Is the Canterbury Partnership Community Health Worker project fulfilling its original
intention?

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Abstract

The original intention for the Partnership Community Worker (PCW) project in 2006 was for it to be an extension of the Pegasus Health General Practice and furthermore to be a bridge between the community and primary healthcare. It was believed that a close working relationship between the Practice Nurse and the PCW would help the target population of Māori, Pacifica and low income people to address and overcome their perceived barriers to healthcare which included: finance, transport, anxiety, cultural issues, communication, or lack of knowledge.

Seven years later although the PCW project has been deemed a success in the Canterbury District Health Board annual reports (2013-14) and community and government agencies, including the Christchurch Resettlement Service (2012), many of the Pegasus Health General Practices have not utilised the project to its full extent, hence the need for this research.

I was interested in finding out in the first instance if the model had changed and, if so why, and in the second instance if the promotional material currently distributed by Pegasus Health Primary Health Organisation reflected the daily practice of the PCW. A combination of methods were used including: surveys to the Pegasus Health General Practices, interviews with PCWs, interviews with managers of both the PCW host organisations and referring agencies to the PCW project. All the questions asked of all the participants in this research were focussed on their own perception of the role of the PCW.

Results showed that the model has changed and although the publications were not reflecting the original intention of the project they did reflect the daily practice of the PCWs who are now struggling to meet much wider community expectations and needs.

Key Results:

Partnership Community Worker (PCW) interviews: Seventeen PCWs of the 19 employed were interviewed face to face. A number expressed interest in more culturally specific training and some are pursuing qualifications in social work; for many pay parity is an issue. In addition, many felt overwhelmed by the expectations around clients with mental health issues and housing issues now, post-earthquakes.

Medical Practice surveys: Surveys were sent to eighty-two Pegasus Health medical practices and of these twenty five were completed. Results showed the full capacity of the PCW role was not clearly understood by all with many believing it was mostly a transport service. Those who did understand the full complexity of the role were very satisfied with the outcomes.

PCW Host Community Manager Interviews: Of the ten out of twelve managers interviewed, some wished for more communication with Pegasus Health management because they felt aspects of both the PCW role and their own role as managers had become blurred over time.

Referring organisations: Fifteen of the fifty referring community or government organisations participated. The overall satisfaction of the service was high and some acknowledged the continuing need for PCWs to be placed in communities where they were well known and trusted.

Moreover results also showed that both the Canterbury earthquakes 2010-2011 and the amalgamation of Partnership Health PHO and Pegasus Health Charitable Limited in 2013 have contributed to the change of the model. Further future research may also be needed to

examine the long term effects on the people of Canterbury involved in community work during the 2011-2014 years.

Glossary of terms

Bio-medical model: A conceptual model of illness that excludes psychological and social factors and includes only biologic factors in an attempt to understand a person's medical illness or disorder (MediLexicon, 2006). (While this term is often referred to there is technically no such term- and it is a biological model).

Community Health Worker (CHW): A paid or unpaid member of the community who assists the public to access healthcare or educate or promote healthcare.

General Practice: The General Practice is a clinical specialty oriented to primary healthcare. It is a first level service focussing on maintaining, restoring and co-ordinating a patient's health. This is generally in collaboration with other health and community agencies.

Iwi: a tribe or family group.

General Practitioner (GP): A qualified medical graduate with particular knowledge and skills to provide personal, family, Whānau and community oriented comprehensive primary healthcare which is not limited by the age, sex, religion or social circumstances of their patients.

Mana whenua: the historical occupiers of areas of land.

Māori: Indigenous people of Aotearoa New Zealand

Marae: The courtyard in front of the Wharenui (meeting house) or more commonly the whole gathering place is referred to as the marae

Missing out populations: Those identified by the Canterbury District Health Board (CDHB) in this report as individuals or populations not accessing primary healthcare.

Nurse Practitioner: In addition to Registered Nurse responsibilities, the Nurse Practitioner has the authority to prescribe some medications.

Pacifica: The people of the Pacific Islands who have migrated to Aotearoa New Zealand.

Pākehā: Europeans who settled in Aotearoa New Zealand from the 19th century onwards.

Partnership Community Worker (PCW): The name Partnership Community Worker, as referred to in this report, was chosen for those CHWs employed for this initiative as not only were these CHWs partnering with the Pegasus medical practices but also partnering with the community.

Pegasus Health Charitable Ltd.: A group of General Practices acting as a Primary Health Organisation (PHO) in Canterbury, New Zealand.

PHO: Primary Health Organisations in

 Aotearoa New Zealand, are healthcare providers that are funded on a capitation basis by the New Zealand government by a district health board. They are usually set up as not-for-profit trusts their goal being the improvement of a local population's health.

Practice Nurse: A Registered Nurse who is usually attached to a medical practice. Daily tasks may include vaccinations, taking blood, cervical smears, and providing more social interaction with the patients than the General Practitioner (GP) may have time for.

Primary Healthcare: Primary healthcare is a scientifically based essential healthcare system accessible to individuals and families within the community and is concerned with addressing social and environmental determinants of people's health.

Socioeconomic (wider) determinants of health: The range of personal, social, cultural and environmental factors which determine an individual or populations health status.

Whānau: family or extended family groupings

Whare: house/home

Chapter 1: Introduction

In 2006 the World Health Organisation (WHO) report identified as a research priority, assessing the feasibility of successfully engaging Community Health Workers (CHWs), also known in some places as Health Navigators, in low income multicultural communities to reduce the incidence of unmet health needs. The sought outcome was to find a way to overcome perceived barriers, and also to provide solutions for better access to primary healthcare. WHO recognises that the causes or influences on a person's health and wellbeing are a combination of factors and because many of these factors are beyond the control of the individual it is unfair to give credit (good or bad) to them for their individual health. WHO suggest that the following influences are the main determinants of health:

- Income and social status

- Education

- Physical environment

- Social support networks

- Culture/ethnicity/spirituality

- Genetics

- Health services

- Gender

WHO (2011) considers that these inequities in health are avoidable but because of people's individual circumstances of where they live, grow, and age, as well as the political and cultural influences on them, they are not always in a position to change their health outcomes. For this

reason they may need an intervention, such as the CHW programme (WHO, 2002). WHO also recognises that health interventions are not a sustainable answer to the problem, and for example, that poverty or poor housing can best be addressed by addressing the issue of poverty rather than the symptoms of poor health. However the political forces in most countries that determine the gap between rich and poor. A history that involves colonisation or ethnic cleansing leaves long term detrimental effects for the populations who have been victimised to have to overcome (Harris et al., 2012).

The research that is the subject of this thesis is focused on the Partnership Community Workers employed by Pegasus Health Charitable Limited, (hereafter, Pegasus Health), in Canterbury, Aotearoa New Zealand. The PCW initiative is designed to assist the same low income multicultural communities that were identified by WHO, and this study is aimed at determining the full nature of the role of the PCW, as well as the implications for PCWs, not only in the communities they serve, but also for the current PCW workforce in Canterbury.

The 2011-2012 New Zealand Health Survey identified the population with the most health need in the Aotearoa New Zealand context as being Māori, Pacifica, or low income (Ministry of Health, 2013). This population is reported as accessing healthcare the least, with Māori having 1.5 times higher unmet health needs than non-Māori, and in the overall Aotearoa New Zealand population as one in seven adults had healthcare needs that were not met by the primary care service during that year. The New Zealand Health survey statistics mention cost, transport and availability of service as being the main reasons for unmet needs to primary healthcare which could suggest that although the services are available to all, some of the community are missing out. In his 1971 Inverse Health Law, Hart suggested that those who need healthcare services

most are often the ones who access it the least. There is little to suggest that much has changed in forty years. Although it is the intent that the New Zealand Healthcare system is freely available to all it appears that those people missing out include Māori, Pacifica, and those on low incomes. Consideration must also be given to the refugee and migrant community in Christchurch which has been identified by the Canterbury District Health Board (CDHB, 2013) as another of the groups who miss out on services. The following provides a context for what the CDHB refer to as "missing or missing out populations".

1.1 Māori Health

In the Māori Health Plan (2012, p.3) produced by the Canterbury Clinical Network the number of people in Canterbury enrolled with a General Practice team is quoted as over 483,000 (Māori Health Plan, 2012) with 6.6% of those identifying as Māori (Statistics New Zealand,2013). Ngai Tahu/Kai Tahu is the main iwi (tribal) affiliation, the mana whenua (people of the land) in Canterbury. Other iwi affiliations include Ngati Porou and Nga Puhi from North Island regions although many of the 120 other iwi in Aotearoa New Zealand are also represented in Canterbury. It is noted that the health status of Māori in Canterbury is better than Māori nationally, but it is still worse than non-Māori (Ministry of Health, 2013). Reference is also made to the fact that Canterbury, like the rest of Aotearoa New Zealand has a youthful Māori population with 52% under 25 years of age. (Ministry of Health, 2013, p.3). Linkages can also be made to fertility rates among Māori being higher than non-Māori, which suggests that this is a growing population with potentially higher healthcare needs than the rest of the population, and they will therefore require extra support and resources to help overcome perceived barriers to available healthcare. The same report also outlines the following as necessary considerations for the plan to be effective:

- Relationships

- Strengthening services for Māori

- Workforce development

- Innovation

The report also identifies the Māori community, Primary Care environment, Māori providers, Social Service environment, as well as local and national Government as the key stakeholders to ensuring a better health outcome for Māori. It continues and notes that Te Kahui O Papaki Ka Tai, which is a combined group of primary care organisations, clinicians, community representatives, Māori health providers, and Government will be kaitiaki (overseeing and monitoring) the progress of the three year health plan, and will also provide strategic advice in the areas of:

- Treaty of Waitangi – Te Tiriti O Waitangi (1840), based relationships

- Poor general understanding of the Iwi-Crown relationships with the health sector

- Underdeveloped relationships between General Practice and Māori health providers

- Māori represent 14% of the Aotearoa New Zealand population with a younger and distinct age structure

- High number of Māori families living in socioeconomic deprivation

- High number of Māori families emigrating

Whilst there may be a poor general understanding by health providers of the Māori cultural approach to health it is also true that not all Māori have poor health outcomes and, therefore, consideration as to strategy needs to be exercised. The complexities of the differences between rural and urban statistics for Māori have the potential to produce results which do not necessarily

represent the reality of the many Māori, who are living a lifestyle that is comparable to their Pākehā counterpart (migrants of European ethnicity who settled in Aotearoa New Zealand from the 19th century) (Consedine, 2012). For example, to suggest that all Māori be given access to funding that is aimed at low income, Māori, and Pacifica populations may not be appropriate. Apart from the PCW project, which has an alliance to the Te Whare Tapa Wha, Whānau Link is another service provided by the CDHB which has as its focus helping the at risk Māori who are not accessing primary healthcare. This service is based on the Whānau Ora approach. (Māori Canterbury Primary Healthcare Report, 2011-2012).

The Whānau Ora Tool in the context of other strategy and planning documents

Macro variables impacting on health outcomes are recognised in a number of policy and strategy documents that have informed the development of this Tool.

The Whānau Ora Tool is designed to assist organisations to give effect to the policies and strategic pathways woven into He Korowai Oranga: Māori Health Strategy 2002. It can be applied at national, regional and local programme or project levels to enhance the effectiveness of health programmes for Māori.

The actions identified in the tool support the four pathways for achieving whānau ora described in He Korowai Oranga. The pathways that guide the activity in this tool are as follows:

He Korowai Oranga

Overall Aim — Whānau Ora

Directions — Māori Aspirations and Contributions / Crown Aspirations and Contributions

Key Threads — Rangatiratanga / Building on the Gains / Reducing Inequalities

Pathways — Whānau, Hapū, Iwi, Māori Community Development / Māori Participation / Effective Service Delivery / Working Across Sectors

PATHWAY ONE Development of whānau, hapū, iwi and Māori communities	The Crown will work collaboratively with whānau, hapū and iwi and Māori communities to identify what is needed to encourage health as well as prevent or treat disease. This includes supporting whānau development and participation in both te ao Māori and wider New Zealand society, to improve health and wellbeing.
PATHWAY TWO Māori participation in the health and disability sector	The goal is active participation by Māori at all levels of the health and disability sector in decision-making, planning, development and delivery of health and disability services. This pathway supports Māori provider and workforce development.
PATHWAY THREE Effective health and disability services	This pathway aims to ensure that whānau receive timely, high-quality, effective and culturally appropriate health and disability services to improve whānau ora and reduce inequalities.
PATHWAY FOUR Working across sectors	This pathway directs the health and disability sectors to take a leadership role across the whole of government and its agencies to achieve the aim of whānau ora by addressing the broad determinants of health.

Figure 1: The Whānau Ora Tool in the context of planning and other documents (Ministry of Health, 2011)

1.1.1 Māori Healthcare.

Ehara taku toa he toa taki tahi engari he toa take tini

Progress is not made alone but by many striving as one (Maori proverb, n.d.)

1.1.1.1 Te Whare Tapa Wha Model of Health.

In 1982 Mason Durie developed the Te Whare Tapa Wha model of health which has subsequently become widely used and recognised in the Aotearoa New Zealand Public Health and socioeconomic setting, (Durie, 1999). The main concept of the Te Whare Tapa Whā, model is the four cornerstones (sides) of Māori health. With its strong foundation and four equal sides, the symbol of the wharenui illustrates the four dimensions of Māori wellbeing. Should one of the four dimensions be missing or in some way damaged, a person, or a collective, may become unbalanced and subsequently unwell.

For many Māori modern health services, which focus on *Tinana* (physical health), the recognition of *Taha Wairua* (the spiritual dimension) is missing. In a traditional Māori approach, the inclusion of the Wairua, the role of the *Whānau* (family) and the balance of the *Hinengaro* (mind) are as important as the physical manifestations of illness (Pollock, 2014). The Māori view of health and gives a clear description of a holistic approach to the wider determinants of health.
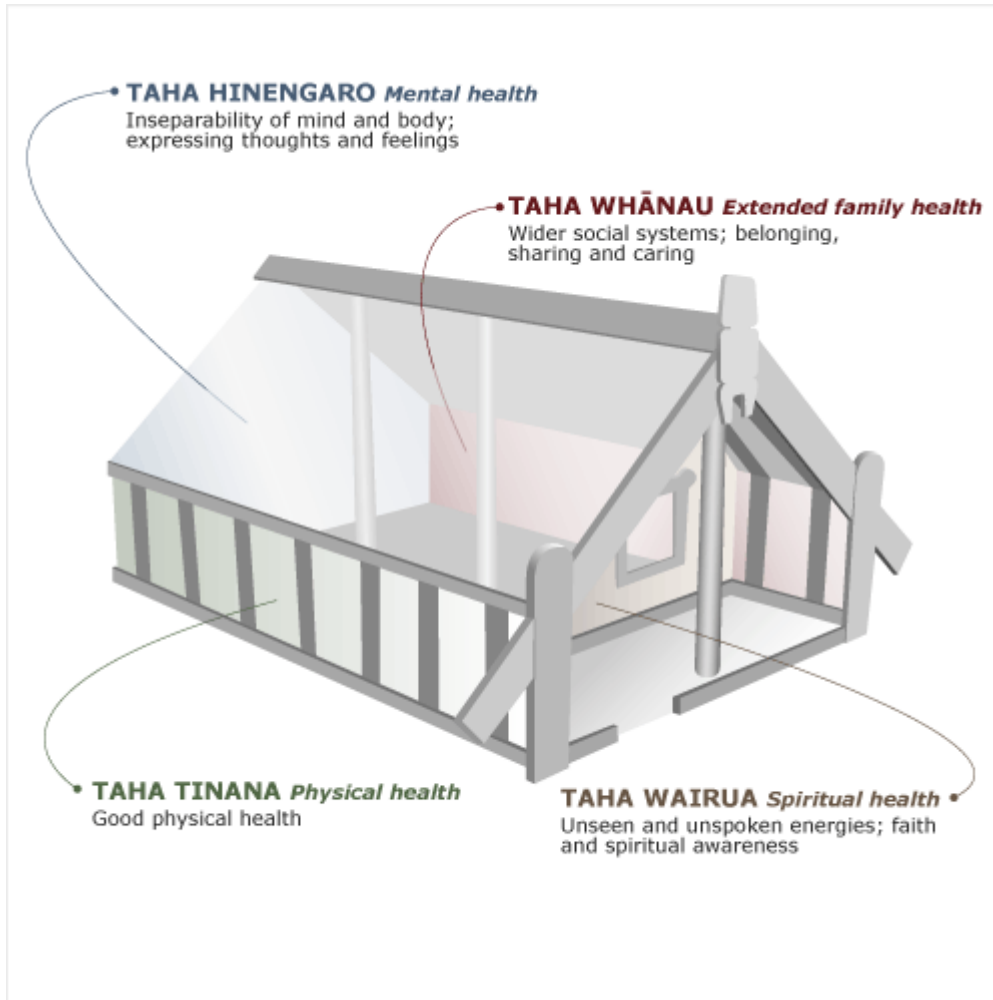
Figure 2: Te Whare Tapa Wha model of Healthcare (Ministry of Health, 2013)

1.1.1.2 Munford and Walsh-Tapiata (2006) community development model.

Although the model by Munford and Walsh-Tapiata (2006) is a community development model,

it is included here because in a more holistic approach to healthcare that many Māori take this

model would be in keeping with the Whānau Ora approach and the Te Whare Tapa Wha model.

The Munford and Walsh-Tapiata Māori model overlaps with more western models such as that

developed by Greenaway and Witten (2006) who emphasised the need for strong relationships

between individuals, groups and organisations, and gaining knowledge through critical

reflection. When considering the context of Māori communities and Māori as an integral part of the focus of the target group in this research Māori community development models such as Munford and Walsh-Tapiata also needs to be acknowledged. Munford and Walsh-Tapiata suggest seven key principles:

1. Having a vision for the future and what can be achieved
2. Understanding local contexts
3. Locating one-self within community
4. Working within power relations
5. Achieving self –determination
6. Bringing about positive social change for all communities in Aotearoa New Zealand
7. Action and reflection.

1.2 Pacifica Health

The Ministry of Health website notes that the reasons for the Pacifica population's relatively poor health status are "complex and numerous" (Ministry of Health, 2014).

The Ministry of Health cites the following social and economic factors as being major influences: income and poverty, employment and occupation, education, housing, and ethnicity. These are once again the recognised major determinants of health as outlined earlier in this paper. The Ministry of Health (2014) article reports the following:

- 27 percent of Pacifica meet the criteria for living in severe hardship compared to 8 percent of the total population. In addition, 15 percent of Pacifica live in significant hardship, with only 1 percent enjoying "very good living standards".

- Pacifica are less likely to own their own homes (26 percent compared to 55 percent nationally) and more likely to live in overcrowded households.

- Pacifica unemployment rate is nearly twice the national unemployment rate.

- Lifestyle factors, including values and preferences, can influence how Pacifica view healthcare.

Underutilisation of primary and preventative healthcare services by Pacifica and lower rates of selected secondary care interventions are common (Ministry of Health, 2014).As these risk factors become more clearly defined and acknowledged, the interventions required to meet the complex issues for this population may be delivered in a more culturally effective manner. It has been suggested that either the Whānau Ora or Fonofale models of health be taken into consideration as tools for future use. These models are explained later in this thesis.

1.2.1 Pacifica Healthcare.

1.2.1.1 Fonofale Model of health and wellbeing.

Fuimaono Karl Pulotu-Endemann (1995) first published his model of health and wellbeing when he was contracted by the Ministry of Health to contribute towards a strategic plan for the mental health services for Pacifica peoples in Aotearoa New Zealand. This need came about as the result of the over stayer/dawn raids of the 1970s where the ethnic groups including Samoan, Cook Island Māori, Tongan, Niuean and Tokelauan were randomly stopped in the streets,

predominantly in Auckland, Aotearoa New Zealand, to prove their citizenship. Subsequent

forums and group discussions with those communities to discuss the place of Pacifica people in

Aotearoa New Zealand resulted in the creation of the Fonofale model. This was created to reflect

what Pacifica people viewed as crucial components in their own health and wellbeing in the

Aotearoa New Zealand context. Although the model is specific to the Pacifica peoples it has

similarities to the Te Tapa Wha model in that all the aspects of the model have an interactive

relationship with each other. Although each Pacifica nation uses their own language for the terms

 and component elements within a fale (meeting place in Samoan) for each the structures and

meanings and associations with the fale are similar.

Figure 3: Fonofale Model of Healthcare: Pulotu-Endemann 1995 (Ministry of Health, 2014)

The Fale Structure

      The Foundation or the Floor of the Fale - meeting house

Family: (Floor) All Pacifica cultures consider the family as the foundation. Family can be nuclear, extended, or constituted by kinship, partnership, or covenants. History and genealogy tie them to the lands, sea, and gods of the Pacific.

The Roof: (Culture) because the Pacifica people continue to settle in Aotearoa New Zealand their culture continues to evolve and develop with integration and marriage between as Palagi (Pākehā)) and Pacifica. The roof of the fale represents the shelter provided by beliefs and values. Some families continue solely with their Pacifica ways which include traditional healing methods. Other families choose a combination of both traditional and western healing methods.

The four pou (posts) are the connection between the family and their culture:

Spiritual: this dimension relates to the sense of wellbeing which stems from a belief system that includes either Christianity or traditional spirituality, relating to nature, spirits, language, beliefs, ancestors and history, or a combination of both.

Physical: this dimension relates to biological or physical wellbeing. It is the relationship of the body which comprises anatomy and physiology as well as physical or organic and inorganic substances such as food, water, air and medications that can have either positive or negative impacts on the physical wellbeing.

