge and awareness of the other disciplines within the group to recognise and respect where intervention can be shared, delegated, transferred or retained in order to obtain maximum benefit for the patient and their family whānau. Interdisciplinary practice has been identified as one of the most effective approaches to chronic condition management (Boult, et al., 2009), and as a contributor to improvements in patient care, decreased length of hospital stay and decreased costs of hospital stay (Zwarenstein, Goldman, & Reeves, 2009). In order for

interdisciplinary practice to be effective, interprofessional education, interpersonal relationship skills, role awareness and institutional support must be present (Munn, Tufanaru, & Aromatis, 2013; Petri, 2010).

*Case study: When Tom was admitted to the hospital for the third time with a chest infection as a consequence of a complex medical condition, the public health nurse called a case conference with mum, dad, grandma, grandad, Tom, the paediatrician, paediatric outreach nurse, community support worker, social worker, and teacher at Tom's house. The whole group worked together to pull together an action plan to get Tom well and back to school. Because every member of the group knew the skills and capabilities of each other member, and trusted each to do what was needed, Tom has not required hospitalisation since.*

### **Action points**

#### Members

- > Develop an understanding of interdisciplinary practice and take steps to integrate this in your workplace.

#### NZNO

- > Advocate for interdisciplinary approaches to models of care in policy documents and statements.

#### Education providers

- > Promote interdisciplinary/interprofessional education programmes at all levels;
- > develop infrastructure to support interdisciplinary/interprofessional education programmes at all levels.

#### Regulators

- > Promote dual scopes of practice where practical and desirable eg. registered nurse and registered anaesthetic technician;
- > collaborate on common requirements eg. IELTSs, cultural competence, practise standards for procedures undertaken by multiple registrants.

#### District Health Boards and other employers

- > Promote interdisciplinary/interprofessional education opportunities at all levels and develop infrastructure to support this;
- > require and support health professionals to complete a certain number of hours of interdisciplinary education per year;
- > monitor health professional engagement with interdisciplinary practice (anonymous surveys, implementation of remedial action by the employer for non-completion of required hours);
- > monitor outcomes of interdisciplinary practice;
- > continue to develop interdisciplinary networks to support remote nursing practice.

#### Ministry of Health

- > Ensure requirements for interdisciplinary practice and teamwork are written into specifications and contracts;

- > ensure sufficient funding is available on an ongoing basis to support DHBs to enable interdisciplinary practice.

## Health professionals practising to the full extent of their scope

NZNO supports models of care that enable health professionals to practise to the full extent of their scope of practice while maintaining a clear understanding of their role, responsibilities and accountabilities, and a commitment to collaborative practice.

### Rationale

Health professionals practising at the top end of their scope are maximising their education and knowledge for the benefit of patients. In relation to nurses, there is evidence that registered nurses, clinical nurse specialists, and nurse practitioners practising at the top end of their scopes of practice reduce mortality, reduce length of stay, improve patient function at discharge, improve knowledge of medicines management among patients, improve patient satisfaction, and reduce frequency of nurse-sensitive patient outcomes such as pressure ulcers (Butler, et al., 2011; Doran, et al., 2006; Glasson, et al., 2006). In addition there is substantial evidence to support the safety and efficacy of nurse-led care across all health care settings (see for example: Boulton, et al., 2009; Glynn, et al., 2010; Griffiths, et al., 2007; King, Boyd, Carver, & Dagley, 2011; Kuethe, et al., 2013; Laurant et al 2004/2009; Parker, et al., 2012; Peri, Boyd, Foster, & Stillwell, 2013; Schadewalt & Schultz, 2010; Wilkinson, Carryer, Adams, & Channing-Pearce, 2011).

Increasing health care costs and enabling all health professionals to practice at the top of their scope, means some traditional roles and responsibilities may need to be forgone. Ensuring the right practitioner is doing the right intervention with the right patient at the right time is essential and RNs may need to move their focus from 'caring for' to 'caring about' patients. In future, RNs need to be managing the whole patient journey, undertaking effective direction and delegation where required, ensuring that all care provided is compassionate, of high quality and completed in a timely and appropriate manner, while remaining accountable for patient care.