Mental: this dimension relates to the wellbeing or the health of the mind which involves thinking and emotions as well as the behaviours expressed.

Other: this dimension relates to various variables that can directly or indirectly affect health such as, but not limited to, gender, sexuality/sexual orientation, age, socioeconomic status.

The Fonofale contains the three repeated dimensions: environment, time, and context that have direct or indirect influence on one another.

> **Environment**: this dimension addresses the relationships and uniqueness of Pacifica people to their physical environment. The environment may be rural or an urban setting.
>
> **Time**: this dimension relates to the actual or specific time in history that impacts on Pacifica people.
>
> **Context**: this dimension relates to the where/how/what and the meaning it has for that particular person or people. The context can be in relation to Pacifica Island reared people or Aotearoa New Zealand reared people. Other contexts include country of residence, legal, politics and socioeconomics. (Ministry of Health, 2013)

The Fonofale Model is a dynamic model in that all aspects depicted in the model have an interactive relationship with each other. This is not easily understood by a clinically driven bio-medical model of health where the authority in a healthcare situation does not take account of aspects such as spirituality or environment.

1.3 Refugee and Migrant Peoples Health

The Christchurch Resettlement Services annual report 2012/2013 comments that their social work service is in high demand (Wright, 2013). The client base is primarily made up of Bhutanese, Ethiopian, Somali, and Eritrean peoples although many other cultures are represented. The report notes of the ongoing after effects of the Canterbury earthquakes, especially in the areas of housing shortages (which brings high rents and financial stresses) and relationship issues for families trying to resettle into a new unfamiliar culture, where there are

language barriers and an unfamiliar physical environment. Christchurch Resettlement Services reports an increase of 37% new clients for their social work, youth service, mental health service, and family violence services during 2012/2013. Research by Gordon (2009) acknowledges the post-traumatic effects of natural disasters and the ability these have to highlight previous trauma people have suffered. As Refugees most of these new residents to Canterbury may have experienced serious trauma before arriving here and therefore support in accessing an unfamiliar healthcare system would be both necessary and appropriate. Finney and Lamb (2011) from the New South Wales Refugee and Migrant Health service noted similar EAG. They found the overall health of these new arrivals was complex both in terms of co-morbidity and also barriers such as language and anxiety. The barriers related to trusting persons in authority, such as doctors and other healthcare professionals. They also found that this limited trust and fear may arise from situations such as language and cultural barriers between a refugee and a health professional, or the experience of torture where a health professional has had an involvement. Most of the newly-arrived refugee groups also have significant oral healthcare needs which not only caused reliance on public dental services but also required support and interpreters to access those services. Finney and Lamb (2011) also reported the fact that although the Australian General Practitioner (GP) had access to interpretation services by telephone they were reluctant to use it. Similarly Canterbury GPs are concerned that they may make an incorrect diagnosis because of a misunderstanding in the interpretation process over a telephone line.

Another major factor in the Canterbury healthcare context is the impact that the recent earthquakes have had not only the refugee and migrant community but also on Canterbury as a whole, and therefore, in turn, on the role and workload of the PCW.

1.4 Major Earthquakes in Canterbury 2010 – 2013

Although the CDHB reports (CDHB, 2012) acknowledge that the PCWs are doing effective work in the area of need that the project was designed for, which is primarily facilitating access to primary healthcare, it is also becoming apparent from PCW own reporting that the Canterbury earthquakes 2010-2011 have had a major impact on the mental health complexities now presenting to the PCW. This has resulted in the original and expected case mix of clients to expand following the earthquakes to now include new and unexpected conditions that were rarely seen before the earthquakes. In September 2010 Canterbury experienced a major earthquake with a magnitude of 7.1. This was just the first of many in a series of earthquakes that affected the region particularly in the next months, but also for a number of years. The most destructive earthquake occurred on 22 February 2011; it was a magnitude 6.3 quake and was centred on the Port Hills close to the city of Christchurch. It claimed 185 lives, maimed and injured thousands and caused widespread damage to homes and buildings, especially in the central city and eastern suburbs. In total there were 57 earthquakes of a magnitude 5 or more, 476 earthquakes of magnitude 4 or more and 37,773 earthquakes of magnitude 3 or more(Earthquake Commission, 2014).

As a result of these (quite literally) earth shattering events the government declared 7,349 properties to be "red zoned", that is they were declared "unsafe to live in", either because of liquefaction or rock fall danger. The flow on effect of this decision to red-zone so many properties caused many Cantabrians to be homeless, or at the best unable to replace their existing property because of both financial and housing shortages. It has been anticipated that about 10% of people who suffered direct trauma are expected to develop Post-Traumatic Stress Disorder (Post traumatic stress disorder, 2011).

The Timaru Herald: 1 February 2014 reported that post –earthquake research by Torstonson and Whittaker (2011) revealed that in Canterbury there is now a very much heightened risk for people with an undiagnosed mental health issue to be overlooked because many people with past traumas had now had the stress of the earlier trauma triggered by the trauma of the earthquakes. The population had now largely realised that the city was in fact unsafe and consequently there was present a predominant theme of emotional stress alongside the already existing mental health disorders. Whether this upsurge in mental health complexities would have been a natural progression in Christchurch can only be speculated; however, statistics from the Ministry of Health website (Ministry of Health, 2013) indicate that nationally mental health intake levels are not as elevated as those of Canterbury for the same period. The target group for the PCWs of Māori, Pacifica, refugee and migrant peoples suffering mental health issues also required extra support during this confusing time. Because some were already in a client-PCW relationship it was often the PCW they looked to. An added complication for the target group was housing because many lived in the predominantly affected east areas of the city which suffered significant land damage from liquefaction and damaged water pipes. This in turn caused a significant loss of essential facilities such as access to potable water and toilet facilities. Some of these services were unavailable for weeks, even months (Lambert, 2014).

1.5 Background of Services to Improve Access Project (SIA)

Medline is a bibliographic database that provides citations and abstracts for biomedical and health journals, and its definition of *access to healthcare* and Bidwell (2013) suggests it is the degree to which people are inhibited or facilitated in their ability to gain entry and to receive care from the healthcare system (Bidwell, 2013). In 2004 the Aotearoa New Zealand Government, in

conjunction with National District Health Boards, set up a service plan they named Services to

Improve Access (SIA) As a result of this new funding scheme (whose aim was to tackle the issue

of health inequities for Māori, Pacifica and low income populations), the CDHB and the

Partnership Health Primary Health Organisations (PHO) identified their own target group as

"missing out". A variety of strategies were implemented including a *pathway team* where the

Practice Nurse of the Pegasus Health General Practice and a PCW attached to that General

Practice would work closely together to help facilitate the required healthcare of those patients

failing to attend appointments or enrol with a GP. The General Practice received an amount of

flexible funding on a quarterly basis dependent on the number of the target population within

their enrolled population; this is shown in Figure 4.

Ethnicity	Partnership Health Canterbury	%	Rural Canterbury PHO	%	Christchurch PHO	%	DHB Totals	%
Māori	**24,455**	**6.7%**	**5,479**	**6.3%**	**1,989**	**6.4%**	**31,923**	**6.6%**
Pacific peoples	9,189	2.5%	1,176	1.3%	792	2.5%	11,157	2.3%
Asian	23,738	6.5%	1,257	1.4%	4,059	13.1%	29,054	6.0%
Other	308,580	84.3%	79,559	91.0%	24,244	78.0%	412,383	85.1%
TOTAL	365,962		87,471		31,084		484,517	

Figure 4: Ethnic breakdown of PHO enrolled population – (copied table from) 1 July 2013 (Ministry of Health, 2013)

The flexible funding is available for reducing or removing costs, such as GP and Practice Nurse

fees, pharmacy charges, and the purchase of health aids, such as nebulisers or glasses, or for

specialists' appointment costs. An additional four hours per week was available to the General

Practice for the Practice Nurse to identify the patients who were either missing medical or

hospital appointments or missing out on regular vaccinations. When the Practice Nurse had

identified the patients it was then the job of the partnering PCW to contact the patient and, in all

likelihood to make a home visit to work together with the client to overcome their perceived

barriers to attendance. The expectation was for this partnering or pathway team to take referrals

from not only the missing or missing out population but also from secondary care and in

particular the Emergency Department of the Public Hospital. It was also hoped that this

partnering pathway team would be involved in health promotion and education, outreach through

home visits, and possess the flexibility required to meet the needs of different cultures and

communities. It is important to note that the research in this thesis is focussing on the

GP/Practice Nurse and PCW partnership in regards to accessing primary healthcare even though

other services exist, for example marae based free health checks (Partnership Health Canterbury,

2009).

Services to Improve Access -
assisting Maori, Pacific and low income people to access
primary health care

Access Project

General Practice **Practice Nurse –** **Partnerships Community Workers**

Target Maori, Pacific People and lower socio-economic populations –
"The missing ' those patients who are not enrolled with a general practice team
"The missing out" those patients who are enrolled but not accessing healthcare appropriate for their health status e.g. diagnosed diabetics, who have not accessed primary health care for their ongoing needs This project aims to minimize the barriers to primary health care access e.g. financial, transport, cultural, language.

4 Hours per week funded PN time for
- One on one time with high needs patients
- Developing connections with the local community
- Liaising with other agencies and services for the benefit of their patients
- Working collaboratively with their PCW

Identify and establish local Community Networks – to reach the target populations not accessing General Practice via
- Schools – both primary and secondary
- Church Groups
- Community Centres
- Local marae
- Refugee Groups
- Youth Groups
- Child health centres
Link into general practice health care services – patient choice of primary care provider within local area.
Identify the barriers for the patient and support to transcend those barriers
Assess the patient's general circumstances to identify issues that may be impacting on health and well being.
Establish links with other funded and non-funded agencies
Link patients into other services and resources for ongoing support

Access funding is available at the discretion of the clinical staff in all general practices under Partnership Health Canterbury PHO.
Access funding is utilized by general practice to support the care of their patients that fit the criteria.
This flexible funding can be used for consults, prescriptions, transport, home visits, wound care, f/u visits/letters, specialist consults or any other support or equipment the general practice deem appropriate for their patients

Access funds are limited so where appropriate, ongoing care is linked into other PHO activities e.g. CarePlus, Health Promotion, Smoking cessation etc.

Partnership Health Canterbury – Access Project Overview October 2009

Figure 5: Services to Improve Access – Assisting Māori, Pacifica and low income people to access primary healthcare (Partnership Health Canterbury, 2009)

In 2006 the plan was implemented with contracts for the GPs mainly in the east of Christchurch where the demographic profile indicated the highest enrolled patient list of the target group. Figure 6 (copied table MOH, 2013) indicates the breakdown of high needs patients by ethnicity and also the demographic profile. Deprivation 9 and 10 are the lowest socioeconomic markers for Aotearoa New Zealand and these factors are parallel to those identified by the 2006 WHO report as contributors to the wider determinants of health (See Appendix A).

Row Labels	"High Needs"*	Non-"High Needs"	Unknown	Total	%
Māori	3,565			3,565	15.6%
Pacific peoples	1,495			1,495	6.5%
European	3,598	10,905	1,822	16,325	71.3%
Asian	247	497	114	858	3.7%
Other	140	263	53	456	2.0%
Not Stated	20	35	139	194	0.8%
Grand Total	9,065	11,700	2,128	22,893	

* Defined by the FFP funding stream as Māori, Pacific people and people in Dep 9 and 10

Figure 6: Improving Access to Primary healthcare for children and youth (Ministry of Health, 2013)

The SIA committee recommended that PCW employment contracts be established with community based social services groups, such as Anglican Care, Presbyterian Support, Te Whare Roimata, Waltham Cottage, Linwood Community Support, the Department of Corrections, and Women's Refuge. It was decided to base each PCW within an already established community group, who would then become the PCW's employer because this would enable the enhancement of networks of both the community groups and the PCW team. Many of these new *host employer organisations* were already employing a range of social workers, community development workers, and other allied health workers, and therefore the addition of a PCW was considered to

be very complementary to their teams. Another requirement was for the PCW and Practice Nurse to meet with the PHO manager on a regular monthly basis to establish a better understanding of each other's role and to share knowledge. This was perceived to be important as the whole project was relationship based. A relationship based approach fitted well with the target group, and in particular the Māori philosophy of health which is explained well in the Te Whare Tapa Wha wellness/ holistic health model developed by Durie in the early 1980s. Durie describes the way that the concept of *wellness* separates into four parts (or four basic beliefs of life): Te Taha Hinengaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health), and Te Taha Whānau (family health) (Durie, 1999). This model is widely applied in Aotearoa New Zealand whenever a Māori health issue, whether physical or psychological, is being considered. This model is discussed later in this chapter.

Finau (2006) notes from a Pacifica point of view, when looking at the way forward for primary healthcare for hard to reach Aotearoa New Zealand people, noted, "Cultural democracy is the ability of the people to practise their culture and language with relative freedom without discrimination." The Fonofale model of healthcare, which is described more fully later in this chapter, may be a model to address this need (Pulotu-Endemann, 1995). An American study by Grim and Walker (2011) of the Community Health Foundation of Western and Central New York, which focussed on neighbourhoods with complex needs, such as racial, ethnic, and low socioeconomic groups also reached a similar conclusion with regard to community bases and values. Grim and Walker concluded that the CHW could not merely be defined as a workforce but as a set of principles and values that emphasised, "trust, understanding, empathy and shared experience". They also note that CHWs are a connection between and within neighbourhoods,

community groups and Institutions which include "building community capacity, advocating for individual and community needs, and building self-sufficiency" (Grim & Bauer-Walker, 2011).

1.6 Background to the PCW initiative

The name Partnership Community Worker, as referred to in this report, was chosen for those CHWs employed for the initiative because it was deemed by the CDHB to indicate the partnership between the Pegasus Health medical practices and the Canterbury community. The role of not only the PCWs but also the CHWs and/or Health Navigators, as they are commonly referred to in the international literature, seems to be difficult to define. Some authors struggle to define the role and some refer to them as Navigators and some as community health workers (Grim & Bauer-Walker, 2011; Henderson& Kendall, 2011; Wells et al., 2008). The United States (US) Department of Health and Human Services, for example, comments on specialised workers like the cancer patient navigator (United States Department of Health and Human Services, 2009). The patient navigation scheme was formed to address similar challenges to those faced by the CDHB, as there were inequalities in particular areas of the population in regards to accessing healthcare including ethnic minorities and low income populations.

First implemented in 1990, patient navigation interventions are emerging today as an approach to reduce cancer disparities; however, as with the PCWs there is lack of consensus about how the role of patient navigation is clearly defined, and what their qualifications should be. Wells et al., (2015) also report that this patient navigation scheme does not appear to have been clearly evaluated for cost and efficacy. Perhaps this approach to cancer interventions is more aligned to an holistic approach as in the Te Whare Tapa Wha model (Durie, 1999) and a more in depth

study of "What value does a CHW/ Health Navigator add to the health care

intervention/outcome?" may produce interesting results.

Unlike the above patient navigator studies, the cost effectiveness of the PCW project is not under

scrutiny and has satisfied its funders and this can be seen in both CDHB and Pegasus Health

annual reports (2012, 2013, 2014). The question for the PCW project is not "are they effective?"

but it is "how do we define the PCW?" The vagueness in definition could be seen to be an

advantage because, on the one hand, the role can be developed to suit particular contexts and

populations, but on the other hand, it can also cause confusion for those working as a PCW,

those referring clients to the service, and those who employ a PCW. Along with the interviews of

the stakeholders in the PCW project the Partnership Health Canterbury Marketing Manager at

2006 was also interviewed to help clarify the PCW role and the following is a summary of that

interview. A further discussion of the interview appears later in this report.

1.6.1 Summary of an interview with the 2006 Partnership Health Marketing Manager

The 2006 Partnership Health manager responsible for marketing the PCW project (2006) for the

Pegasus Health General Practices, was interviewed in 2014 by the researcher to obtain

background information. She reported the following:

> The [PCW] project was designed in the first instance for the Pegasus Health medical
>
> practices to adopt a PCW to support their practice to find the missing and the missing
>
> out [population] and to re-engage them with the GP. In the second instance it was
>
> designed for the PCWs to reach into the wider community in order to refer the clients on
>
> to the appropriate community service; however, the wider community was quick to

realise the strength in the PCW knowledge and advocacy and began to not support the clients of the PCW, but to also refer their own clients to the PCW service which they began to perceive as a social work extension. There is now a change in balance of the referrals with approximately 60/40 in favour of the community as opposed to the original higher referral expectation from the medical practices. The need to promote the professional skills and abilities of the PCW to the Pegasus Health culture was recommended and also acknowledgment of the workload on the GP and his/her staff was noted as a possible significant factor in the lack of GP referrals (2006 Partnership Heath Marketing Manager, personal communication, July 11th, 2014).

In addition to exploring the theme of referral rates the question being asked by both the PCWs and their community organisation managers whether the PCW role has become more a social work role than the original community health work one. When interviewed, 37% of the PCWs reported "feeling out of their comfort zone," and were looking at acquiring social work qualifications, not only for their own peace of mind, but also for the implied (medical practices') need for PCWs to have a greater educational/professional credibility. The need to be seen as a more professional group of health workers may be something that the Pegasus Health management needs to investigate not only for the "outsider looking in" but also for the confidence of the PCWs who are being asked to move into situations which were not on the original brief.

A PCW, who has only been in the PCW team for the last two years, relayed this situation during her face to face interview with the researcher:

A recent referral to me was an unemployed man who was living in a park. He had

moved into Christchurch post-quake, hoping for work in construction; however, the

probable employment had not eventuated. He was now without money, very unwell

mentally and emotionally due to not taking his medication for some weeks as he could

not afford to see a local GP. I was asked by the referrer to visit the man in the park as he

was too anxious to move away from his meagre belongings. We eventually found him a

GP, a safe place to live, albeit temporary, and he started his medication regime again.

This situation was at times somewhat overwhelming for me to deal with as although I

have had basic mental health training, his needs were very complex. My supervisor and

manager both worked closely with me during the three to four weeks it took to connect

this man to other agencies and gradually help stabilise his mental health. (PCW,

personal communication, June 21, 2014).

The earthquakes and the effects thereafter on both the community and the PCWs themselves

threw the PCW team full force into the wider determinants of health. Some were more prepared

and able to deal with this than others were because of past experience, previous training, and

education in public health. Another reason why some PCWs coped better than others is the

reality that some of the PCWs themselves had been significantly adversely affected by the

earthquakes and were themselves struggling with damaged homes and loss of personal

belongings, in the same way as were their clients. Pegasus Health management seminars

conducted by Dr Rob Gordon, an Australian trauma and disaster psychologist, in 2012 and 2013,

were immensely beneficial to those of the PCWs who managed to find the time in their

increasingly busy schedules to attend his seminars. Discussions during their interviews in this

study found those presentations bought a sense of "normality" to their own feelings and emotions

and gave them a better ability to cope with the complex situations they were facing in the community. Dr Gordon emphasised the need for community and health workers to be kind to themselves, lessen personal expectations on their ability to solve problems and in general know that all were in for the "marathon rather than the sprint". Although this was excellent advice, which the intellect can rationalise, the caring dispositions of the CHW, which included the PCWs, indicated they were always going to find it difficult to put themselves before others. At times, therefore, they worked beyond their own means and resilience levels, which caused extra stress not only on themselves, but also on their families (Henderson & Kendall, 2011). Post-earthquake, resilience became the word of the moment for the Canterbury population and the media, but the word eventually lost its impact and became the butt of cynicism amongst some Cantabrians. People began to reject the idea they were brave or something special because they were simply surviving the after effects of the earthquakes and wanted it to be understood that they did not actually have a choice. Their families, livelihoods and homes were all in Canterbury and for many there was nowhere else to go until financial disputes with insurance companies and the Earthquake Commission (EQC) had been resolved. People's lives had been irrevocably changed, their outlooks and paradigm of life and ontological security turned upside down and inside out and a new way to live life was forced on them. Giddens (1991) refers to ontological security as a sense of order and continuity in regard to an individual's experiences. He argues that this is reliant on people's ability to give meaning to their lives when they experience positive and stable emotions, and by avoiding chaos and anxiety. When an event not consistent with the meaning a person puts on life, for example a loss of home because of an earthquake, the person's ontological security is threatened and their outlook on the future is challenged. As noted earlier some coped better than others with the effects of the earthquakes; however, past trauma and

unresolved issues swam freely to the surface. The Aotearoa New Zealand Government was quick

to allocate funding for these emotional issues and this was widely advertised as a free service to

the Canterbury population and continued for more than four years (Earthquake Commission,

2014). A conversation in 2012 between the researcher and a group of workers from the PCW

team produced the following heartfelt explanation of their feelings.

> The PCW team, the Pegasus Health management team, the referrers, the host
>
> organisations, and the clients were all in the same river just trying to swim. Some had
>
> had swimming lessons in the past and some had not. Some of us had learned to be
>
> lifesavers and knew where to throw the inflatable ring but many of us did not have a
>
> clue. We were just drifting, surviving day to day doing our job the best we could…scary
>
> (PCWs, personal communication, 2014).

Further future research may be needed to examine the long term effects on the people of

Canterbury involved in community work during the 2011-2014 years.

The Red Cross listed the following tips from seminars run by Dr Rob Gordon on his visits to

Christchurch following the 2010-2011 earthquakes. These tips were originally aimed at the

survivors of the 2009 Australian Bush Fires but were deemed to be appropriate for all natural

disasters and the recovery process which would follow on.

> **1.** A fast recovery is not necessarily a good recovery. Pace yourself and focus on things
>
> that give your life value and meaning e.g. relationships, family, recreational activities,
>
> your health or your career.

2. Take time to assess your energy levels. If you are feeling tired or stressed consider ways you can recharge your battery. Maybe you could get away for a weekend or take a walk, listen to music or, talk to friends – you decide how best to take care of yourself.

3. Ensure you maintain control of your own recovery by identifying, and focusing, on the things you can control. It's ok to acknowledge things beyond your control but try not to focus on them.

4. Ask yourself: "What am I not doing that I used to do? How do I maintain the quality of my life during this long and, at times, difficult recovery period?"

5. Maintain your established daily or weekly routines, or, if necessary create temporary ones during the recovery period. Established routines protect us from uncertainty and constant change.

6. Deal with small problems before they become bigger. Don't let things slip, or postpone them till after it is all "back to normal". Recovery means finding a new normal and it needs to include what is valuable and important to you (Gordon, 2009).

1.6.2 Amalgamation of Partnership Health with Pegasus Health Charitable Ltd. in 2013.

Coupled with all the earthquake related upheaval, in 2013 there were further changes for the PCWs when Partnership Health PHO integrated its services with Pegasus Health Charitable Ltd., who are a clinically driven model of healthcare with a membership of 95% of the Canterbury GPs. The amalgamation occurred as part of Aotearoa New Zealand Ministry of Health's drive to reduce the 80 PHOs to approximately 30. Pegasus Health Charitable Ltd. and the then three

Canterbury PHOs initially viewed this move by the government as an opportunity to streamline services and simplify systems by working as one. The Christchurch PHO and the Rural PHO; however, both made the decision to keep their own identities because they did not perceive there to be any gain from working with such a large organisation as Pegasus Health. This left Partnership Health and Pegasus Health Charitable Ltd. to begin the task of combining a medical model and a community based model. In a recent interview with one of the Directors of Pegasus Health Charitable Ltd., recalled that one of the risks of the amalgamation of the two entities was "the potential loss of community engagement is an ongoing challenge" (personal communication). Part of the strategy initiated to overcome this challenge was the introduction of a community board which would sit alongside the clinical board of Pegasus Health Charitable Ltd. and both governed by the Pegasus Health Charitable Ltd. Board.

At the time of the amalgamation of Pegasus Health Charitable Ltd and Partnership Health PHO, a Director of the Pegasus Health Charitable Ltd. Board described his perception of the PCW role as:

> "An important part of the evolution of primary healthcare and part of the way forward in setting up broader roles for accessing primary healthcare by those missing out in the community. The need for partnership and collaboration in the healthcare arena is still taking time for all to settle in." (Pegasus Health Director, personal communication, March 30, 2014)

For the PCW team the amalgamation has meant a change in physical location for team and education meetings along with a now corporate environment, which was quite foreign and somewhat intimidating to many of the PCWs, who are used to the more nurturing community

style environments. This physical change was also accompanied by a change in overall leadership. Furthermore some PCWs commented in interviews that they felt disengaged by the new clinically driven model and business-like approach which seemed initially to be taking over their previous more caring community-minded management; however, most appreciated that at the time changes were needed for reasons that were not always obvious to them.

One of the newer approaches researched and tested by the formerly G.P. directed General Practice medical centres, both at a national and international level, is the nurse led clinic which appears to have a significant increase in effectiveness around overcoming barriers to accessing primary healthcare (Marshall et al., 2011). It would appear that the nurse led clinic with a more collaborative community approach, including closer relationships with the CHW, or in Aotearoa New Zealand with the PCW, has the potential not only to benefit the target population, such as the SIA initiative, but also to release the GPs at the clinic to work more time efficiently with complex cases they encounter on a daily basis. This would suggest a win/win for all concerned. As already discussed the target population consists mainly of Māori, Pacifica, and low income peoples. When the Pākehā first arrived in Aotearoa New Zealand in the 19th century they bought their own medical model of health; however, the indigenous people, Māori, already held their own values and beliefs, one that included an environmental and spiritual aspect which was not so apparent in the bio-medical model.

This difference in understanding of health and wellbeing continues to be a challenge as Aotearoa New Zealand evolves to a more multicultural society. A report recognising that Aotearoa New Zealand is a multicultural society and written after discussions between individuals, their whānau, and the healthcare providers stresses the need for healthcare to be sufficiently flexible to

be culturally appropriate for all individuals in the Aotearoa New Zealand society. (MOH 2011)

The same report recognises that although there are other similar plans available from the United

Kingdom (UK) (NHS, 2008) the New Zealand Health Strategy has its own context, and therefore

one that includes responsibilities to the Treaty of Waitangi – Te Tiriti O Waitangi (1840), such

as:

- Partnership

- Participation

- Protection

The development of the Whānau Ora approach by the government attempts to integrate the *He*

Korowai Oranga: Māori Health Strategy (Ministry of Health, 2002), and mainstream thinking.

This collaborative approach supports the intention of the PCW initiative and the following

models of healthcare have been identified as a possible knowledge base for the Pegasus Health

management in regards to future models for the PCW/Practice Nurse pathway team.

1.7 National and International Models of Healthcare Workers: PCW, CHW and Health Navigator roles

1.7.1 Partnership Community Worker original model. (Canterbury, Aotearoa New Zealand)

The report to the SIA committee of Partnership Health Canterbury, (Belgrave, 2010) gives the

following overview of the Partnership Health Community Workers. It addresses the need to

identify and encourage ways to develop further by using multidisciplinary approaches to services

and decision making including co-ordination of services with secondary care, public health and

other community based services:

The PCW service is based on the understanding that health and wellbeing is more than

physical health and advises the Te Whare Tapa Wha and the Fonofale models of health

have both been utilised in the model of practice for the PCW role (Belgrave, 2010).

The PCWs have four key responsibilities:

1. To assist people in the community to *gain access* to primary healthcare.

2. To identify the barriers preventing people from accessing primary healthcare, then walk

   alongside each person/whānau to find *sustainable ways to transcend those barriers.*

3. To support people and their whānau to *address their broader health and wellbeing needs.*

4. To assist people to make *connections* to a range of resources and services (Belgrave,

   2010).
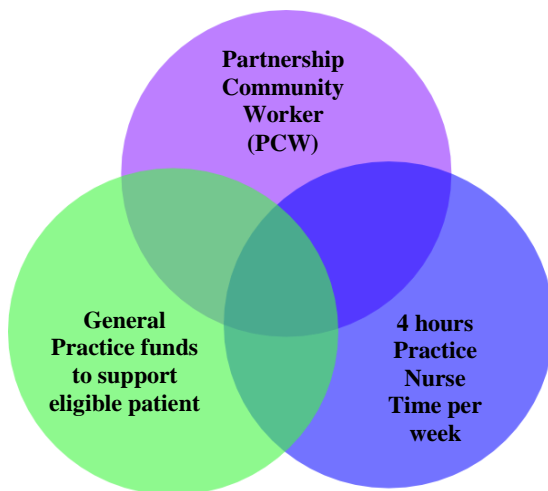
Figure 7: The interaction hoped for between the General practice, PCW and Practice Nurse. (Belgrave et al., 2010)

During 2009-2013 the following publications were distributed widely to the community and General Practices to inform both the medical practice staff and the wider community of the role of the PCW because this would enable them to then refer appropriate clients to the PCW service.

Figure 7: was distributed to the Pegasus Health General Practices in 2010 in order to further help them understand the SIA project

Figure 8: shown in the next page, used what was to become a key message in Christchurch during 2012 in regards to the PCW team. "Partnership Community Workers, *they know what to do*. This key message *they know what to do* was used in order to offer the necessary community support required after the Canterbury earthquakes 2010-2011. This message was presented to the public during a submission to the CDHB Quality improvement and Innovation Awards 2012 where it is likely that the PCW role widened in community expectations. These expectations included solving major post-earthquake housing and accommodation shortages. This housing issue became very burdensome to the PCWs who were powerless to change the accommodation shortage in the city but nonetheless were continually referred vulnerable clients requiring at the very least a bed.

Figure 9: in 2012, 2013 Pegasus Health followed up Figure 8 with this publication which appeared in both a double sided postcard form and an A4 flyer. This resource was handed out to the community including clients and General Practice to further promote understanding of the role of the PCW.

The promotional material from figures 8, 9, and 10 were used in this study to help explain the way the PCW role has been described to the community organisations, the Government

organisations and the medical practices. Furthermore to try define what became a more complex

role during the Canterbury earthquakes of 2010-2011.

Figure 8: They know what to do
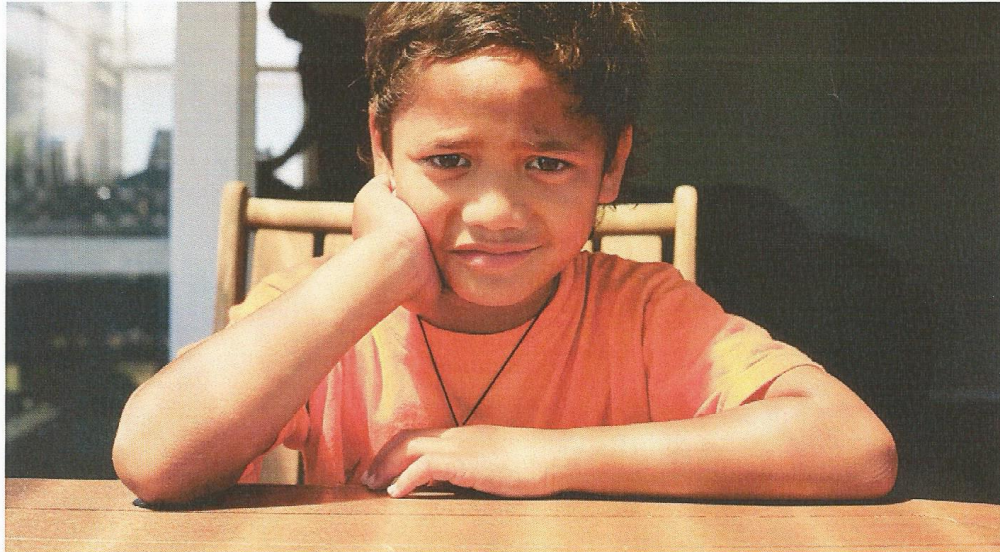
PARTNERSHIP COMMUNITY WORKERS – PCW

Daily our Pegasus PCWs are out in communities assisting people with their health and wellbeing needs.

The key role is to assist people with the barriers that prevent them from accessing health care. They provide or arrange transport to appointments and this greatly reduces the DNA rates of health providers.
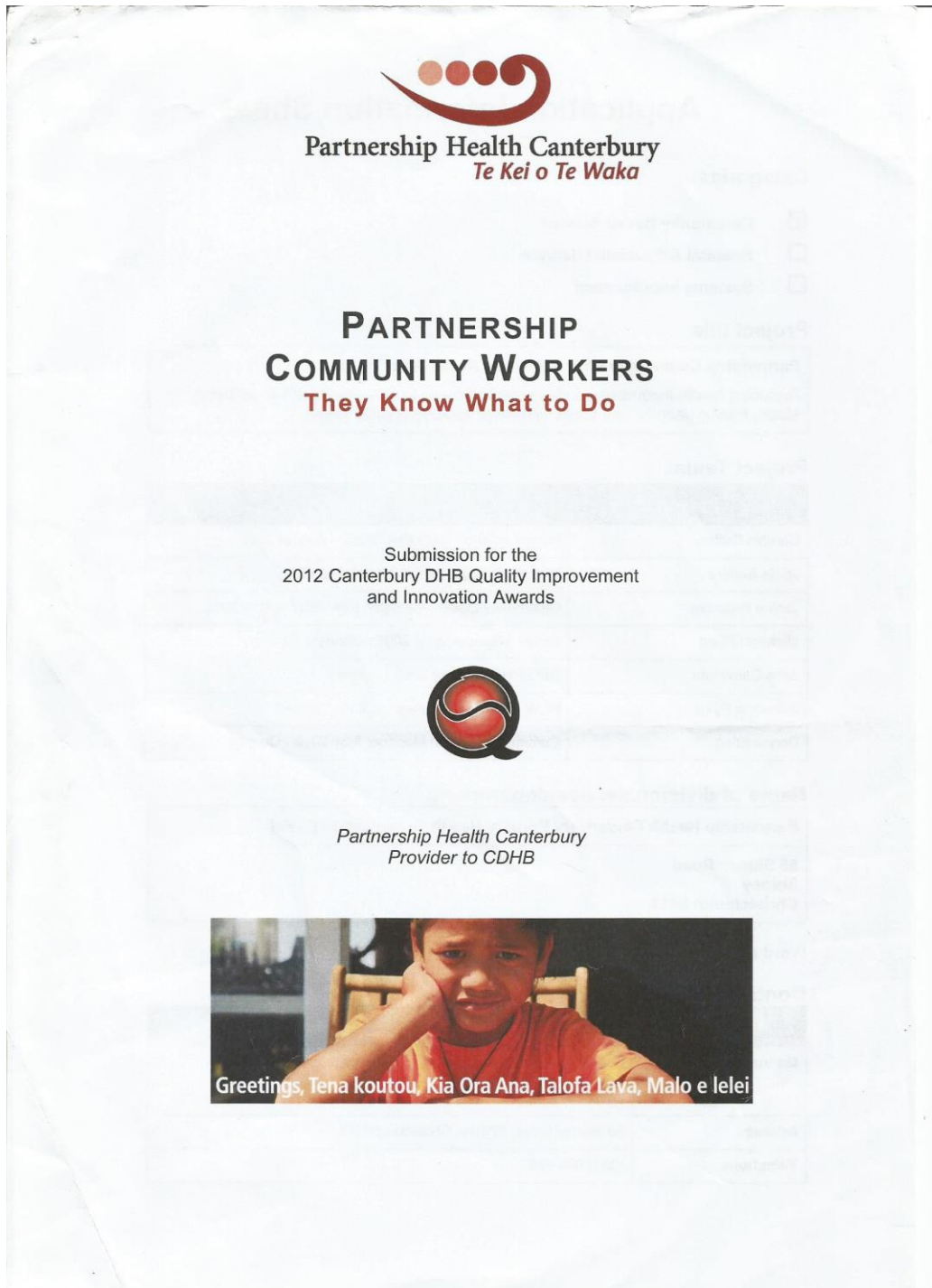
Post-quake the range of needs for people have become increasingly complex. PCWs are ready to meet these needs by advocating for decent housing and heating, income entitlements, cultural support and assisting those who are socially isolated.

PCWs provide a vital linkage and navigation role and demonstrate care and concern for people that lifts them up , increasing their well being and social connectedness.

HERE ARE SOME WORDS FROM THOSE OUR PCWS HAVE HELPED:

"Helping me in getting to and from my appointments – overall they have helped in a way that my son said to me "Daddy you look so happy!". I was so stressed out cause I wasn't getting to the Hospital but now I'm not stressed at all. PS Thank you all so, so much. Also when I get the OK to drive I would love to help by getting other people to their appointments."

"She was really supportive and in constant contact with me over quite a period of time. She was very caring and understanding . I don't know what I would have done without her because I was at a very low point."

"She has been very patient and understanding and stuck with us all the way."

"I have nothing but praise for what has been offered and the means by which it has been facilitated. This combination of supports has lifted my life."

" PCW informed me of my rights at the Doctors and let me know I was entitled to a grant at Red Cross. Also talked through the effects of the earth quakes with me.. She was very supportive."

"The result of PCW involvement helped the person to be less anxious which in turn help her feel more confident in herself. I have observed how the person is more actively involved in the community as a result of the PCW support." (Referrer)

"The patient felt well supported and I think without the PCW the patient would not have made the same health gains." (Referrer)

OUR PCWS ARE MAKING A REAL DIFFERENCE IN PEOPLES' LIVES AND GOING THE EXTRA MILE...

THANK YOU FOR ALL THAT YOU DO

PEGASUS HEALTH

Figure 9: Promotional material explaining the role of the PCW. (Pegasus Health, 2013)

1.7.1.1 The current PCW model as described on the Pegasus Website 2014.

The PCW forms a diverse network that is based in community organisations and high schools.

PCWs work in collaboration with General Practice teams and their local communities to develop

pathways into primary health services. PCWs focus either on people who are not enrolled in a

General Practice or who are enrolled but are not visiting their General Practice teams as often as

needed. They focus on identifying and managing the barriers that a person/family/whānau may

have in accessing healthcare. These barriers could be money, language, transportation, or social

isolation.

PCWs can:

- assist people to attend appointments

- support clients to address other needs that are impacting on their health, e.g., housing, benefits, social isolation

- link clients with other community support services

- provide referrers with information and resources about supports available in the community

- provide cultural support and interpreter services

Figure 10: The current promotional two sided card explaining the role of the PCW to the community (Pegasus Health, 2014)

1.7.2 The nurse led clinic model.

In 2009 the 50th Nurse Practitioner was registered in Aotearoa New Zealand. A publication put together by a partnership of representatives from the Ministry of Health, Nursing Council, the Future Workforce Nurse Practitioner Facilitation Programme, and the Nurse Practitioner Advisory Committee of NZ (NZAP-NZ), and Dr Mark Jones, Chief Nurse with the Ministry of Health, was keen to praise the work of the Nurse Practitioners. (MOH. Nurse Practitioners: A healthy future for New Zealand 2009). Jones emphasises the shortage of GPs in Aotearoa New Zealand and the way in which Nurse Practitioners, because they are so highly trained and highly skilled, are filling major gaps in human resourcing and are thus helping to free up GPs for more

complex work. Jones' comments concur with other studies such as Koperski (1995), and Perry (2007) showing nurses work well in partnership with other health professionals by adding knowledge skills and experience to the mix (nzDoctor.co.nz 2015).

A recent article in the nzDoctor.co.nz (4 Feb 2015) tells the story of the nurse owned medical practice in South Canterbury. RN Chris Chamberlain and Nurse Practitioner Tania Kemp bought the practice from Dr van den Bergh with the arrangement that the day-to-day roles would remain unchanged. The two nurses have always been the face of the practice, with the GP on call and in clinic once a week. The success of the two has been welcomed in the community and acknowledgement was made that the two nurses had already built up strong local relationships and as a result were well supported within the South Canterbury community. A Northland GP Tim Malloy is quoted in the same article as saying that the future of General Practice lies in a collaborative model because no-one works in isolation anymore and the poor availability of GPs mean that the clinics may not be able to meet the needs of the local communities in regards to opening hours. GP Campbell Murdoch at Palmerston's East Otago Health agrees with Malloy and has no problems working for a Nurse Practitioner. "I don't think it's a big deal" he says. "Our Nurse Practitioner recently retired, much to the dismay of the patients, and she is hard to replace as Nurse Practitioners are thin on the ground". Many benefits of the Nurse Practitioner are expressed in all the articles including; both the Nurse Practitioner and the Practice Nurse can help ensure that more of our communities can access expert healthcare.

1.7.2.1 Definition of a Nurse Practitioner.

- Makes professionally autonomous decisions for which he/she is accountable
- Receives patients with undifferentiated/undiagnosed problems

- Screens patients for disease risk factors and early signs of disease

- Makes differential diagnoses

- Orders necessary investigations, provides treatment and care

- Has the authority to admit or discharge patients from their caseload and refer patients to other healthcare providers as appropriate

- Can prescribe some medications

  (Nursing Council of New Zealand, 2002)

From the above it would appear that either a nurse led clinic or a Nurse Practitioner run clinic may well form a future model which could harness the skills of both the PCW and the nurse. These combined skills which include knowing the communities and more available time than a GP, may further bridge the perceived barriers of the communities who are missing out on the healthcare they need. Support and further discussion for these considerations will be further discussed in the literature review.

1.7.3 Manukau Institute of Technology 2009: Community Health Worker Course.

During the search for both national and international models to help define the role of the PCW the following Aotearoa New Zealand based CHW course at the Manukau Institute of Technology was identified. This course appeared to have all the components required for a PCW training module and it was the intention of the researcher to follow up with the Manukau Institute of Technology as to whether their one year course was transferrable to another institute in Canterbury closer for the PCW team to access if required. The website info@manukau.ac.NZ 2011 also informed readers that the 16 graduates of the course were all working for a PHO. By 2014 the course was no longer being offered and the explanation given by administration office at Manukau

Institute of Technology was it was cancelled because of a lack of enrolments, info@manukau.ac.NZ. The aim of the course had been to:

- Develop communities capacity to manage their own health and wellbeing

- Assist with identifying those families at risk

- Encourage stronger community involvement

- Facilitate patient attendance at appointments

- Improve patient access to services

- Assist clients to access non-government and government organisations.

1.7.4 Logan, Australia: Community Navigator.

Logan is a city in Queensland Australia with a population of 305,110 residents, representing 217 ethnicities with 26.1 % of its population born overseas. Logan residents include people from:

New Zealand, England, Philippines, South Africa, Samoa, Scotland, Fiji, India, Germany, China and Papua New Guinea. The Top 11 languages spoken at home other than English in order of the highest are; Samoan, Mandarin, Hindi, Spanish, Vietnamese, Arabic, Khmer, Cantonese, Tagalog, German, Romanian (Australian Bureau of Statistics, June 2014)

In 2011 the Australian National Health Reform included a key component to improve access to primary healthcare because there was awareness that certain Culturally and Linguistically Diverse (CALD) in Australia were not accessing the services available to them which resulted in poor health outcomes (Henderson & Kendall, 2011). As a result of this awareness a group of nine people from the different local ethnicities within the community were selected and

employed by two non-government organisations as Health Navigators. The purpose of the Health Navigator role was to support this CALD community to access primary healthcare and also to promote and educate the population around chronic diseases such as diabetes, heart disease, and nutrition. A one year training plan was instigated and overviewed by Griffith University alongside regular weekly group education and peer supports meetings for the nine navigators. The following modules made up the one year training:

> **Module one**: Introduction to the community navigator model of support and culturally diverse models of health

> **Module two**: Strategies for supporting community members and building community capacity; health service systems and health promotion

> **Module three**: Prioritising and goal setting; communication skills development; advocacy; the social determinants of health, such as housing, income, unemployment

> **Module four**: Working alongside health service planners, funders and providers to improve the provision of culturally safe services

> **Module five**: Strengthening and formalising community partnerships to ensure coordinated and complementary services and activities to the target CALD communities (Henderson & Kendall, 2011).