### Action points

#### Members

- > Maintain clarity regarding role, responsibilities and accountabilities;
- > Commit to collaborative practice with colleagues.

#### NZNO

- > Advocate for models of care that enable health practitioners to practise at the top of their scope;
- > lead debate on the changing practice of RNs and their relationship to clinical nurse specialists, enrolled nurses and health care assistants.

#### Education providers

- > Focus on ensuring health practitioners are able to reach competence in direction and delegation;
- > focus on education that enables nurses to manage the whole patient journey in collaboration with other health professionals;

#### District Health Boards and other employers

- > Identify and implement evidence-based models of care that support health practitioners to practise at the top of their scope;
- > monitor health entities (PHOs, hospital units etc) to ensure all health practitioners are enabled to practise at the top of their scope, and teams are working collaboratively;
- > ensure adequate monitoring and evaluation of the links between practise and patient outcomes;
- > remove functional barriers to health practitioners practising at the top of their scope;
- > ensure the enrolled nurse role is included in models of care and that enrolled nurses are enabled to practise at the top of their scope.

#### Ministry of Health

- > Remove legislative, functional, funding and contractual barriers to health practitioners practising at the top of their scope;
- > recognise and acknowledge the health professional as an asset not a cost (poorly staffed and unhealthy workplaces where staff are unable to practise at the top of their respective scopes result in greater costs through increased length of stay, higher mortality, increased medication errors);
- > implement care capacity demand management using a statistically validated tool (Trendcare) in all District Health Boards;
- > continue to undertake evaluative and economic research into the cost/benefit ratio of safe staffing and healthy workplace principles.

### Leadership and authority

NZNO supports effective leadership throughout the health sector and believes nurses are experts in patient care delivery systems whose voice and experience must be heard at all levels and across all disciplines.

#### Rationale

Nursing leadership is considered ‘...critical for implementing evidence-based, ethical practice and promoting optimal patient outcomes’ (Davidson & Sindhu, 2014, p.234). A systematic review examining the relationship between nursing leadership and patient outcomes found a range of positive outcomes associated with effective nursing leadership including: improved patient outcomes, significantly reduced patient adverse events and complications; an association between effective leadership and decreased mortality rates (Wong & Cummings, 2007). There is also strong evidence that effective nursing leadership improves nurses’ productivity and performance in the workplace (Germain & Cummings, 2010) and contributes significantly to a positive working environment (Tomey, 2009). This link to a positive working environment is particularly important, as it has been clearly demonstrated that such an environment is strongly associated with lower patient mortality and failure to rescue in acute care environments (Aiken, et al., 2008).

#### Action points

##### Members

- > Demonstrate effective leadership on a daily basis.

## NZNO

- > Advocate for, and model, effective nurse leadership at all levels.

## Education providers

- > Ensure education on leadership and management is made available to nurses and students of nursing at all levels – both as separate courses and embedded within other courses.

## District Health Boards and other employers

- > Undertake affirmative action to ensure nurses are involved in planning and decision-making at all levels and throughout the health sector;
- > identify leaders within health organisations and provide opportunities for them to be involved in robust planning and decision-making at all levels and throughout the health sector.

## Regional Hubs

- > Develop and offer appropriate leadership courses for all health practitioners with affirmative action to ensure participation by nurses.

## Ministry of Health

- > Fund training programmes including post graduate education for nurses in leadership and management;

## Communication and integration

NZNO supports models of care that are founded on effective communication between consumers, health professionals, organisations, providers and funders, and that integrate services throughout the sector.

## Rationale

Effective communication is essential for achieving effective interdisciplinary practice, integrated care, and improved health outcomes (Sargeant, MacLeod & Murray, 2011). It is underpinned by effective use of information technology including integrated IT support, IT access, IT training and telehealth. Telehealth or telemedicine is the use of telecommunications technology for medical diagnosis and care (Currell et al., 2000) and is noted as particularly useful in rural contexts (Moffatt & Eley, 2010). There is growing evidence of the usefulness of telehealth with reports that usage improves access to healthcare for patients and improved professional development for health professionals (Moffatt & Eley, 2010). In addition, information technology is being increasingly used as a health intervention, with examples such as online cognitive behavioural therapy and mindfulness training for young people showing good outcomes (Merry et al., 2012; Monshat et al., 2011).