The Australian National Health Reform (2011), aims to improve primary healthcare by focussing on the specific needs of local communities. Henderson and Kendall (2011) report that the

community navigators in the Logan model knew how to meet the needs of their own communities:

> Specifically, they adopted an attitude of servility that enabled them to "work for" their communities at all times. They acted as knowledge brokers, attending to broad factors that impacted on the health of their communities and they walked with their communities, building on their own understanding of the experiences and circumstances. They connected community members with various health and social services, such as GPs, mental health services, disability services, and housing and welfare organisations. (Henderson & Kendall, 2011).

As with both the Logan Community and Manukau Institute of Technology training models, the University of North Carolina (**1.7.6 pg. 43**) recommend the future PCW management may well consider and incorporate a similar staff training structure.

1.7.5 New York: Community Health Workers as a bridge.

Grim and Walker (2011) attempted to define the role of the CHW during their study based in Buffalo New York. Although they failed in their own estimation to do so they recognised similar community worker attributes as the Manukau Institute of Technology, University of North Carolina and Logan studies as being necessary for success of the role.

Grim and Walker's model of CHWs (2011) came out of the study *Challenges and Opportunities for Community Health Workers* (Grim & Bauer-Walker 2011), which focussed on neighbourhoods in Buffalo, New York, where there were complex needs in an ethnically diverse environment consisting of those primarily of low socioeconomic status, rather than a

monocultural environment of white middle class Americans. Grim and Walker refer to their model of CHWs as a connection between and within neighbourhoods and institutions. Their study had difficulty in defining the role of a CHW but determined the following:

- Building individual and community capacity

- Help patients to navigate the health system and manage their conditions

- Building self-sufficiency

- Provide health education

- Co-ordinate care

- Advocate for individual and community needs

Grim and Walker (2011) suggest that "CHWs play a critical role on both sides of the 'bridge' to build capacity and build better health outcomes".

They considered that using diagrams to explain complex situations was a useful addition to both written and verbal explanations (Grim & Bauer-Walker, 2011) (see Figure 11).
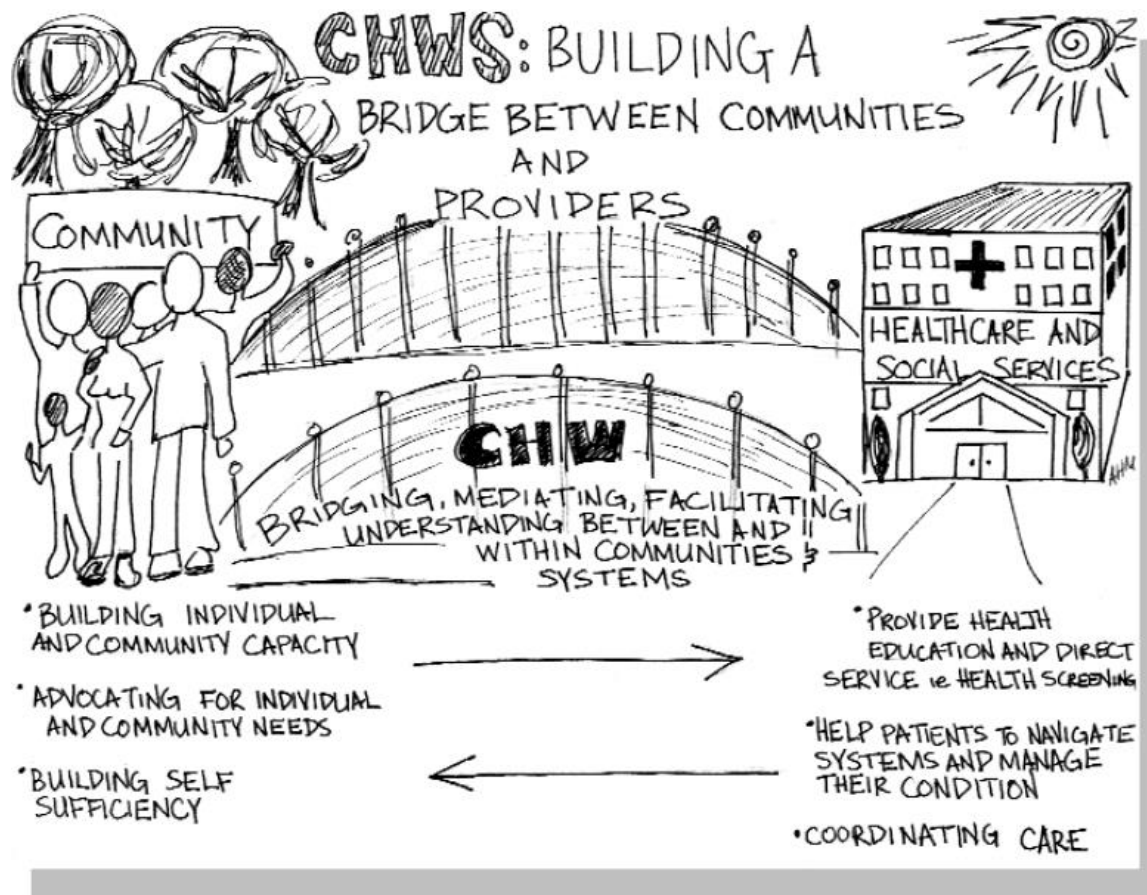
Community Health Workers can be envisioned as a "bridge" between communities and health care/social services. CHWs play critical roles on both sides to build capacity and foster better health outcomes.

Figure 11: CHWs building a bridge between communities (Grim & Bauer-Walker, 2011)

1.7.6 University of North Carolina: model of Community Health Worker.

One of the international examples of the attributes and skills of a CHW was taken from a study by Viswanathan et al., (2009) at the University of North Carolina. It would appear that the Manukau Institute of Technology course well suited the outcomes identified by Viswanathan et al., (2009) as requirements for a proficient CHW.

1. Performs health-related tasks to create a bridge between community members, especially hard-to-reach populations, and the healthcare system (i.e., performs tasks extending beyond peer counselling or peer support alone).

2. Has health training associated with the intervention; training is shorter than that of a professional worker (i.e., training does not form part of a tertiary education certificate).

3. Is recognised (or can be identified) as a member of the community in which he or she works, defined by but not limited to, geographic location, race or ethnicity, and exposure or disease status (Viswanathan et al., 2009)

Even though the Manukau Institute of Technology course has been discontinued because of a shortage of enrolments it appears to have been based on data relevant to the University of North Carolina study, as has the following project in Logan Australia. Although the Logan project was designed primarily for the CALD (culturally and linguistically diverse communities) communities, the CHW course training modules have outcome expectations comparable with both the Manukau Institute of Technology modules and the University of North Carolina recommendations. A combination of these training recommendations may well help form future training modules for the PCW initiative as similar target groups such as minority ethnicities are involved.

1. 8 Summary

The following are two very quick sketches produced by PCWs during interviews. They each felt more able to define the role in a simple sketch. Like Grim and Walker (2011) one of the PCWs in this report also referred to her role as a bridge between the community and the healthcare system, while the other PCW expressed herself as "love in a car".
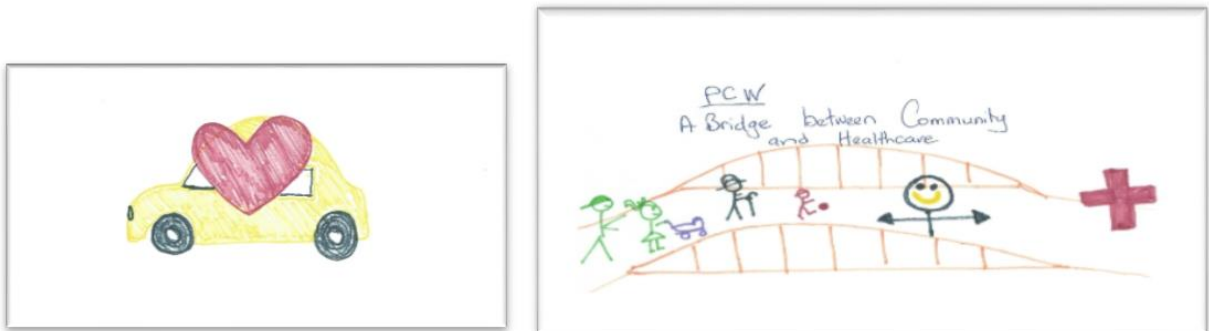
Figure 12: Quick sketches by PCWs to describe their role: Love in a Car and Bridge Builder (PCWs, 2014)

These simple sketches concur with the sentiments of Ragsdell (2000) and Zweifel & Wezemael (2012), that drawings and diagrams can sometimes explain a complex social situation better than just words. As both of these simple sketches (fig. 12) depict a caring dispostion (open arms, smile and heart), it may well reflect the insight of the PCWs who understand the frustrations and needs of their own communities. These sentiments are also representative of what other PCWs verbalised during their interviews and would further support Ragsdell's (2000) notion that integrating drawing or mapping alongside speech gives an interviewee an opportunity to more fully explore their own thoughts and feelings.

Chapter 2: Literature Review

The literature review was undertaken in relation to CHWs and what their role has been both internationally and nationally in an effort to address access issues to primary healthcare. Different models of healthcare are also examined including Culturally and Linguistically Diverse Communities (CALD), Māori, Pacifica, and nurse led clinics because the target population of the Canterbury PCW project is focussed on these communities. The Canterbury earthquakes of 2010-2011 were a significant factor in this project and therefore reviewing the effects of those earthquakes in regards to the PCW role and the Canterbury region they work in is also included.

Key words are: community health worker, Māori, Pacifica, Pegasus Health, access, barriers, nurse led clinics, primary healthcare, inequality, CALD, earthquakes, Canterbury, and the following data bases and websites were searched for information;

Databases searched included: Google, Pub med, Medline, UC Library, Websites used often included: www.cochrane.org.au www.ncbi.nlm.nih.gov http://www.who.int/en/ www.pegasus.health.nz/ www.nzdoctor.co.nz/ www.psychologytoday.com www.health.govt.nz The 2006-2014 annual reports of Partnership Health, Pegasus Health, and the Canterbury District Health Board (CDHB) were reviewed in order to establish the initial intention of the SIA project which included the PCW role. Further reports studied included Canterbury Non-Governmental Organisations (NGOs) who either hosted the PCWs or who referred their clients to them. A number of journals and articles were read including *Best Practice* and the *NZ Doctor*.

2.1 Inequities in Accessing Primary Healthcare

International studies ranging from Gray in 1982 to Butler and Peterson et al., in 2013 recognise there is an inequity in accessing primary healthcare by those living in more deprived

socioeconomic areas than those living in least deprived economic areas. As a specific instance of healthcare inequity arising from socioeconomic status the Oxford Journal of Infectious Diseases (2013), published the results of a study in Scotland on antibiotic prescription rates and found that those living in areas of greater socioeconomic deprivation were prescribed antibiotics 27% more than those living in the more wealthy areas. For Butler and Peterson et al., (2013) this is an indication that those in low socioeconomic areas have poorer health than those who are in high socioeconomic status areas. They posed the question as to why this is, and what can be done to help people access primary healthcare more often? They concluded that "deprivation was found to have a consistent association with increased rates of antibiotic prescribing in Scotland, which may have significant implications for antimicrobial stewardship and public health campaigns" (Butler & Peterson et al., 2013).

The Black report (cited in Gray, 1982) had the potential to be a major influence worldwide for discussing the correlation between poverty and poor health. Gray (1982) widely discusses both the 1948 Health Reforms and the ever widening gap between poverty and health in the UK and concluded that the problems with the then current system were mainly attributable to the social inequalities influencing health, including: income, education, housing, diet, employment, and conditions of work. The report recommended a wide strategy of changes in social policy; however, the then secretary of Social Services chose to disregard the report and as a result it was not widely distributed (Gray, 1982). In a background document for the National Health Service in Scotland the Black Report is summarised and of the four possible reasons for health inequalities "material [conditions] and social life circumstances" appear to be the most important determining factors: factors such as "poor housing, certain occupations, pollution, unemployment and psychosocial stress have all been associated with poorer health" and are

"hazards inherent in society to which the more disadvantaged have no option but be exposed" (Gray, 1982)

Although the Black Report (cited in Gray, 1982) relates to the UK context a similar argument is relevant in Aotearoa New Zealand. The New Zealand Health Survey 2011/2012 reached similar conclusions and notes the following: "Adjusting for differences in age, sex and ethnic group, people living in the most deprived areas were 1.4 times as likely to have experienced unmet healthcare need as people in the least deprived areas (Morgan & Baker, 2007).

2.2 Culturally and Linguistically Diverse Communities (CALD)

In addition to socioeconomic materialist factors there is also evidence that ethnic minorities were some of the worst affected populations and that a keenly placed CHW intervention was more likely to overcome the barriers to healthcare if certain principles were followed, such as: community acceptance and ownership of the CHW, the CHWs personal knowledge of the community, and careful selection and training (Chew-Graham et al., 2014). Utenhanann and Sanders (2012) suggested that the CHW programmes thrived in already mobilised communities but struggled if given the responsibility of mobilising the community. They also commented that a CHW programme is not a cheap option for facilitating healthcare and needs good planning and resourcing, and realistic expectations for the outcomes. This concurs with Grim and Walker (2011) who suggest that the CHW programmes are an asset-based approach and endeavour to put people and community health issues into a holistic context. Such an approach needs the CHWs to be specifically trained for their own communities where they have an understanding, shared experience, as well as acceptance by that community. Most studies mentioned that unless the

CHW initiative was well resourced, supported, and skilled the sustainability of the CHWs themselves was questionable (Henderson et al., 2011).

A review by Henderson et al., (2011) of 24 studies on culturally appropriate interventions in CALD communities in Australia concluded that the use of trained bi-lingual health workers, who are culturally competent, is a major consideration in the development of an appropriate health service model for CALD communities. Given the increasingly bilingual and multicultural facets in Aotearoa New Zealand the findings from the Australian context are relevant to the wider Australasian context. It would therefore be relevant to the future PCW model to take into account the findings of Henderson et al. (2011) as pertinent to the desired outcomes of accessing healthcare for the intended populations including the CALD communities.

Viswanathan et al., (2009) argue that the gaps in current studies showed that culturally specific placed CHWs can serve as a means of improving outcomes but a lack of information in regards to their training methods creates a problem for evaluation.

When looking to answer the question of how to tailor CHW training to improve health outcomes the Agency for Healthcare Research and Quality, a division of the US Department of Health and Human Services, recommended future research to improve CHW daily practice. In 2009, Viswanathan et al., as part of a wider study, also reviewed the results of 53 US training programmes used for CHWs, but because most of the programmes reviewed did not have a written plan for training it was difficult to determine the effectiveness or otherwise of specific training methods. This may add to the argument that a more formal training plan is advantageous for the PCW project as it would contribute to the ease of the evaluation process and perhaps create further credibility of the staff skills.

2.3 The Partnership Health Reports

The Partnership Health Canterbury Services to Improve Access Plan (2004) makes it clear that the original intention of the PCW role was for the PCW to work within their own community, in partnership with the medical practice, and more specifically with the Practice Nurses. The SIA funding was to include the PCW project and four paid hours which would allow the Practice Nurse to spend time finding those who were missing, and those missing out on healthcare access and in turn pass this information on to the PCW for follow up. All the subsequent Partnership Health SIA reports (2006, 2008, 2010-2011 and 2012) continued with this intention. In 2009 JHI Consultancy was contracted to evaluate the project. The recommendations from the JHI consultancy report (2009) included the need for stronger promotion of the PCW service to the medical centres because although there was partnering with the Practice Nurses in some medical centres, it was not happening at all in others. In fact one Pegasus Health medical practice replied to the survey for this research stating they had never heard of the PCW service. *Improving access to primary healthcare for children and youth*, a comprehensive literature review by Bidwell (2013) on barriers to accessing healthcare, centred in part on the PCW. Positive aspects include the following:

> PCWs were respected by all the services they worked with and their effectiveness was highly rated in social service organisations. PCWs had access to and were able to connect clients to a wide variety of services and this direct support was felt to have been a valuable contribution in achieving good social and health outcomes (Bidwell, 2013).

Bidwell (2013) also notes aspects for improvement, for example, that there was a perception that the PCW workers were not professionally trained and that this appeared to be a barrier to their

acceptance by some health professionals. Bidwell (2013) recommended the Pegasus Health promotional material that is circulated to the community and the medical practices about the PCW role included their professional status, variable though that may be. Bidwell (2013) and JHI Consultancy Ltd. (2009) individually recognised that the role of the CHW was not easy to define and that key issues for CHWs included the level and extent of training required, how they are supervised, hours and remuneration, and preventing burnout from community demands. Bidwell (2013) also recommended the need for a greater buy in from the wider health sector and that recognition and support for the role of the CHW could be enhanced by the promotion of the service by GPs already satisfied with the service to the GPs as yet to discover the service. Bidwell (2013) noted that in Aotearoa New Zealand there is the need for the CHW (or in this instance the PCW) to be recognisable in their respective communities to ensure a much better chance of buy in from all concerned. Bidwell (2013) writes, "Community participation in needs assessment and planning of a CHW intervention improves acceptance and co-operation" (2013, p. 15).

Another strong theme that emerged from the literature written by, and for, Partnership Health Canterbury (SIA report, 2006; Maw, 2008; JHI consultants, 2009; and Bidwell, 2013), was for the PCWs to be placed in positions where there was a clearly recognised need such as Plunket, Women's Refuge, high schools, and other youth centred facilities, as well as in organisations that support prisoners, who are returning to the community. These recommendations were based on the fact that the SIA funding was set up to target the identified missing and missing out populations of Māori, Pacifica, and low income people. Data on the Ministry of Health website (2013) also confirm that the health of both the Māori and Pacifica ethnicities is in a poorer state than their Pākehā counterpart. When researching what models of health serve best both Māori

and Pacifica, it is apparent that the current health model used in primary care is not meeting the needs of the whole community. It is also clear that a more holistic and community based approach, which may be more likely to be met by a Practice Nurse led medical team, is likely to be effective. Te Whare Tapa Wha (Durie, 1982) and the Fonofale (Pulotu-Endemann, 1995, 2000) are two such models.

The Whānau Ora approach, which is now operating in some parts of the country, appears to be having a better success rate than the current traditional western health model (Bidwell, 2013). Boulton et al., (2013) suggest that the Whānau Ora approach may have difficulty achieving success because it is a model that tries to use whānau concepts within a western framework. It may also be a complicated model because it has the potential to sit within iwi (tribe), hapu (sub-tribe or clan or extended family based on genealogy), and marae (a communal or sacred meeting place) based interventions. As each iwi has its own identity the possibility of difficulties with measuring outcomes from different base positions may be too complex for the western measurement system currently in place to deal with. It would be disappointing if the recommendations to use the Whānau Ora model were not adhered to because Ministry of Health statistics (2013) indicate that the Whānau Ora model in General Practice collectives is proving successful already in the areas of smoking cessation advice (up 29.2%) and diabetes patient review (up 3.8%). It would appear then that there are several models with the potential to help reduce barriers to healthcare for the Māori and Pacifica population and so the hope would be that western outcomes and timeframes do not constrain the possibilities of using culturally appropriate models to prove improve health outcomes for the target population. These models are based around a collaborative approach to healthcare and hence the notion of a nurse led clinic as a base is not without merit.

2.4 A Nurse Led Clinic Approach

Two UK researcher teams, Koperski, et al. (1997) and Perry et al. (2005), suggested that including a Nurse Practitioner as well as a Practice Nurse had significant benefits for the medical practice and the GP, such as caring for the homeless and disadvantaged population (including minority ethnicities), longer appointment times with the GP, triage capability, telephone advice, same day appointments, and overall access to care improved. It was also observed that the GPs themselves had greater job satisfaction. This UK research has been supported by recent Aotearoa New Zealand studies (Marshall, Floyd, and Forrest, 2011) study on nurse led healthy lifestyle clinics. Their research showed that 94% of patients had a better understanding of their diagnosis than those who were not in a nurse led clinic. One significant limitation of this study was that they did not reach the target population of people with known inequalities of health (Marshall, Floyd, Forrest, 2011). This meant the outcomes they hoped for were unable to be established. They did, however, recommend other options for engaging these patients. In 2008 the Ministry of Health (MOH) funded and evaluated a nursing initiative in primary care. The findings were published as *An approach to risk reduction for cardiovascular disease and diabetes* (Horsburgh, Good-Year Smith & Yallop, 2008). This project centred on the low socioeconomic high needs populations in Auckland and Northland, including rural and urban primary care practices. Several clinics volunteered for the study which was monitored and led by the Auckland School of Nursing who provided mentoring, clinical support, educational resources, and the development of a model of care for the lead Registered Nurses. Again, results showed that a multidisciplinary team (which may include a CHW), a Nurse Practitioner or Practice Nurse led practice was a more successful model than a GP led practice. The study did not always have the buy in of all the GPs within the practice and therefore embracing change was not guaranteed

despite evidence that demonstrated improved patient health outcomes. One of their conclusions also suggested that possibly the best way to improve health and wellbeing of Māori was to incorporate whānau – a notion consistent with Māori models of health outlined by Durie (1999). The study also believed the focus was better put on wellness rather than illness, diagnosis and intervention. This belief was supported by the notion that: "*Nurses are effective in chronic disease management with key elements being service organisation, teamwork and structured care*" (Horsburgh, Good-Year Smith & Yallop, 2008). As a result of working in a more Whānau centred approach the nurses involved included in their own evaluation of the study that they would benefit from training such as Motivational Interviewing, cultural competence, population health approaches, and health promotion.

A paper published by Ministry of Health (2005) follows eight clinics led by Registered Nurses. They included a Mobile Community Ear Clinic, Leg Ulcer Clinic, the Aranui Neighbourhood Nurse, nurse led acute care team, and a Mental and Youth Health Clinic. Among the conclusions from the study was the need for Registered Nurses to have the opportunity for more specialised and advanced training. However even with more upskilling, the employment opportunities which are mostly within General Practices, would appear to be limited even when the nurses achieve the Nurse Practitioner stage of their career.

The *Better Sooner More Convenient* approach to integrated healthcare that the government released in 2009, which gives a provides for a patient centred approach rather than institution centre delivery, encourages the District Health Board (DHB) and General Practices to work in a more mindful and collaborative approach across primary, community, and public healthcare (Ministry of Health, 2009)

Such an approach gives opportunity for the nurse led clinics to become more prevalent in the Aotearoa New Zealand context. It would appear that the clinics are somewhat lagging behind their UK counterparts in gaining their foothold in nurse led clinics in this country. One wonders if the aging GP population means that younger GPs, who will take their places in medical practices, may have a different paradigm of what the nurse led clinic can achieve.

2.5 The General Practice

In 2006 the Royal New Zealand College of General Practitioners published the paper *Forecasting GP Workforce Capacity-Towards an understanding of GP workforce capacity, long term forecasting and benchmarking tools* (Fretter & Pande, 2006). The suggestion is that the GP workforce is reducing because of the increasing age of the GP population and a lack of interest in commencing in General Practice because of poor working conditions, such as the difficulty of taking proper annual leave, as can the rest of the population. Such working conditions are not generally acceptable in today's environment. Apart from the lack of a holiday other possible outcomes include burnout and relationship breakdowns (Fretter & Pande, 2006). One suggestion to ensure better patient care and a healthier life for the GP is to widen the scope of the General Practice team. Fretter and Pande (2006) also recognise that as there is no current clear direction or standardisation of exactly what the GP could hand over to other members of a multidisciplinary medical team and hence the current model of General Practice is likely to continue for some time. Fretter and Pande's 2006 study also recognised that the population base for both Māori and Pacifica is growing and, therefore, that ethnicity based models of working would be advantageous.

2.6 Whānau Ora Approach to Healthcare

Whānau Ora is described as a tool to assist organisations to give effect to the policies and strategic pathways woven into *He Korowai Oranga: Māori Health Strategy*, 2002. The overall aim of the approach is for the needs of Māori to be met in a culturally appropriate way with the assistance of the government. The difference between this approach and other health strategy approaches, as in the bio-medical approach, in Aotearoa New Zealand, is the commitment by government to work collaboratively with other organisations, predominantly Māori, who have been contracted to provide services to Māori in social services and health. Māori have a much more philosophical approach to life and believe their link to both their spirituality (wairua) and the environment (taiao) is fundamental to their health and wellbeing (Durie, 2002). Perhaps a more Indigenous Knowledge approach (Ellen & Harris, 1996) by the government rather than a bio-medical approach would enable Whānau Ora to be applied more readily. Warren (1991) describes the Indigenous Knowledge approach as:

> Indigenous knowledge (IK) is the local knowledge – knowledge that is unique to a given culture or society. IK contrasts with the international knowledge system generated by universities, research institutions and private firms. It is the basis for local-level decision making in agriculture, healthcare, food preparation, education, natural-resource management, and a host of other activities in rural communities. (Warren, 1991)

In contrast to the value laden indigenous knowledge as in the Te Whare Tapa Wha or the Fonofale models of healthcare, the empirical or scientific knowledge approach which the Bio-medical model is more aligned to, tends to separate itself from the moral, or religious beliefs of a society. The scientific knowledge approach, or, in the Aotearoa New Zealand context, the bio-medical approach

to healthcare, is mostly interested in solving problems with an evidence based approach rather than in taking a philosophical approach.

Roberts (2009) would suggest that the challenge for government agencies when applying the Whānau Ora approach is to better understand these complexities and to ensure that adequate time and information is provided for informed consultation between the parties involved at any particular time. Moreover this more collaborative approach can only enhance the outcomes desired by all.

The following chapter discusses the mix of methods used in this research which were deliberately chosen by the researcher to further focus on the sense of collaboration surrounding the PCW project.

Chapter 3: Methods

The participants in this study are the PCWs who work in the greater Christchurch area and are based in a variety of community organisations or high schools within that area. The managers of those organisations and high schools also participated along with people from the Pegasus Health medical practices and the other referring agencies to the PCWs. Pegasus Health management contributed historical reports and publications for background information for this study.

All questionnaires, surveys and consent forms were submitted to the ethics committee of the University of Canterbury for approval (see Appendix B).

3.1 Research Question

Is the role of the Partnership Community Worker fulfilling its original intention?

3.2 Expected Outcomes and Objectives

The expected outcome of this research is to define the current model of practice for the PCW role and to make recommendations for a future model. The intention is also to provide a clearer picture of the PCW role, not only to the General Practices and community organisations that make referrals to the PCW, but also to the current and future PCWs, and to those who manage the PCW programme.

1. To examine the original PCW model of practice
2. To define the current PCW model of practice.
3. To examine best practice models through both national and international literature.
4. To consider how a future model of practice might look

3.3 Design of the Study

A mix of both quantitative and qualitative research is used in this research. Munhall notes that

the value of a qualitative approach is that "it is known for giving voice to people, to hearing

people's own personal narrative and using the language of our participants in research" (2011).

A qualitative approach was used for interviews with PCWs, host organisation managers,

referring agencies, Pegasus Health management both past and present, and one Pegasus Health

Director. A quantitative approach, however, was used with the medical centres who completed

written surveys. This study could be described as an "intrinsic" case study design (Stake, 2008)

because the intention of the study is to better understand the issues, contexts, and interpretation

of the role of the PCW itself, rather than to find its context in the academic world. This is in

contrast to an "instrumental" case study which is more focussed on the concerns of the

researcher who might use the case to illustrate their own concerns (Stake, 2008).

In both international and national literature the CHW role is recognised as a complex one and to

explore it requires input from a wide range of people. The data required are similarly complex

and for this reason a mix of methods was used because it is the optimal way to capture as much

valid and useful data as possible. Stirling (2013) proposes that using a mix of both qualitative

and quantitative methodologies increases the prospect of gaining more information in complex

situations. He goes further to say that a mix of phenomenology and grounded research increases

the opportunity of sensitive issues being addressed. An example for this study is to understand

the needs of the medical profession with their bio-medical model of healthcare as well as the

values of the many cultures with their indigenous knowledge based model of healthcare who are

the recipients of the PCW project in order to create an effective healthcare model for all

concerned. Ragsdell (2000) proposes the use of simple participant-drawn sketches as a

mechanism to help explain a thought or thoughts in a complex situation when words cannot always depict the meaning. Unfortunately time constraints and other factors prohibited this additional research method from being used widely; however, several PCWs were prepared to use this method in their own time and two sketches were sent in to the researcher after the interviews (see Figure 12). These have been used to illustrate some of the comments in the PCW interview section. 4.1. I acknowledge and am grateful to these participants for their efforts and although there are not sufficient drawings for this research method to form the basis of conclusions, the great benefits of this method appear clear and I will be able to explore this as a method of data collection in future research projects.

3.4 Sampling and Recruitment

The University of Canterbury (UC) Human Ethics Committee approved the project in March 2014) (Appendix B). To provide potential participants with as much information as possible before they agreed to participate an outline of the study was distributed prior to the study (Appendix C) as was a letter of consent, which included the researcher's details in case clarification were needed at any point of the study (Appendix D). Prior to sending invitations to participate in the research the researcher spoke at a PCW monthly forum and explained the purpose of the research and also discussed with the PCWs whether they would feel comfortable asking their assigned GP practices if the practice would be willing to participate in the research. During this discussion between the researcher and the PCW team it was agreed that each PCW would be given envelopes which included an information letter that invited the medical practice team member to participate, a consent form, and a survey (Appendix E) as well as a stamped return addressed envelope. PCWs were asked to hand this to their main contact at their respective medical practices. As there are over 100 medical practices in the Pegasus Health group a sample

of at least 25 was hoped for. Once again there was no pressure for the PCW to carry out this task and their Pegasus Health management team was present at this meeting.

A personalised pack in a colourful paper bag was given to each PCW. The bag contained a consent form for themselves to fill in, an information letter to remind them of the project, and a reminder that an interview with them individually was requested. In addition each bag held a few chocolates. It seemed useful to have both an e-mail and a personal reminder as emails can sometimes get "lost" in the often large quantities that are received by the PCWs as a result of their constant networking. They all appeared to receive the hand-outs in good humour and affirmed the research project warmly. Seventeen PCWs were eventually interviewed.

Information from monthly PCW reports was used to find appropriate community groups. A sample of 20 of the referring community groups, from an estimated total of 50 were offered the same opportunity to participate in the research project with a questionnaire. They were contacted by post or e-mail and the purpose of the research was explained before sending out the questionnaires. Time constraints prevented calling more agencies and so the first 15 who answered either their telephone or their e-mail were selected. It should be noted that some of those interviewed were already in a professional relationship with the researcher, who had formerly been working as a PCW, which may have inclined them to agree to participate. As mentioned earlier in this report networking and professional relationships are very important in community based projects.

3.5 PCW participants

At the time of this research there were a total of 19 PCWs employed in the city. There were also a number of former PCWs and retired PCWs who indicated they were open to be interviewed for

the research. All of the current PCWs were approached and 15 participated. The point was clearly made that this was a voluntary undertaking and all were given time to read the information sheet, consent form, list of questions to be asked, and discuss the research with whomever they chose. Two former PCWs were interviewed; however, contact could not be made within the timeframes of the project with others who had previously indicated they would be happy to participate. Of the 21 people interviewed 19 were women and two were men. The majority are in the 40-50 age brackets with the youngest in her late 20s. Three of the PCWs are from the refugee and migrant communities (including one from Bhutan), five are New Zealand Māori and one is Samoan, and the other twelve are Pākehā. Some participants are bi-lingual (for example one of the Māori PCWs is fluent in Tongan), and the refugee and migrant PCWs spoke at least two languages.

3.6 Medical Practices participants

Survey forms (re appendix E) that were delivered by the PCWs to medical practices. The PCWs had been instructed by the researcher to hand the envelope containing the information letter, consent form, survey form and self-addressed and stamped reply envelope to the person they most dealt with at the medical centre. Because the person the PCW has most contact with is the Practice Nurse it is highly likely that they are the ones who completed the questionnaires. Two of the returns were, however, completed by GPs, each of whom had signed a consent form. Because the surveys were anonymous it was neither relevant nor possible to determine the ethnicity or gender of the respondent. For a future study this type of demographic data may be useful to collect. For this research project the surveys were kept anonymous to encourage complete honesty in replies. In fact some Practice Nurses had written their names beside their signatures and some had stamped their envelopes with their practice stamp, which also acted as an

identifier. Where this occurred these data were not recorded, nor taken into account in the findings.

3.7 Referring Agencies and Participants

Fifteen agencies, including community groups and government agencies, were selected for the questionnaire. Each was posted and emailed an information letter with an attached consent form, a list of the questions in the form of a questionnaire, and the invitation to participate in a face to face interview. Five of the respondents requested face to face interviews, nine returned answers to the questionnaires, and one sent a letter outlining the main points of her preference for the service.

3.8 Host Organisation Manager Participants

At the time of the study there were 12 organisations across the city hosting the 19 PCWs. Most were part of medical centres but there were also two high schools. These managers were contacted by e-mail or telephone with an invitation to participate. This invitation included a copy of the information letter, a consent form, and a list of questions which would be asked at the time of the interview. Three managers did not reply and returned a survey form because it had already been sent invitations to respond. Two managers were away at the time and sent apologies. An opportunity to interview on their return did not arise because of the research time constraints.

All of the managers interviewed were women and all were well grounded into their communities. One school was represented by a team leader who was not familiar with the contract but very familiar with the 3the PCWs based there on either a full time or part time basis. Most managers identified as Pākehā and one identified as Māori. All gave their time freely and indicated they felt happy to participate and had no reservations about the person they had employed. Some,

especially those that had been involved from the beginning of the initiative, questioned the changes to the role and this is discussed later in the research.

Interviews of an hour in duration were conducted in places of the respondents choosing, and included the opportunity to use the University of Canterbury's School of Health Sciences' facilities. Interviews were audio recorded on a digital dictaphone for later transcription. As discussed above written surveys were delivered to all Pegasus Health medical practices by their allocated PCWs. Questionnaires were sent to managers of referring community groups and the managers were later interviewed, if they wished to be.

All transcripts both audio and written were analysed through the Thematic Analysis approach described by Braun and Clarke (2006). Descriptive qualitative research was also recognised as part of the methods when interviewing the health and community providers because the goal for the study was what Sandelowski terms a "comprehensive study of events" (Sandelowski, 2000). Holloway (1997) describes descriptive qualitative research as a way for people to interpret their own experiences and form their paradigm of the world they live in. And this approach fitted well with the main focus of the research, which was to identify each person's perception of the role. How each sector of the community was involved and interpreted the role of the PCW helped form the overall picture and current best practice model.

3.9 Data Management and Analysis

Interview transcripts were saved as Word documents on a password-secured storage device. All questionnaires were stored in a secure file. In each of the transcripts were comments that reinforced the value of the project: to try to define the role into a clearer model of practice. Typical of the

variation of comments are the following. They suggest not only the variety inherent in the PCW role but also the need for research such as this – research that helps define the role and best practice:

- "They think I am a social worker"

- "She is an extension of our medical team here at …"

- "I feel like a taxi driver"

- "Not quite sure what he actually does but he's really helpful to our service"

- "Not sure which team I actually belong to sometimes"

- "This is the best most rewarding job I have ever had!"

The above comments made by participants in this study were common throughout all interviews and suggested emerging themes such as; "unsure exactly what the role of a PCW is, not sure who my actual boss is e.g. my NGO or Pegasus", "the main reason for me continuing in this role despite the lack of clarity is because I have a passion for it", and "sometimes I am a taxi driver however that is often where the most valuable dialogue occurs with a client." These themes were consistent with all PCWs interviewed and while they could be seen as negative, often a comment would also follow such as, 'it's great to have flexibility.'

The thematic analysis was done concurrent throughout the duration of data collection. Each recorded interview was transcribed by the researcher and the themes collected and analysed. Initially it had been anticipated that this analysis would occur from September 2013 to December 2013. For a variety of reasons the data were not collected until between April and August 2014. The following section presents the results including responses to the surveys sent to the medical practices and interviews with PCWs and others. As earlier stated the data was collected with the participants speaking from their own personal perception of the role of the PCW.

Chapter 4: Results

4.1 PCW Interviews

The researcher attended a monthly PCW meeting run by the Pegasus Health management.

Because the researcher had previously been employed as a PCW most of the current PCWs knew

her. The researcher was given time to explain the research to the PCWs and emphasised that it

was not a critique of their individual work but a critique of their perception of the nature of the

role. It was also emphasised that participation in the research was voluntary and all responses

would remain anonymous. All PCWs present were given a letter of introduction to the project

and a consent form. The PCWs were later emailed to arrange an interview time for those who

wanted to participate. Seventeen of the 19 PCWs responded and were subsequently interviewed.

Two retired PCWs were also interviewed. Questions explored are listed below and appended as

Appendix F:

1. Tell me about your induction process. How long? Who with? etc.

2. How would you describe your ongoing training and education, including cultural
   training?

3. What does your supervision consist of? (Group, individual, external)

4. How do you find being placed in a community organisation? Advantages?
   Disadvantages? Supports? Frustrations? Isolation?

5. Have you ever considered what it would be like to work together with the other PCWs in
   one hub? e.g. Pegasus Health HQ?

6. What is your professional relationship with your allotted medical practices?

7. How do you think the medical practices perceive your role as a PCW?

8. What is your overall impression of your role now that you have been in it [X period of time]?

9. How could your job description be structured differently to reflect the reality of your practice?

10. How do you explain your role as a PCW to others in your life?

11. Who do you perceive your boss to be? Your NGO manager or your Pegasus Health manager?

12. Are there any other comments you would like to make regarding the PCW role?

These are summarised below;

Q1: Tell me about your induction process

In total 25% of the PCWs were orientated the role by their predecessor, 25% by the manager or team leader, 37.5% with a buddy system, which mainly consisted of teaming up with a fellow PCW for a day or two a week for a few months. This approach was well received and considered to be of benefit to both parties as it relieved the isolation sometimes felt by the PCWs. The remaining 12.5% had a mixture of induction processes used because their position was a new role, and/or a new location. The length of the induction process varied between 1.5 hours to 2 days with the manager or team leader. The follow up process was also varied but all were happy with the availability of the team leader or manager when there were questions to be answered. Half the PCWs were happy with the induction process, 25% felt a bit isolated or lost, 12.5% were not happy, feeling that it was a case of "the blind leading the blind", and 12.5% wanted a more of a structured approach. As one PCW said, "I am a structured person and needed more

information and structure. Luckily I had a health background and could figure it out eventually. Having said that support was always available by e-mail or telephone".

Q2: How would you describe your ongoing training and education including cultural training?

A significant number (70%) would like more specific cultural training, including Māori, Pacifica and new migrant education. Responses were varied, but included:

- "What cultural training?"
- "Was surprised at how little others knew. Thought I was the uneducated one as far as Māori culture went".
- "Paid for my own Treaty of Waitangi course".
- "Things have changed now we have joined with Pegasus. PHO use to pay for all training I asked for. Have just paid for my own MHERC [Mental Health Education and Research Centre] session".

Most were happy with the training sessions that were provided at their own 6-8 week hui although some commented on the fact there was no longer any time for discussion between the PCWs themselves because of the number of outside speakers that were now involved. Despite this, all commented on how useful it was to have the outside speakers and the information was invaluable as it extended their own networks of community support and knowledge which ultimately helped their clients.

Q3: What does your supervision consist of?

Many PCWs (65%) attend group supervision sessions on a bi-monthly basis, noting that they "love to hear the issues faced by others. Realised that same issues no matter what the culture, just different language barriers". A number (20%), however, who have their own Non-Government organisation manager as supervisor, as opposed to an externally appointed supervisor, were not happy with that arrangement, commenting "Doesn't understand the issues I face as the rest of the NGO has different priorities. Tries to though. I prefer outside supervisor with more specific knowledge of the issues I face". The remainder of the replies (15%) were varied, from not realising that they were entitled to an outside supervisor to "Very happy with my internal manager. Don't need the group supervision or anything else thanks. But I know it's available".

Q4: How do you find being placed in a community organisation?

A number of the PCWs noted advantages; the main theme was "It can bring a holistic approach" and

> can share resources with other team members, makes sense to have a collaborative community approach to a community issue, great benefits for the local community, great to bring in such a range of knowledge to the wider team, new connection to other ideologies, great we all spread out, school networks excellent, love it in the heart of the community.

A number of disadvantages were also noted; the main theme was "isolation from the other PCWs and health issues" and isolation from other social workers big NGO, "where do I fit?" And the problem of loss of focus if in a dual role e.g. centre manager and PCW, "I'm not a social worker

or nurse and could use others advice at times," isolation in dealing with inappropriate "gate keepers" at medical centres, can feel isolated in large rural base, "felt connected when we joined the PHO but now we have grown and not sure where I fit in large business based organisation like Pegasus."

Q5: Have you ever considered what it would be like to work altogether in one main hub?

Most (65%) prefer being community-based, 25% never considered being in a hub, and only 10% would love to be in a hub at Pegasus Health. The reasons given were varied:

- "Yes but not sure if Pegasus the right place. Pegasus [use a] business model whereas we are community development model, It may be nice to spend two days a week in one hub."
- "I can always visit other PCWs if I am feeling isolated."
- "Beauty is now we are in community organisations where we belong…engaging with the community."
- "I would love to be in Pegasus where there may be more opportunity to access the GPs."
- "Multi choice of entrance in NGO drawing on cultural capital of agency."
- "Be great to work altogether in one hub sharing skills and knowledge."

Q6: What is your professional relationship with your medical practices?

There was a mixed reaction to this question. Most PCWs reported that they had a very good relationship with the medical centres that did refer clients to them but a quarter of PCWs reported that only a small percentage of their allocated practices made referrals to them. Half of the PCWs reported that it had taken a great deal of effort to get to the situation they now had

whereby medical centres were making referrals. Of note, is that 20% reported that they would like Pegasus Health to take a more active role in promoting the PCW service. Most reported that it was a great help to understand the way each medical centre operated as they were all different depending on the number of GPs that worked there. With multiple GPs came multiple Practice Nurses and hence it took a greater effort to get to know each situation. "It was difficult to begin with so I was politely assertive and reminded them that it was for their patients' benefit, not mine".