Integrated care is a type of service delivery that ensures seamless transition for users between services along with co-ordinated care between providers involved in the care of the user (Cumming, 2011). Providers may include not only health services but housing, income, justice and social services providers as well, with the ultimate goal of true integration across sectors and intersectoral collaboration. There is evidence of some success in integrated care in New Zealand.

The Canterbury District Health Board has undertaken significant work toward developing and implementing a health service plan that is focused on integrating care across sectors and can demonstrate that it has low rates for acute medical admissions compared to other health boards in New Zealand, a low average length of stay for medical cases and a low acute readmission rate (Timmins & Ham, 2013). One of the primary elements of the Canterbury approach is the recognition that clinicians are at the core of the initiative and this has improved engagement with those who are using and implementing the various elements of the initiative. Internationally, integrated care models show improved outcomes for people with chronic disease (Kruis et al., 2013) and those that incorporate care pathways reduce in-hospital complications, decrease length of stay and reduce hospital costs (Rotter et al., 2010).

### **Action points**

#### Members

- > Ensure communications are inclusive and extensive at all levels;
- > Commit to integrating information technology in your everyday practice.

#### NZNO

- > Advocate for models of care founded on good communication;
- > use language that refers to integration rather than separation;
- > advocate for access for all health professionals to appropriate IT infrastructure including training and support.

#### Education providers

- > Promote good understanding of a whole of system delivery approach to health care;
- > consider, in collaboration with providers, effective communication strategies that promote greater interdisciplinary practice and integration;
- > ensure use of IT is built into all education programmes.

#### District Health Boards and other employers

- > Remove administrative, contractual and funding barriers to integrated care;
- > ensure funding follows devolved services and that those who receive care in different locations are not disadvantaged by cost;
- > refrain from referring to, funding, or providing health care as primary or secondary; referring only to health care or health care delivery;
- > ensure equitable access for all health practitioners to effective IT infrastructure including training and support.

#### Ministry of Health

- > Refrain from referring to, funding, or commissioning health care as primary or secondary; referring only to health care or health care delivery (as mentioned in policy statement one of this document, primary health care is not just about first point of contact care or care provided in the community);
- > examine the potential for removal of ring-fenced funding provisions and enable DHBs to distribute funding based on ensuring the right care to the right person by the right professional at the right time in the right place.

## Cultural competence

NZNO supports the development of culturally competent organisations and health practitioners.

### Rationale

Culturally competent care is about the health practitioner or organisation's capacity to improve health status by integrating culture (in its broadest sense) into the clinical context (Durie, 2001). The development of new models of care provides an ideal opportunity for organisations to commit to cultural competence as a primary organisational principle and build toward becoming a culturally competent organisation. Culturally competent health systems acknowledge diversity, provide culturally appropriate and culturally safe care, enable self-determination and reciprocity, hold governments and health planners accountable for meeting the needs of all cultures, base care on a culturally competent evidence-base and recognise the need for cultural competence training (McMurray & Clendon, in press). In order for an organisation to achieve cultural competence in New Zealand, there needs to be an acknowledgement that most people receive care from mainstream providers and have a right to receive culturally safe care in this environment.

### Action points

#### Members

- > Commit to ongoing education on cultural safety and cultural competence;
- > Hold your colleagues and organisation to account for their actions and behaviours.

#### NZNO

- > Continue to develop as a culturally competent organisation, demonstrating best practice in cultural competence awareness and training for staff.

#### Education providers

- > Continue to develop culturally safe practitioners with sound knowledge of cultural competence and its broader application to health delivery systems.

#### District Health Boards and other employers

- > Articulate commitment to cultural competence in strategic and annual planning processes;
- > provide appropriate training for all staff to become culturally competent;
- > monitor and evaluate achievement of cultural competence at an organisational and individual level.