Q7: How do you think the medical centres perceive the PCW role?

- 60% of PCW time is spent providing transport. (A number who were interviewed thought the medical centres think the PCW is "just like a free driving Miss Daisy service")
- 50% of PCWs mostly interact with the Practice Nurse
- 44% of medical centre staff do not think they fully understand the PCW role
- 44% of PCW time is spent being a support person to mental health patients
- 32% of PCW time is spent on social wellbeing, housing, heating, etc.
- 32% medical centres ask the PCW for information and knowledge
- 25% of medical centres need to be reminded that PCWs are not social workers
- 20% PCWs find the receptionist difficult
- 19% of medical centres need to be reminded about SIA funding criteria
- 19% of PCWs said that the GPs ring them direct

Q8: What is your overall impression of the role now you have been in it for? (Note: the length of service ranged from nine months to seven years.)

- 50% reported that there are more mental health clients now than pre earthquakes, and that resilience was at its maximum

- 40% agreed job description needs clarification

- 38% agreed it was necessary to be able to relate to and communicate well with all sectors of society from GPs to low income unemployed, to those with complex physical and mental disabilities

- 32% reported prior knowledge was needed

- 25% reported one size cannot fit all

- 25% reported it that it took a long time to discover their role

- 25% social problems have changed over time, which perpetuates the ongoing need for the role over difficult (post-earthquake) times

- 20% found not enough clarity around SIA funding in that GPs and medical practices applied differing interpretations of the criteria

- 20% worry the elderly are not getting all their entitlements

- 20% comment that the role is a very diverse one

Q9: How could your Job Description be structured differently to reflect the reality of your practice?

PCWs recognise that their role varies significantly depending on what type of organisation they are attached to, so that the role was very different for those working in schools from those working in an NGO or at a WINZ (Work and Income New Zealand) site. Different knowledge

and skills are required in each situation. All PCWs recognised the need for patience, for example when waiting for clients at appointments for hours, and also the significant amount of driving involved in the role. They also mentioned the need for training with a greater strength based approach. Each PCW needs to better understand the need for local community knowledge and the need to develop their own practice within that. Aside from this over 60% commented that it seems as if the PCW role is more of a social work one now rather than a health navigation role. One commented that "Social workers have more confidence in collaboration with other agencies as their role is much more defined and understood". Almost half (37%) want to have a standard evaluation and appraisal process, as well as more awareness of the value of the role at induction time, with more emphasis placed on understanding the wider determinants of health. One commented, "Please let them into the role more gently. Don't frighten them off with such extensive expectations!"

Q10: How do you explain your role as a PCW to others in your life?

There were a range of colourful answers to this question:

- "A cross between a taxi driver and a social worker. It's never just the driving. All the real issues causing the barriers to appointments come through during the driving to and fro."
- "A bridge between the community and the health system."
- "Navigating the way for the invisibles - being the torch bearer to better health and wellbeing, warmth, shelter, and food."
- "Making sure there are no barriers to accessing healthcare for Māori and non- Māori."

- "Bit hard to describe - community health worker making sure people get the healthcare they are entitled to including WINZ, being an advocate when required and transport, always say that bit last or I think the role gets misinterpreted."

- "Impact of health, means most stuff -anything else that may be required."

- "Main part is to save [the Government] money, keep them out of the hospital."

Q11: Who do you perceive your boss to be, the NGO or Pegasus Health?

There was some confusion amongst the PCWs and quite a range of responses:

- 62% said Pegasus Health but they report to their NGO as well,

- 25% said NGO and 18.75% of those thought their NGO did not always have a good understanding of the role,

- 13% were not sure but knew their reports had to go to both places, and

- Overall 25% were confused and said both NGO and Pegasus Health were probably equally the boss.

Q12: Are there any other comments you would like to make?

- "PCWs in the east need greater support and resources from the government. I think hope has gone for many people. Can we get some training on how to restore hope?"

- "There seem to be more people just putting their hand in their pockets and giving up. Post Traumatic Stress Syndrome after the quakes? It's all become very complex."

- "Earthquakes and other societal factors have changed the initial intent I think. I went looking for the original intent and couldn't find it in our contract which was interesting."

- "I love it just as much as when I started."

- "I sometimes need to be mindful that we are not a crisis response agency."

- "I have learned to say 'no' to a referral now. Wiser. I am being honest about my own capabilities. Better for everyone."

- "It's a very isolated role at times. I hope they employ people who understand this and can self-manage."

- "The last few years have bought different expectations, issues around housing and finances, mental health challenges. Challenging but enjoyable. There's a lot of personal satisfaction involved for me."

- "The role has evolved a lot. I am aware of the gaps in my skills and am looking at social work papers. I think it will give me more authority to do the role and more respect from others involved."

- "I would like more promotion to the medical centres, however, I have more than enough work and am a happy little camper!"

- "There are big problems with the SIA funding allocations within individual businesses. They need one Practice Nurse to oversee the lot otherwise just a mess."

- "The more I am known the more work there is to be done! I have to learn not to have a crisis management response."

- "I struggle in the role – not sure of where the boundaries are."

- "I have appreciated the supports that are there, educational, training, supervision. I wonder if bigger is better."

- "I have a conflict around pay issues. I think Pegasus should set the pay rate and everyone stick to that."

- "I strongly believe that each PCW should be placed where their own particular skill set lay."

- "I have learned so much along this journey. I just love it."

- "This is a really, really needed awesome role. I am always very busy with demanding hard work. I love it! Originally I got majority of my referrals from the medical centres. Not now though."

4.2 Medical Practice Survey

This part of the process used a quantitative method rather than the face to face interviews used with other participants. The method used required a survey form handed to the General Practice team by their allocated PCW. Questions were a mix of yes-no questions, followed by more detailed questions designed to quantify the extent of the response. As an example, one of the survey questions posed required the medical practice to state not only if they had used the PCW for helping patients access food parcels, but also how many times they had used the service in this way. If the question were just "Do you use the PCW to help your patients to access food parcels" the reply could only have been yes or no, which does not give enough information as to the depth of the service. The survey form asked the question, "Do you use the PCW service for food parcels?" Where the answer was yes the question continued with "How many times in the past 12 months?" A scale of 0-5, 6-10 and 10 or more was used. A consideration to using 1-20 continuum instead of the breakdown used may have given more exact detail but because this research was more interested in the perception of the role rather than the effectiveness this amount of detail was sufficient. The data which emerged from the combination of the survey layout and the analysing tool gives excellent information as to the role of the PCW in practice. This, in turn, helps to translate the theory of what the PCW role is into practice.

Of the 22 respondents to the surveys one reported that they had never heard of the PCW service. The researcher was grateful to this medical centre taking the time to return the survey forms and is hoping that, as a consequence, they have now made some enquiries into the PCW role and are using the service as originally intended to support them and their patients.

The following questions were asked of the medical practices. The survey forms can be seen in Appendix E:

1. Are you as a practice aware of the PCW role?
2. How did your practice first hear of the PCW service which supports your practice/patients?
3. In the last 12 months how often has your practice used the PCW service?
4. For what purpose have you used the PCW service? (Options listed)
5. Did the PCW meet the expectation that you had for your patient?
6. Would you recommend the PCW service to other medical practices?
7. Is the PCW role meeting your original expectations?
8. What is your overall impression of the PCW service?
9. Are there any further comments you would like to make?

Table 1 below gives an indication of how often the PCWs have been used and in what capacity.

Table 1: Breakdown of PCW services used by the medical practices

PCW service used	%	n
Transport to GP medical appointments	86.4	19
WINZ support/advocacy	68.2	15
Housing NZNZ (HCNZ) support	54.5	12
Allied Health e.g. podiatrist, dentist, optometrist	54.5	12
Transport to Hospital and specialist appointments	77.3	17
Food parcels	45.5	10
Other uses	31.8	7

The overall time the PCW had been used by the surveyed respondents during the last year was difficult to ascertain as the questionnaire asked for indications based on: 0-5, 6-10 or 10 or more times. It is a limitation of the results that it is not possible to distinguish whether a check in the final box is 11 or 20. It was estimated by using the thematic analysis tool that the practices surveyed had used the PCW a total of 92 times over the 12 months.

What was clear from the survey results is that there is a high level of awareness of the service as far as transportation is concerned. Results indicated that the medical practice teams were all aware of the capacity to transport their patients to appointments but they were not all aware of the advocacy they could expect from the PCW once they arrived at the destination.

Table 2: Awareness level of the other PCW advocacy supports available to the medical practices

	Yes	No	Total
WINZ support	15	6	21
HCNZ	12	9	21
Hospital appointments	17	4	21
Food parcels	10	11	21
Other	7	14	21

Table 3: Shows how often the services are used by the medical practices and these statistics

result from the respondents replies to Appendix E. pg. 138

	0 to 5 times	6 to 10 times	10 or more times	Total
Transport to medical appointments	5	5	9	19
WINZ support	3	3	9	15
HCNZ support	2	2	8	12
Allied Health	4	1	7	12
Food parcels	0	2	8	10
Other uses	0	3	4	7

Table 4: How the medical practice first heard about the PCW service.

First heard about PCW services through	%	n
PCW personal promotion	54.5	12
Pegasus Health information by e-mail or other means	27.3	6
Community agencies or word of mouth	13.6	3

One respondent did not answer

Table 5: Is the PCW service meeting the original expectations of your medical practice?

PCW service meeting the original expectation	%	n
Yes	77.3	17
Maybe	4.5	1
No expectation	13.6	3

One respondent did not answer.

Tables 4 and 5 above are also results from the respondents' replies to Appendix E, pg. 138

Would you recommend this service to other medical practices?

All the practices said yes they would apart from the one practice who had not heard of the service prior to receiving the survey.

Questions 8 and 9 produced a diverse range of comments

> **Question 8:** what is your overall impression of the PCW service?
>
> **Question 9:** Are there any further comments you would like to make?
>
> - "Vital, helps fill the gap, an advocate on behalf of clients."
>
> - "The ability to help our practice with social work issues, case management advocates for our patients."
>
> - "Supporting consumers to enable them to have access to primary healthcare and social services."
>
> - "Good to call on for people who don't have close or good family/friend support, to help with transport, visiting and other things."
>
> - "Provide transport to medical appointments/hospital, give support in the community for needs that are impacting on their health e.g. housing and budgeting. Link patients in with other community organisations that may be helpful to them."
>
> - "Very useful health advocacy/patient advocacy/medication compliance/appointment compliance/enrol compliance, ensuring people's needs are met. Primarily for those isolated or poorly supported individuals in our community."
>
> - "Means of reducing barriers and allowing needy patients access to healthcare."

- "Accessible, personable, informative, and supportive service to our patients to transport, assist WINZ etc., available and responsive to patient needs and staff when and as needed."

- "Means of reducing barriers and allowing needy patients access to healthcare."

- "Readily available, great support to patients, helpful. Always follows through. Professional."

- "To provide social worker type support to our enrolled population."

- "A role that provides a bridge between health, social and community organisations."

- "Practical support for people with few resources."

- "Wonderful service."

- "A role that provides a bridge between health, social and community organisations."

- "PCWs are of great benefit to help medical teams with patient outcomes and patients who are often challenged with getting to appointments or managing their health."

- "Help with community services that we can't help with in the practice."

- "A community social worker, who knows our area, available to support people with financial/housing/transport etc., issues."

- "As an extra support person to assist with the transport for patients and finding information to help assist the patients in need of extra help such as financial funding etc."

- "to those in need often in difficult situations, [PCW is] an advocate, with the knowledge to assist the above."

- "Good support, advice, information for patients and community."

- "We had three of our own community workers and due to funding cuts they were made redundant. When this happened we were told about our allocated PCW through Partnership Health and are very grateful for the service."

- "Help with forms, reporting back to us on home situation, interpreters."

- "Cold calling to help bring in patients."

- "Reminder for medications required for insulin to test and inject."

An interesting result was that of satisfaction with the different aspects of the service. For instance when asked if the involvement about the housing issues met expectations only 60% reported *yes*. This is most likely to be indicative of the housing shortages in the Canterbury region post-earthquake and to what extent the issues were resolved, or otherwise, is an unknown. Perhaps the 40% who replied *no* did not have a clear understanding of the difficult situation or perhaps they had different expectations which the survey did not ask for, or elaborate on. The questions were kept to a minimum number so as to encourage as many respondents as possible. It is worth contemplating for a future study the relative merits and demerits of whether it is better to take a smaller sample and possibly get a more depth data or if it is more beneficial to have a broader spread of data in less depth.

4.3 Referring Community Organisations Survey

The interviews with the referring community managers took place in an informal setting but the questions were asked using structured format thus ensuring each person answered the same questions. All had been sent a copy of the questions before the interview (Appendix G). Also considered in this section are some of the comments made by the host community agencies of the PCWs at the time of their interviews (Appendix H). This is because all of these agencies also

provided referrals to the PCW service because they had other social services, including social workers, attached to their organisations. These host organisation managers understood that their comments would all be considered in this report.

How did you first hear about the PCW role?

There were a range of responses to this question including, Pegasus Health promotional material, manager networking meetings, community networking, Heartlands, and a client hearing about the role from the GP. Of these the most came from community networking (35%) and 25% said that referring community organisations found out about the PCW role by word of mouth from current or new clients.

Describe your initial contact with a PCW?

All mentioned that the PCW was respectful, patient, kind, and caring. Other comments included:

- "Nothing was a problem."
- "Great communication both with myself and the client."
- "Fabulous source of information."
- "Very professional and unflappable."

What is the main reason that your organisation chooses to refer to a PCW?

All organisations were grateful for the service because their own funding did not include transporting clients to appointments and some organisations realised that at times this led to the clients' needs falling through the cracks especially those clients with intellectual disabilities. People with a mental health diagnosis were more likely to receive extra support than those on the

borderline of diagnosis or an intellectual disability and this caused stress for both the agencies caring for them and the clients themselves. Most organisations (80%) trusted the PCW with their vulnerable clients. Some of these clients had mental health issues and needed an advocate at appointments, or the clients were too anxious to take a bus. Almost half of the organisations (40%) referred clients because the clients were not attending clinics, such as dental or diabetes clinics, and needed a reminder and transport support to get there. Some organisations mentioned that there were cultural issues involved and a home visit was needed to help with language barriers and arranging interpreters for appointments.

How do you explain the role of the PCW to your clients?

Most organisations replied that they assured their clients that they could trust that a caring, reliable person would transport them to their medical appointment and sit with them to help fill in forms, or explain later what had taken place if they had not fully understood what was said at the time. All the organisations believed that the PCW knew the area they worked in and this fact gave the client confidence to trust the PCW.

How do you describe the role of the PCW to others? (e.g. Government, departmental and other NGOs)

All organisations refereed to the fact that the PCW was able to transport clients and advocate for them at medical appointments. Most organisations described the PCW as an informed caring, professional, community health worker, who treated clients with sensitivity and patience.

Does the PCW role meet your organisations initial expectations?

All organisations believed that the PCW met initial expectations, and more, to the extent that many made comments along the lines that "there's nothing too hard for my PCW" and "her knowledge continues to amaze me and she always goes the extra mile". All commented on the incredible level of patience shown by the PCWs. Only a few (10%) expressed disappointment that occasionally a PCW was appointed to an area they did not have the skills or knowledge to work confidently in. This caused a breakdown in communication for all concerned until the PCWS skill level increased; however, by then it was perceived as too late and the referrer had moved to a different solution for their clients.

How do you see the PCW role developing in the future?

Organisations recognised the value of the PCWs to their organisation. Most (70%) were not sure how to improve the PCW service but were adamant that it should be retained because they will continue to use it. A few (20%) went further and suggested it would be good for management to meet with the "people on the ground", such as the host organisations and referring agencies, to the PCW role and sit, talk, and share in a hui-like weekend. A similar proportion were concerned at the health and safety issues, in particular concern was expressed at the PCWs transporting "at risk" clients alone. Almost a third (30%) were concerned as to whether there were any boundaries around the role. Their concern was that PCWs could burn out because their caring nature did not seem to allow them to say "no" at times. These referring agencies were keen to see more hours allocated to PCWs.

Are there any other comments you would like to make about the PCW role?

Almost all (90%) organisations were extremely happy with the work that the PCWs were doing with their agency and some mentioned the fact that the PCW was able to work at the clients pace, and not their own, created trust and respect in all the relationships. About a third (30%) mentioned the seeming lack of boundaries around the role which were always advantageous for the clients but organisational leaders worried about PCW stress levels. All organisations were keen to hear that the PCW had adequate supervision because they knew the information the PCWs often heard on the way to health related appointments could be disturbing. A lot of these agencies were social work based and therefore understood the need for the safety and wellbeing of workers in the social and health related fields. Some organisations suggested that a greater understanding of cultural issues may be useful for general education and some also noted that the PCWs allocated into their own cultural communities sometimes were overrun by the client's expectations for them to be a one stop shop - interpreter, transport, food-bank, and even babysitter. It was suggested Pegasus Health management may need to consider some education of the PCW role to the leaders of the different cultures now residing and working in the city.

4.4 Host Organisation Managers Interviews

The PCW managers were interviewed as part of this research. The interviews explored the following issues: (Appendix H).

1. What is the main reason you chose to employ a PCW in your organisation?
2. How would you describe your links between you as the Manager of an NGO and the PCW management in Pegasus Health?

3. Are you clear which parts of the PCW role are your responsibility and which parts are the responsibilities of the Pegasus Health management?

4. How does your organisation support the needs of the PCW?

5. How do you describe the PCW role to others?

6. How do you see the PCW role developing in the future?

7. What cultural aspects of the role do you encourage for your workers?

8. Is the PCW role meeting your organisations initial expectations?

9. Are there any other comments you would like to make about the role of the PCW?

All of the host organisations responded to the request for an interview. All but two were able to go ahead, and then were only cancelled for varying health reasons. Contacts to all were made both by post and email. Most replied by post with the included consent form signed and returned in the included self-addressed envelope. The remaining signed the consent form at the time of the interview. All received an introduction letter regarding the research at the time of the mail out.

1. What is the main reason you chose to employ a PCW in your organisation?

All of the agencies identified the PCW role as fitting in with their own holistic approach to community development and the particular needs of their geographical area. Some of these agencies were disappointed that the PCW role had now extended outside the original geographical area agreed on and felt their own local community was missing out. All the agencies had expectations of greater collaboration between themselves and the wider community, medical practices and other health related agencies which would enable easier access for their vulnerable client base. About 40% of the agencies reported that the PCW role

was a positive addition to their staff because they also employed social workers. Some of those agencies now employed their PCW/Social workers in a dual role.

2. How would you describe your links between you as the manager of an NGO and the PCW management in Pegasus Health?

A significant percentage (80%) of the agencies noted a difference in communication between Pegasus Health and the original PHO management. Although most agreed it was still positive there was a large degree of realisation that it was now up to them to be proactive about communication whereas previously there had been a more personal relationship with the PHO management. About a third (30%) found the contact minimal and preferred face to face contact rather than e-mail or cell-telephone while 10% felt extremely disappointed and wondered if the scheme had become "too big". Despite these concerns, all NGO managers agreed that the Pegasus Health management was quick to reply to any queries and was always accessible by telephone or e-mail if needed.

3. Are you clear which parts of the PCW role are your responsibility and which parts are the responsibility of the Pegasus Health management?

Half of the agencies were very clear that they had an employer responsibility for administration support (laptops, internal appraisals, etc.,) and that this was clearly written in the contract. A little less than half (40%) thought "clear" might be "pushing it" but they felt comfortable knowing that Pegasus Health was just at the end of the telephone if needed for clarification, and the remaining10% wondered why Pegasus Health just did not employ them outright. Several

expressed concerns about pay anomalies across the PCW agencies particularly given that all agencies were paid the same rate by Pegasus Health.

4. How does your organisation support the needs of the PCW?

All reported they do their best to ensure the PCW is made welcome and comfortable in each workplace. Most expect the PCW to attend in house staff meetings and internal supervision. All enjoy reading the monthly reports the PCWs send to both themselves, as host organisation, and Pegasus Health management follows up on any perceived client based difficulties if the issues have not already been addressed. Only one of the high school based team leaders was available to be interviewed and she was not completely aware of the contractual obligations because only the school management had access to the contract with Pegasus Health. This team leader, however, had exceptional faith in the current school based PCWs and worked collaboratively with them when challenges arose. She understood that each PCW had an external supervisor they could call on when necessary and she was also confident she herself could call on Pegasus Health management if needed.

5. How do you describe the PCW role to others?

Most described the role as a community worker who provides access to healthcare by disabling barriers and some added that they provide information to those in the community who can impact or enable change. They also commented that it had become a very wide role with a holistic approach. Several also added that they believed the role had become much more complicated as a result of the earthquakes and that clients with mental health issues that were becoming more prevalent in the daily working life of the PCW. A significant number of

organisations (40%) expressed concern at the expectations placed on their PCW who did not hold social work qualifications and who were at times overwhelmed by the more social work type complexities they faced as opposed to public health issues they were trained for.

6. How do you see the PCW role developing in the future?

All the agencies working both in the city and in outlying areas, such as west and north Canterbury expressed a compelling need for the PCW role to be operating within those regions. All made comment about the "exploding" population growth in outer Christchurch and were concerned at the needs their agencies were encountering through other services they also provided. The team leader of some of the high school based PCWs s expressed a need for a hardship fund available for the PCW to administer in situations where students needed to attend medical centres for a variety of reasons but where family financial situations prevented this from happening. Some agencies also spoke of the need for a similar discretionary fund because the NGOs generally did not have spare cash for those clients whose medical centre was not accessing the SIA funding it was seemingly intended for. Several agencies also mentioned that sometimes the medical centres themselves were not aware of the SIA criteria and they suggested a separate organisation being selected to administer the SIA funding for all organisations which would give a much more standardised approach.