#### Ministry of Health

- > Articulate commitment to cultural competence in strategic and annual planning processes;
- > provide incentives for DHBs to achieve culturally competent organisations and monitor outcomes.

## Biculturalism and te Tiriti o Waitangi

NZNO supports models of care that demonstrate commitment to biculturalism and te Tiriti o Waitangi.

### Rationale

Biculturalism can be understood as two distinct cultures in some form of co-existence. In New Zealand, this can be understood and enacted as a Māori-Pakeha partnership (Jones & Creed 2011). This partnership is considered equal, not a case of majority membership – thus although Māori may constitute 15% of the population of New Zealand, a true bicultural partnership does not see 15% of governance held by Māori, but 50%. In essence, a bicultural organisation is one that recognises the ideal of equal partnership in governance. Te Tiriti o Waitangi provides the foundation for biculturalism in New Zealand and sets the parameters around partnership, participation and protection for Māori at all levels.

### Action points

#### Members

- > Work toward understanding and implementing biculturalism in your workplace.

#### NZNO

- > Advocate for the development of models of care that demonstrate commitment to biculturalism and te Tiriti o Waitangi.

#### Education providers

- > Ensure provision of education that enables health practitioners to recognise and understand the importance of biculturalism and commitment to te Tiriti o Waitangi.

#### District Health Boards and other employers

- > Ensure development of new models of care include commitment to biculturalism and te Tiriti o Waitangi.

## Mātauranga Maori

NZNO supports models of care for Māori that are based on Māori-centred approaches to health care service delivery.

### Rationale

By Māori, for Māori health services along with mainstreamed kaupapa Māori health services are strongly supported in the literature as a means of addressing disparities in Māori health status. Such Māori-focused health services recognise and implement a Māori-centered approach to health care (kaupapa Māori services), and have been demonstrated as effective in reaching Māori whānau (Hamerton, et al., 2012; Ministry of Health, 2006; Oda & Rameka, 2012). These services also address the need for holistic approaches based on Māori ways of knowing (Mātauranga Māori) and are responsive to the primary health care principle of intersectoral collaboration, providing access to a breadth of services that span housing, research, crime prevention, education, welfare and health (Oda & Rameka, 2012). Kaupapa Māori health providers

not only improve access to affordable and accessible health care for Māori, they also contribute to the economic wellbeing of Māori communities and the Māori workforce (Ministry of Health, 2009).

### **Action points**

#### Members

- > Build knowledge of kaupapa Māori health services and refer to these where appropriate.

#### NZNO

- > Articulate support for models of care for Māori that are based on Māori-centred approaches to health care service delivery.

#### District Health Boards and other employers

- > Demonstrate support for models of care for Māori that are based on Māori-centred approaches to health care service delivery.

#### Ministry of Health

- > Provide appropriate funding for the development and staffing of models of care that are based on Māori-centred approaches to health care service delivery.

DRAFT 2

## Glossary

Kaupapa Māori	Māori ideology - a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society.
Manaakitanga	Goodwill - a commitment to working together within an environment of trust, respect and generosity towards each other. Recognising and understanding the capabilities and constraints each party brings to the relationship (Te Puni Kokiri, 2006)
Mātauranga Māori	Māori knowledge and the body of knowledge originating from Māori concepts including the Māori world view and perspectives, Māori creativity and cultural practices, including language and traditional and environmental knowledge.
Rangatiratanga	Sovereignty, right to exercise authority, leadership
Wairuatanga	Spirituality, recognition and valuing of spirituality
Whakawhanaungatanga	Process of establishing relationships
Whānau	Family
Whānau ora	An inclusive interagency approach to providing health and social services to build the capacity of all New Zealand families in need. It empowers whānau as a whole rather than focusing separately on individual family members and their problems ( <a href="http://www.tpk.govt.nz/en/in-focus/whanau-ora/">http://www.tpk.govt.nz/en/in-focus/whanau-ora/</a> ).

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#### **Mission statement**

NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

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