Almost all of the agencies expressed a desire for the marketing of the PCW role to be more fully focussed on the Pegasus Health Medical Centre so as to develop further the collaboration between the PCW and the staff there. Some also wished the PCW role could cover non-Pegasus Health medical centres because a portion of their clients attended medical centres under a

different PHO banner. One agency was keen for the PCW project to return to a more geographical approach and research the local issues more fully.

All of those interviewed were adamant the PCW role was an extremely valuable resource for the community and the target population and were hopeful it would be continued and expanded as required by the community and not hindered by financial constraints. But a real issue is how the role grows: "A question for Pegasus Health" said one manager "do they want to put boundaries around the role or do they want to let the PCW role evolve around the community?"

7. What cultural aspects of the role do you encourage for your workers?

40% of the managers understood that Pegasus Health provides the cultural training for the PCW and that they were responsible for providing a workplace in alignment with the Treaty of Waitangi – Te Tiriti o Waitangi. Some of these organisations had a Kaumatua (male elder) or a Kuia (female elder) attached to their agency which they believed to be an excellent resource for any cultural issues. Others expressed concerns that their organisation was multicultural and wanted funding available to help train their staff in other cultures fast appearing in their neighbourhoods, such as people from the Philippines, rather than focus solely on Māori culture.

All the host and referring agencies managers noted that the PCWs showed respect for all clients no matter what the client's background. One host manager was very disappointed that the National Government had made cuts to funding for professional development which they had used previously for staff cultural training sessions, for example for Treaty Of Waitangi Days. One host manager added that even amongst Pākehā there was a "diversity of cultures" and they were mindful of using a community development model which focussed on being in tune with

the person and not working beyond the client's pace, even though at times this conflicted with health funding needs to meet goals at a faster rate. As one manager put it: "A person's needs versus professional needs – it's all cultural!"

8. Is the PCW role meeting your organisations initial expectations?

Only a few of the organisations (10%) believed that the emphasis had changed from a community focus to a business model and were disappointed with this. In contrast, 80% were extremely happy with the role, although some had not been with the project from its inception and they acknowledged that. Most also acknowledged the way the role had expanded from predominantly transportation and advocacy at medical centres to now being about support in whatever form that support may be required within the realm of the wider determinants of health. A number of managers also commented on the way the PCW role helped them network within the wider community and bought knowledge and information to their own wider staff. A majority of host managers felt this was a major part of the original intention to partner with community groups and medical centres but they also felt the interaction with a lot of medical centres had not reached the potential these host managers had hoped for.

9. Are there any other comments you would like to make about the role of the PCW?

What follows is a representative selection of the comments made:
- "I can see how easily PCW morphs into social worker role. People can grow into a role but the question is, is that the intended role in the first place?"
- "I am just extremely happy with the way the school is being serviced by the PCW team here. Please keep up the funding as we value their expertise greatly."

- "A bit concerned about the level of transport required here as it is now a larger area than agreed on".

- "The important thing is keeping people in their own homes and out of the health system for as long as possible."

- "Such an added bonus to our holistic centre here. We can get 'siloed' in here and so a PCW can bring in the outside world. Such a great service and it expands our minds in the process."

- "Feeling bothered by the unfairness of the way the SIA funding is used. Would like to see an outside agency controlling it all and making it available on a more standardised criteria and referral system".

10. How do you describe the role of the PCW to others? (e.g. Government Departments, other NGOs)

Most described the PCW as an informed caring, professional Community Health Worker who treated clients with sensitivity and patience. All refereed to the fact that the PCW was able to transport and to advocate for clients at medical appointments.

11. Does the PCW role meet your organisations initial expectations?

There was 100% affirmation that the PCW met organisational expectations – plus much more. Most comments included "there's nothing too hard for my PCW," and "her knowledge continues to amaze me and she always goes the extra mile". All commented on the incredible level of patience shown by the PCWs.

12. How do you see the PCW role developing in the future??

- 70% said they were not sure how to improve it but to please keep it around as they will continue to use it more.

- 30% wondered if there were any boundaries around the role as they felt the PCWs could burn out as their caring nature did not seem to allow them to say no at times. These referrers were keen to see more hours allocated to some of the PCWs.

- 20% suggested it would be good for the management to meet with the "people on the ground" and sit, talk and share in a hui-like weekend.

- 20% were concerned at the health and safety issues regarding the PCWs transporting "at risk" clients alone.

4.5 Partnership Health PHO Marketing Manager at 2006 interview

A former employee of Partnership Health PHO reported that because the practices in the east of Christchurch already participating in the SIA scheme were pleased with the results she was employed by Partnership Health in 2006 to roll out the project to the rest of the Pegasus Health medical practices. She went on to say:

> It was perceived by the initiators of the project and confirmed by those initial medical practices in the east that the community knows the people requiring support to access healthcare and can steer them into a GP. My role was to get out and talk to the GPs and develop that relationship between them and the community and nurture the project across the city (2006 Partnership Health Marketing Manager, personal communication, July 26, 2014).

Although the project had already been deemed successful there were barriers to her marketing

role. She found that in some medical practices there may be up to six GPs with three or four

Practice Nurses. This sometimes caused confusion and frustration to get information to the right

person. She also found some medical practices were caring for financially disadvantaged patients

themselves and didn't want yet another "new scheme" to work with. Some GPs were near

retirement and were not interested in seeing her. Some were already at capacity and therefore

were not interested in enrolling more patients. Some saw the PCW as just a transport aid for

patients.

> The PCWs are not just taxi drivers. They are professional people with qualifications in
>
> their own right. I think because they are all so different and there is no standard
>
> qualification it makes it difficult for people like GPs to trust them. Until they get to
>
> know them individually some GPs think the PCWs are just another unqualified
>
> community worker (2006 Partnership Health Marketing Manager, personal
>
> communication, July 26, 2014).

She also suggested that the boundaries for the PCW role have more recently become blurred and

the role was never intended to address wider social needs such as housing.

> The diversity and uniqueness of each PCW is right for their own communities. However
>
> it would seem necessary now for more emphasis to be put back on the original intention
>
> of partnering with the Practice Nurses. Helping clients with things such as WINZ is fine
>
> but not housing in this post-quake city of Christchurch. Let's get Pegasus Health to
>
> educate and promote the PCW role to the community and the GPs because now the

community is referring more than the medical practices! (2006 Partnership Health

Marketing Manager, personal communication, July 26, 2014).

It would appear from the interview with the 2006 Partnership Health Marketing Manager that the

intention of the PCW role has changed although it would also seem that perhaps the role was

never fully understood by all of the medical practices from the start. Maybe Pegasus Health still

have a challenge to promote the benefits of the project to the medical centres thus creating trust

and greater collaboration between all parties.

The following discussion in chapter 5 looks at the key findings from the perspectives of the

PCW's, and the Medical Practices who were the original focus of the PCW initiative.

Consideration of Maori, Pacifica and Refugee and Migrant Health is also discussed and the main

emerging themes are;

- Relationships

- Trust

- Collaboration

Chapter 5: Discussion

5.1 The Current Model as Perceived by the PCWs

Interviews with PCWs indicate their current model role is three-fold: transport, health support, and advocacy. This is outlined below.

Figure 13: The PCW model as perceived by the PCWs (Penfold, 2015)

Community Health Worker: is the way that most described their main role. As with the WHO (2006) definition of a CHW these PCWs had trouble at times knowing the boundaries and expectations associated with the role. The far reaching expectations the role have now evolved to encompass a definition that is hard to put parameters around, but it is much wider than the CHW role as described by the WHO (2006).

Transport: is a large component of the role. Time used for transporting clients gives the client an opportunity to talk openly about other needs in their lives which then allows the PCW to work collaboratively with other agencies as required. This aspect of building trust with clients is a major factor in the effectiveness of the PCW project.

Housing Officer: Although advocacy for housing was in the original intention for the PCW role this aspect has now become a major issue for the PCW. As discussed earlier in this paper thousands of houses have been destroyed or are in the process of being rebuilt because of the 2010-2011 earthquakes in Canterbury. Many of these homes are in affluent areas, and this has placed pressure on the rental market from those who would otherwise not be in rental accommodation. In addition many of the homes that were destroyed are in areas where many of the PCW target population live. There is therefore further pressure on rental accommodation because much of the council accommodation was also destroyed. As a consequence, rental properties have become overpriced and difficult to find. Desperation has therefore set in amongst many of the PCW target population: low income, Māori and Pacifica. The PCW team are often required to help find accommodation for clients, and the necessity of this and difficulties in securing accommodation have frequently resulted in stressful situations and disappointment for all.

Social Worker: is how many described the role, but not many PCW have been formally trained as social workers. As with some of the comments from interviews with the wider community the PCWs now often carry a case load which was not originally intended. At their job interview the PCW was given to understand that their role would be that of providing a brief intervention for the target population. It would appear that the increase in complex mental health issues in

Canterbury and the seeming lack of facilities now available has put an enormous amount of pressure on the PCWs who are expected to provide interventions that they are mostly not qualified to initiate. It would appear, however, that because of the nature of the workers themselves they are managing to meet many of the more social worker type expectations with support from their host organisation management alongside the Pegasus Health management.

Mental Health Worker: The complexities of mental health issues now being referred to PCWs are causing some PCWS significant stress. Those with social work, or specific mental health, qualifications seem to be better equipped to cope than those who were either new to the role or who had received only basic mental health training. Partnership Health PHO, and now Pegasus Health are both organisations committed to training their staff in all areas of health but the recent increase in complex cases, (mainly because of earthquake trauma) has meant that some of the training is insufficient for the requirements (Gordon, 2009). This, coupled with the fact that specialist mental health organisations are also at capacity (CDHB, 2013), has left a major gap in the community.

5.1.1 Wider discussion of the PCW role.

In the Henderson and Kendall (2011) study the CHW participants accepted that they were primarily knowledge brokers, linking community members to information about the various systems that had an impact on their lives. They also provided support and strategies to negotiate those systems. To perform this role, they were forced to adopt a broader approach to health than originally intended, recognising the significant impact of social determinants of health such as housing, education, and employment. The need to extend the role of lay helpers to include a focus on the social determinants of health was also suggested by Bishop et al., (2002). An

extension to the scope of practice for Health Navigators increased their workload on a temporary basis, but it does provide a longer-term opportunity to build capacity.

The PCWs noted that most of their referrals now come through the community and while this is more than expected they wonder if Pegasus Health could approach the medical centres in a different way to encourage more collaboration and referrals from medical centres themselves. Some PCWs were aware of the monthly group meetings that had been held with the Practice Nurses, but which have been discontinued. All were keen to see some form of this meeting re-introduced. All recognised the benefit not only to the client, but also to the medical practice, of a better partnership between PCW and Practice Nurse. Some suggested that there be a regular monthly meeting to be held at the Pegasus Health office while others were happy to make individual approaches to their allocated medical centres for regular chats and updates from both sides. Some PCWs were very happy with the referral system and already had formed a strong relationship with their allocated practices.

What did become evident is that there is an anomaly in the pay rate between PCWs and most would like to see some standardisation around this. Petrol allowances were also a topic of discussion because, again, there seemed to be some quite significant differences in compensation here. The current recommended New Zealand Inland Revenue Department rate for re-imbursement of a private motor vehicle is 77 cents for each kilometre driven. Many did not receive this amount and although some PCWs were provided with a work vehicle, for many their main mode of transport when working was private car. And at times the personal cost was overwhelming. In addition to this, most roads in Canterbury were damaged in the earthquakes and many still have significant potholes and broken road surfaces, or are being repaired. In either

event the roads are difficult to navigate and force greater wear on vehicles than might normally be expected. As a consequence some PCW are concerned about the longevity of their cars.

Another area of concern for PCWs is whether they have been adequately educated and trained in the mental health field. Some felt overwhelmed at times because of the expectation on them to resolve complex issues, in which they had no or little experience. Most had back up and support either in their own host agencies or their community networks. All reported that help was always readily available from Pegasus Health but there were times when they were required to make decisions on the spot which were not within their previous experience. Supervision, both group, individual, and private was also considered a very much appreciated valuable and needed resource however finding the right supervisor was at times difficult for some especially for the non-Pākehā PCW.

5.2 The Medical Centre Perception of the PCW Role

The medical practices who responded to the survey used the service mostly as it was intended. Some were unaware of the advocacy roles the PCW played once the patient had been transported to specialist or allied health appointments. The medical practices surveys were mostly completed by the Practice Nurse who appeared to understand the full extent of the role; however, because only 28% of the medical practices completed the surveys it is difficult to ascertain from this study whether the remaining 72% of Pegasus Health medical practices are either aware of the role or understand the role.

When interviewed, five of the seven PCWs who had been in the role since its inception were upset that the regular monthly meetings between PCWs and the Practice Nurses had been cancelled. They believed this was a crucial event which helped to form and to cement the

relationship between the medical centres and the PCW service. Other PCWs interviewed who were new to the role and had yet to experience such gatherings, were very interested at the suggestion for such an opportunity to build relationships. The reason why these monthly meetings were cancelled is not confirmed, but it is likely that a lack of both time and space because of earthquake damage is a possibility.

One main theme from the Partnership Health Annual Reports 2004-2012 is the need for closer links to be formed with the medical centres and the PCW service. It is, therefore, to be hoped that this seemingly vital link between the Practice Nurse and the PCW is re-established.

When analysing the literature around the intention to partner the PCWs with Practice Nurses and thus become an extension of the medical practices one has to wonder why the recommendations made consistently for Pegasus Health to put more time into informing the medical practices of the availability of both the Practice Nurse hours and the PCW service, which clearly had evidence of supporting both them and the patients was not taken up.

One serious issue for medical practices is funding. Maw (2008) discovered that most GPs wanted to be rid of the number of "fragmented" pieces of funding they received and would prefer a more simplified package. It is not clear whether all medical practices are accessing all the funding to which they may be entitled, whether for PCWs or other matters. Around 50% of those the 2006 Partnership Health Marketing Manager surveyed were taking advantage of the PCW service and they all reported being very happy with it, although some felt the hours allocated to their practice was insufficient. All Pegasus Health medical centres can now have a PCW attached to their practice, but it would appear that they are not all aware that this is the case. The question may be pondered as to whether these medical practices have time to read all the literature that comes

their way, and if that is the case then if Pegasus Health is to continue to make this SIA funding available then what can be done to support the medical practices to receive funding to which they are entitled?

Most of the practices surveyed who were using the PCW service believed it to be a bonus both to them and their patients because of the community knowledge the PCWs bought with them and these medical practices supported the PCW service being rolled out to the rest of the city.

5.3 Māori Health and the PCW Service

When considering the context of Māori communities and Māori as an integral part of the focus for the initiative Māori community development models such as Munford and Walsh-Tapiata (2006) need to be acknowledged. They suggest seven key principles: having a vision for the future and what can be achieved, understanding local contexts, locating one-self within community, working within power relations, achieving self–determination, bringing about positive social change for all communities in Aotearoa New Zealand, and action and reflection, can overlap with more western models such as that described by Greenaway and Witten (2006). Greenaway and Witten (2006) emphasised the need for strong relationships between individuals, groups, and organisations as well as gaining knowledge through critical reflection. The challenge may be for Pegasus Health management, the GP practices, and the community to collaborate in a more purposeful way to incorporate the models described above. Strategic planning may then involve a different way of working and the client base may achieve a better health outcome.

Both Durie (1998) and Salmond (2003) argue that colonisation has had a material impact on the health of Māori. Both note that the long term effects of British colonisation on Aotearoa New Zealand in the 18th and 19th centuries when land was confiscated and Māori were disempowered

makes a significant contribution to the current outcomes of Māori health today. Although the Aotearoa New Zealand Government of the 21st century continues to honour Treaty of Waitangi – Te Tiriti O Waitangi settlements with the descendants of those from the past, one can only watch and hope that future generations may have their mana (dignity) restored to the same equity as those past ancestors and with it renewed hope, wealth, and health.

5.4 Pacifica Health and the PCW Service

The Pegasus Health Pacifica Reference Group includes members from across the Canterbury health spectrum including PHOs, CDHB, Planning and Funding, Community Public Health, Pacific Trust Canterbury and a community representative. The Canterbury Pacifica Health Framework which is based on the Māori Health framework was close to being finalised at the time of this research and this Canterbury Pacifica Health Framework group was considering suggestions on what outcome measures might be included to monitor progress.

The Pacific Canterbury Primary Healthcare Report (2010-2011) notes that there were three Pacifica people working within the PCW team and two of these were based at Pacific Trust Canterbury. It also reported that 19% of the total clients who used the PCW service that year were Pacifica people and that 18.2% of the total PCW hours worked per week were undertaken by PCWs, which was an increase from the previous year. These statistics are confirmed by the Pegasus Health Pacifica reference group's September report (2014). This report also discusses the fact that Pacifica youth do not access GP services. This is causing concern and there needs to be a change the current model of healthcare to a more culturally compatible model.

The spiritual aspect of the Pacifica culture is not currently taken into account in primary healthcare and this provides confusion and deters youth from accessing GP services. The issue of

shyness amongst Pacifica women was also referred to, as it had been in previous reports. This lack of acknowledgement of these major components of Pacifica culture has led to mental health issues and these need to be addressed by not only the GPs but also the CDHB in general because this is one of the populations identified by the CDHB as missing out on health services. Education and training in Pacific cultures as described in the Fonofale Model of healthcare is required. In addition more consultation with the Pacifica community is needed to strengthen the systems and policies around programme development across the board at CDHB level if the health and wellbeing of the Pacifica people is to improve to any significant extent. This is illustrated in the following:

> Affordable and adequate housing also continues to be a major issue for Pacific people, especially given the shortages in Christchurch. Income is often low and they have no choice but to take substandard houses at high rents, meaning their focus is on paying rent, buying food and keeping warm. Gas fires are often used instead of heat pumps as running costs are cheaper; however this can lead to breathing problems, particularly for children, which in turn can lead to avoidable hospital admissions. (Pegasus Pacifica Health, 2014).

The Pacifica community, which continues to grow in Canterbury, clearly needs a much more intense approach than it is currently receiving. It would appear that having the PCWs based in organisations that are based on Pacifica principles and values is helpful but it may well be that increased workforce resources are still needed. There is, however, a further issue to be addressed, one that relates to a comment made by a PCW during an interview. She said that the Pacifica community was not always keen to have "one of their own" knowing all their health issues. As is

the case in most communities there are often complex issues to overcome. The PCW monthly reports note that in relation to the Pacifica population transport continues to be the most significant barrier to access, followed by lack of understanding of health needs and of services that are available.

A resource booklet prepared for the Medical Council of New Zealand by Mauri Ora Associates *Best health outcomes for Pacific Peoples: Practice implications the New Zealand healthcare system does not always meet the needs of Pacific patients and their families* (2010) says that despite the Pacifica patients seeking care appropriately:

- Pacific people often don't receive the high quality, timely services they need.
- Pacific patients and their families may expect different things from their doctor than non-Pacific families; for example, they may place a high value on spending time getting to know the doctor.
- Cultural misunderstanding by doctors can contribute to Pacific health disparities."

The summary of the Ministry of Health, (2014) report would lend itself to the view that an advocate, such as a well-informed PCW who possesses knowledge of the different aspects of Pacifica healthcare and wellbeing of Pacifica peoples, would be an asset to them when accessing primary healthcare.

5.5 Refugee and Migrant Health and the PCW Service

As the PCW project is aimed at those sectors of the community who are missing and missing out on healthcare it is appropriate to consider the refugee and migrant population within the CDHB region. There are currently two female and one male PCWs working in this sector. Apart from

the 'published' (see figure 8, 9, &10) duties of a PCW these workers are also faced with the complexities of language and cultural barriers for their communities. They are often asked to translate at medical appointments even though there is a translation service already in place and considerable support is given to this service through Pegasus Health. In 2011 comprehensive documentation was sent to all the Pegasus Health medical centres explaining and offering the interpreting service to them and their patients. It was careful to point out the disadvantages of having a family member or support person translate for a patient and also how misunderstandings in communication are often difficult within the same culture let alone two cultures trying to understand what could be a complex medical condition. This information provided by Pegasus Health emphasised that professionally trained interpreters were available and how to engage with the Interpreting Canterbury Service, giving both telephone numbers and an e-mail address with very specific instructions on contact details. It would seem that although this service is readily available there are times when the medical centres do not access this for a variety of reasons and it appears that their Australian counterparts are also having the same issues, according to a report to the New South Wales Refugee Health Service (Finney Lamb & Smith, 2002). One of the reasons given in regards to the Pegasus Health GPs is that situations such as emergency consultations give no time to arrange the interpreter, but some of the PCWs reported that they were expected to be interpreters as they could speak the language even though they were only employed as a support person. Even though PCWs may know the boundaries expected of them sometimes the expectations of their own communities were greater and therefore at times this extra workload of interpreting expectations impacted on their family time, causing them concern and fatigue. In her study about lay helpers, Gammonley (2009, p.64-80) also identified role overload as a common problem that had an impact on the physical and mental

health of lay workers. Her study revealed a dilemma in simply educating the navigators about how to place boundaries around their work actually placed them under greater pressure because doing so meant that they could not meet the expectation of their communities, and themselves.

As Gammonley notes: "Ironically, the close connection they maintained with their community was the main source of this expectation, but was also their greatest success factor" (p. 64-80). Gammonley (2009) goes on to note "that if we wish to draw on lay helpers to address inequity and access barriers for CALD we need to understand that the success of the role comes with serious personal implications for which they must be adequately compensated". (p.64-80). This is just as relevant in the Canterbury context to the Canterbury refugee and migrant communities. Indications both here and in Australia are that the intervention of a CHW and an interpreter has a greater potential for addressing the barriers to healthcare for this part of the population than leaving them to struggle alone. A recent PowerPoint presentation by the Enliven Community Services Manager, included a section on the PCWs in which she noted "PCWs support clients with needs that impact on their health-housing, benefits; to link with other support services; provide cultural support and Pegasus Health provide interpreter services" (Enliven Community Services manager, personal communication, 2014). This indicates that some larger community groups are aware of this vital service and are now advertising it widely through their own networks which may help address the issue by encouraging referring agencies to call an interpreter before simply relying on the PCW. One would hope that greater awareness around this issue of the interpreting service line will be supported by the Pegasus Health fraternity in the near future which may include educational training at their own meetings. Earlier visits to the primary health centre of course gives a greater expectation of less hospital admissions in the

future and so all strategies to help this disadvantaged community receiving timely primary healthcare needs to be adequately resourced and utilised.

The themes that have presented themselves throughout this study are relationships, trust, and collaboration will now be discussed.

5.6 Relationships

Grim and Walker (2011) discuss the need for strong relationships between all the parties in the primary healthcare sector to give the best result for the client, and ultimately the funding partners. The findings of this thesis support this. Without the co-operation of the GP and the Practice Nurse in the medical practice the work of the PCW is limited. Without a strong positive relationship between the Practice Nurse and the PCW, the service the PCW could provide was compromised and without a strong positive relationship between the host managers of the PCWs and the Pegasus Health management the opportunity for confusion over boundaries was high.

Relationship models that appear to be the most appropriate for the target populations in this study are those based on the Pacifica and Māori models, such as Te Whare Tapa Wha and the Fonofale, combined with the Whānau Ora approach. Combinations of these models are being practised in some communities and this approach has been recommended by the Expert Advisory Group for looking at issues such as reducing child poverty (Pegasus Health Expert Advisory Group, 2012).

5.7 Trust

The issue of trust, while necessary and applicable to all parties involved in primary healthcare, seemed to be noted mainly between the GP workforce and PCWs in this study. This was in the

area of a lack of understanding of the professional skill level of the PCWs and therefore the development of a standardised qualification may be of help here. The current practice of providing a medical centre with a photograph of the PCW assigned to their practice may be more useful if there is also an indication of the professional skills of that PCW. It would also seem that once the professional relationship between the GP and the PCW is established the trust factor becomes less of an issue and referrals are made as required. This professional relationship is established either directly with the PCW or more often through the recommendation of the Practice Nurse. The lack of regular contact between the Practice Nurse and the PCW was mentioned often and all the PCWs who had previously been involved with the organised regular meetings between themselves and the Practice Nurse were keen for them to resume. Pegasus Health management (2014) showed interest in returning to these regular meetings and suggested that the reason they were dissolved 2012 was perhaps due to lack of space post-earthquakes rather than that they were not needed. Pegasus Health are working on re-implementing this meeting as soon as possible. Aside from this for as long as the cultural component is missing from the equation there will remain a lack of trust by some of the target populations.

5.8 Collaboration

The Oxford Dictionary definition of collaboration is "the act of working with another person or group of people to create or produce something." As mentioned above strong relationships and trust between parties that result in full collaboration are the essential ingredients in the PCW initiative. Collaboration also needs to be extended to involve the CDHB and the leaders and managers in the target population fields. Models of health already created by Māori and Pacifica, as well as other community development models give an excellent base for the CDHB and the

Ministry of Health to address the issue of accessibility to primary healthcare in Aotearoa New Zealand.

The current evidence of the nurse led clinic and its impact in the whole community is that it is very successful. As noted in international and national research the nurse led clinic has a greater success in involving the community and understanding the needs of the community (Almond & Cowley, 2010). Collaboration between the nurse led clinic and the PCW, who is also already in relationship and collaborating with the community, has the potential to create a successful model of healthcare. More recently the vice-president of the New Zealand Nurses Organisation, NP Rosemary Minto, strongly suggested a paradigm shift was needed to further progress the New Zealand healthcare system to a more equitable and effective service (Minto, 2015). Whilst she acknowledged some positive changes such as the language changing from 'doctors and others' to 'teams,' she also lamented that perhaps the lethargy for more substantial change required to create a system that suited all New Zealanders, was that it may require things to be done 'too differently.' (Minto, 2015).

Therefore the discussion section of this study would lend itself to suggest that there are many considerations required to further the PCW role, to develop it as it was originally intended which was to reduce barriers to primary healthcare by vulnerable population groupings. However the participants recognised that relationships, trust, and collaboration were the main ingredients to form the partnership between the community and primary healthcare. A clearer understanding and acceptance of the cultural and social needs of this diverse population by all participants would therefore have an enormous potential to enable greater health benefits for the future, not only on an individual basis but surely on long-term government budgets as well. It can only be

hoped that the current policy makers of healthcare in Aotearoa New Zealand will take note of the many experienced healthcare practitioners both nationally and internationally and bring about the paradigm shift those practitioners are ready and waiting for. It can also only be hoped that the findings of this study will add to the momentum to provide further discussion to this end.

Chapter 6: Implications, Recommendations, and Conclusions

6.1 Limitations of the Study

There are two main limitations to this study:

PCW recruitment: as the author was a PCW at the beginning of the research process and therefore known to all but one of the PCWs interviewed before the research began there is a possibility that this professional relationship may have had an impact on the interviews. There was no suggestion during the interviews that this was the case in a negative way and it is more likely that a high level of trust between the author and the PCW team allowed a more honest approach to the replies given to interview questions. The author retired from the role six months into the study because of family health issues which left at least a twelve month gap of any interaction with the PCW team before the completion of this report. However as the author is now working with socially isolated older persons helping them to connect with their neighbours and local communities collaboration with PCWs often occurs.

Medical centres: As the medical practice surveys were anonymous it was difficult to ascertain if all the 84 surveys handed out to PCWs by the researcher were delivered to the person who may have been most likely to complete them at the medical centre. This is in no way a criticism of the PCWs or the medical practices but rather a recognition that the medical practices are businesses with at times large teams of both GPs and Practice Nurses which sometimes causes difficulties in information sharing.

6.2 Further Research

As the study neared completion it became apparent to the researcher that perhaps a greater interest or acknowledgement of the ethnicities of the participants may have been useful and this could be explored in further research studies. Due to the nature of the target group, for example the Pacifica community, it may have been of interest to that community to know how many Pacifica Practice Nurses or GPs are currently involved in primary healthcare in Pegasus Health medical practices.

It would also seem that although the Practice Nurse was generally the person who completed the survey on behalf of the medical centre, questions about the monthly meetings were not included in the medical practice survey. This is a limitation in the study in relation to this part of the discussion because although the PCW perspective is clear is not known what the Practice Nurse view is on this issue. This would be a fruitful focus of future research. The question was not put to the medical centres because it was not recognised as a significant issue at the time the survey questions were prepared.

As mentioned earlier Ragsdell (2000) found drawings and sketches to be helpful to describe complex situations. The two simple drawings supplied by two PCWs allowed them a clearer insight into their own perception of their roles than either were able to verbalise when interviewed, "I find my role really difficult to put into words as I am very intuitive and there are many times I just sort of know what to do…" (PCW participant). In further research involving complex situations, participant sketches and drawings may be of use as a means of data collection.

6.3 Recommendations

The implementation of the following recommendations in regards to a future PCW working

model are dependent on: the continued funding of the SIA project by the CDHB, the

commitment of Pegasus Health Charitable Ltd to educate their GPs as to the benefits of

community collaboration, and moreover, the current high standard of the PCWs needs to be

recognised and extended.

The recommendations are as follows:

1. That a standardised educational competency package is developed, which includes

    multicultural models of health, mental health, and the full social determinants of

    health components and leads to an NZQA (New Zealand Qualifications Authority)

    qualification. The Logan model in Australia may be an appropriate starting point.

2. The regular bi-monthly meetings between the Pegasus Health Practice Nurse and the

    PCW be re-established to help regain the necessary trust ingredient the project was

    founded on and research has supported.

3. The promotional material be worded to reflect a more realistic expectation of service

    delivery in post-earthquake Christchurch, for example housing advocacy may not be

    an appropriate advertised issue

4. More recognition is given to the current skill levels and knowledge base of the

    PCWs by Pegasus Health in the way that the service is promoted to both their own

    staff and to the Pegasus Health GPs.

5. The nurse led clinic is the favoured medical practice model because it is more likely

    to incorporate culturally appropriate healthcare methods. A nurse led clinic model of

    healthcare also has the potential to permit those who use it to collaborate with the

wider community in conjunction with the PCW. Moreover this type of team based

approach releases the GP to spend more time with complex cases, which gives the

potential for greater positive healthcare outcomes for primary care.

6.4 Implications and Conclusions

In 2009 the Government released its *Better Sooner More Convenient* approach to integrated

healthcare across primary and secondary health providers with the patient rather than the

institution as the centre of service delivery. As this is also the focus of the PCW model the

challenge is to incorporate all the components involved to collaborate together in a closer way.

This involves the client, GP, Practice Nurse, and the wide range of referring community and

government agencies developing closer relationships and thus greater trust between each other.

When looking at the best practice models for the CHW/navigator/PCW, both nationally and

internationally, there are many similarities but there are none that are quite the same as the PCW

model.

If the original (2010) model is compared with the current model of PCW practice, (Pegasus

Health 2014), it would appear the current model has expanded to encompass more of the wider

WHO defined determinants of health. The original intention, although it included housing and

mental health advocacy, did not intend for the PCW to be the main provider of these services but

rather that they act as an advocate of these services. This would be more aligned with several of

the CHW or navigator models used in both Australia and the United States of America; however,

most of the international models have a particular health focus, such as chronic illness.

Moreover, in the CALD communities as in Logan, Australia, which reports a large Pacifica

population, including Māori, Samoan, and Tongan, plus a refugee population, including those

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from the Middle East and Africa, the navigators were employed specifically to represent their own ethnic groupings. In the United States of America, the New Jersey CHWs had a main focus of mothers and babies. In contrast, the PCW model is more widely focussed on general public health; however, like the Logan project there are amongst the PCWs a number of Māori, Pacifica, refugee and migrant representatives.

A difficulty with boundaries and parameters is seen in each of the models used for CHWs. Some of the models used both paid and unpaid workers, whereas the PCW model always uses the PCW in paid employment. In the area of training the Logan model seemed the most comprehensive, requiring competency in five separate modules over a one year period and also including regular weekly supervision sessions leading to a navigator qualification.

These international reports also noted that during interviews with the navigators, (as it was with the PCWs), comments were made concerning the difficulty they had with perceptions by their own communities as to the exact nature and parameters of their role. In this instance the Logan navigators found the training and education sessions very helpful for themselves in regularly comprehending the need for boundaries for their own personal safety and wellbeing otherwise the opportunity of their somewhat altruistic natures could allow fatigue and burnout. Like the PCWs these Logan navigators commented (Kendall & Henderson, 2011, PCW interviews) about the struggle the GPs they interacted with had in using the available interpreting services. Although the same struggle applies to the Canterbury GPs there was also in Canterbury an added barrier to using the PCW service itself which was not so apparent in the international studies.

It would seem that the international studies had a better buy in from their GPs and this may be the result of a greater percentage of the population being non-English speaking, which could then

require a more focussed approach to communication between that population and the GPs. For example the 25.3% of non-English speaking residents in Logan Australia (2001 census), may be centred around a particular medical centre which may then encourage the use of not only a community health worker or navigator role but also the benefit of interpreter services. Similar cultural barriers exist in Aotearoa New Zealand and in Canterbury and perhaps research such as that by Henderson & Kendall (2011) may help to educate the local GPs to understand more clearly what the most effective healthcare approach is for CALD communities. Moreover the housing referrals from community organisations, who it would appear have no other option for their clients because of the huge increase in demand for these services, is an added unwelcome strain but is mainly because of the Canterbury earthquakes as they have resulted in major housing shortages. As this study suggests the impact of the 2010-2011 earthquakes cannot be overlooked on the community workers in Canterbury however future implications for the PCW role may not necessarily be as great as they have been in the last four years.

It is clear that the original intention of the role was to help the target group to access primary healthcare in Canterbury. It is also clear that the way forward for communities to become healthier requires a model of community driven public health uniting with primary healthcare to benefit the whole community.

It may therefore be that a revised 2015 model for the PCW project may well consist of a combination of a number of models of healthcare, including the Te Whare Tapa Wha, Fonofale, and nurse led clinic styled medical centre, along with elements from the original model the CDHB and Partnership Health had in 2004 when the PCW project began. It would also seem that to achieve this a much more determined and standardised approach towards PCW education and

training, such as in the Logan model, needs to be undertaken, as this would enable a more recognisably professional PCW. Such developments it is hoped would enable the GPs to be more trusting of the role, therefore enabling them to refer their patients more readily. Should Pegasus Health management choose to use a mixture of models, which are appropriate to the specified target group of Māori, Pacifica, and low income peoples, this project has the capacity to further build on the relationships and trust factors inherent in the original intention of the PCW service and moreover extend the service to the people of Canterbury who need it most.

References

Almond, P., & Cowley, S., (2009*). Partnership for Public Health:* Professional Involvement to improve health and well-being. Public health skills: A practical guide for nurses and public health practitioners. Pages 91-101

Australian Bureau of Statistics (June 2014). www.australia.gov.au/about-australia/facts-and-figures/statistics

Belgrave, J. (2010). Services to Improve Access: May2010*: Overview of the Partnership Community Worker Team- Focus on Maori and Pacific.*

Bidwell, S. (2013). *Improving access to primary health care for children and youth: A review of the literature for the Canterbury Clinical network Child and Youth Workstream*. Christchurch: Canterbury District Health Board. Retrieved March 15, 2015 from: http://www.cph.co.nz/Files/AccessPrimaryCareChildrenYouth.pdf

Biomedical Model. (2006). In *MediLexicon.* Retrieved on March 15, 2015 from: http://www.medilexicon.com/medicaldictionary.php?t=55643

Boulton, A., Tamehana, J., Brannelly, T., (2013). *Whānau-centred health and social service delivery in New Zealand*. Mai journal 2 (1), 18-32

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Butler, D. C., Petterson, S., Phillips, R. L., & Bazemore, A. W. (2013). Measures of social deprivation that predict health care access and need within a rational area of primary care service delivery. *Health Services Research*, *48*(2 Pt1), 539-559.

Canterbury District Health Board Annual Reports. (2012, 2013, 2014). http://www.cdhb.health.nz

Canterbury Primary Healthcare Report. (2011-2012). http://www.cdhb.health.nz

Chew-Graham, C., Burroughs, H., Hibbert, D., Gask, L., Beatty, S., Gravenhorst, K., Dowrick, C. (2014). Aiming to improve the quality of primary mental health care: developing an intervention for underserved communities. *BMC Family Practice*, *15*, 68. doi:10.1186/1471-2296-15-68

Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty (EAG). (2012a). *Working Paper no. 4: Child Poverty - International Approaches and Comparisons*. Wellington, New Zealand: The Office of the Children's Commissioner.

Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty (EAG). (2012b). *Working Paper no. 14: Reducing child poverty in Maori- Whānau* Wellington, New Zealand: The Office of the Children's Commissioner.

Consedine, R. (2012). Anti-racism and Treaty of Waitangi activism: Early attitudes and anti-racism. In *Te Ara: The Encyclopaedia of New Zealand.* Retrieved on March 15, 2015 from: http://www.TeAra.govt.nz/en/anti-racism-and-treaty-of-waitangi-activism/page-1

Durie, M. (1998). *Te mana te kāwanatanga: The politics of Māori self-determination.* Auckland, New Zealand: Oxford University Press.

Durie, M. (1999). Te Pae Mahutonga: A model for Mäori health promotion. *Health Promotion Forum of New Zealand Newsletter* 49, 2-5.

Ellen, R. & Harris, H. (1996). *Concepts of indigenous environmental knowledge in scientific and development studies literature: A critical assessment:* draft paper East-West Environmental Linkages Network Workshop 3, Canterbury. Cited in The Journal of Agricultural Sciences, 2006, vol. 2, no. 1

Finau, S. (2006). Cultural Democracy. The way forward for hard to reach New Zealanders. NZFP, vol. 33, p. 314

Finney Lamb, C., & Smith, M. (2002). Problems refugees face when accessing health services. *New South Wales Public Health Bulletin*, *13*(7), 161.

Fretter, J. & Pande, M. (2006). *Forecasting GP workforce capacity: Towards an understanding of GP workforce capacity, long-term forecasting and benchmarking tools* [Occasional Paper 8]. Wellington, New Zealand: Royal New Zealand College of General Practitioners.

Gammonley, D. (2009). Psychological well-being and social support among elders employed as lay helpers. *Journal of Gerontological Social Work*, *52*(1), 64–80.

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age.* Cambridge, England: Polity Press.

Gordon, R. (2009). *Community and psychological responses to disaster: APS briefing 3/03/09*. Melbourne, Australia: Australian Psychological Society. Retrieved on October 12, 2014 from https://www.psychology.org.au/Assets/Files/Bushfire-Rob-Gordon.pdf

Gordon, R. (2013). *Dr Rob's tips: Helping in Canterbury.* Wellington, New Zealand: New Zealand Red Cross Incorporated. Retrieved June 18, 2015, from: https://www.redcross.org.nz/yk-files/eb9fe5a907f54035eb820fbdde4d1e83/RC Dr Robs Tips v2.pdf

Gordon, R. (2004). The Social Dimension of Emergency Recovery. Appendix C in Emergency Management Australia, *Recovery, Australian Emergency Management Manuals Series No 10* (pp. 111-143). Canberra: Emergency Management Australia.

Gray, A. M. (1982). Inequalities in health. The Black Report: A summary and comment. *International Journal of Health Services 12*(3), 349–80.

Greenaway, A. & Witten, K. (2006). Meta-analysing community action projects in Aotearoa New Zealand. *Community Development Journal, 41.* 143-159. [Abstract] A173.

Grim, K. & Bauer-Walker, J. (2011). *Challenges and opportunities of community health workers in Buffalo, New York* [White paper]. Retrieved March 15, 2015 from: http://www.empirestatephtc.org/resources/res/chw/Challenges-and-Opportunities-Buffalo.pdf

Harris, R., Cormack, D., Tobias, M., Yeh, L., Talamaivao, N., Minster, J., & Timutimu, R. (2012). The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Social Science & Medicine*, *74*(3), 408–15.

Hart, J. (1971). "The Inverse Care Law". *Lancet* **1**: 405–12

Henderson, S. & Kendall, E. (2011). Community navigators: Making a difference by promoting health in culturally and linguistically diverse (CALD) communities in Logan, Queensland. *Australian Journal of Primary Health* 17, 347-354.

Henderson, S., Kendall, E., & See, L. (2011). The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review. *Health & Social Care in the Community, 19*(3), 225–249.

Holloway, I. (1997). *Basic concepts for qualitative research*. Oxford, England. Blackwell Science.

Horsburgh, M., Goodyear-Smith, & Yallop, J. (2008). Nursing initiatives in primary care: An approach to risk education for cardiovascular disease and diabetes. *NZFP, 35*, 176-182.

JHI Consultancy Ltd. (2009). *Evaluation of the Practice Nurse Funding & Partnership Community Worker Initiatives of Partnership Health's Access Project*: JHI Consultancy Ltd. Christchurch

Jones, B., & Silva, J. (1991). Problem solving, community building, and systems interaction: An integrated practice model for community development. *Community Development Society Journal*, *22*(2), 1–21. http://doi.org/10.1080/15575339109489937

Koperski, M., Rogers, S., & Vari, D., (1997). Nurse practitioners in general practice: an inevitable progression? The British Journal of General Practice, 47 (424), pp. 696-698. ISSN (print) 0960-1643

Lambert, S. (2014). Indigenous peoples and urban disaster: Maori responses to the 2010-12 Christchurch earthquakes. *Australian Journal of Disaster and Trauma Studies*, *18*(1). Retrieved from http://www.massey.ac.nz/~trauma/issues/2014-1/AJDTS_18-1_Lambert.pdf

Maori Primary Healthcare Report 2010-2011: *A report on behalf of the Canterbury Primary Health Organisations.* (March 23rd 2012)

Marshall, B., Floyd, S., & Forrest, R. (2011). Clinical outcomes and patient' perceptions of nurse-led healthy lifestyle clinics. *Journal of Primary Health Care*, *3*(4), 289–297.

Maw, K., (2008). SIA project Survey Report. March/April 2008

Medical Council of New Zealand. (2010). *Best health outcomes for Pacific Peoples: Practice implications*. Wellington, New Zealand: Author. Retrieved from http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Pacific-Peoples.pdf

Medilexicon. www.medilexicon.com

Ministry of Health. (2002). He Korowai Oranga: Maori Health Strategy. Wellington: Ministry of Health.

Ministry of Health. (2005). Evolving Models of Primary Health Care Nursing Practice. Wellington: Ministry of Health

Ministry of Health. (2009). Better sooner, more convenient healthcare in the community. Wellington: Ministry of Health.

Ministry of Health, Nursing Council of New Zealand, DHBNZ, & NPAC-NZ. (2009). *Nurse Practitioners: A healthy future for New Zealand.* Wellington, New Zealand: Ministry of Health. Retrieved from http://www.health.govt.nz/system/files/documents/publications/nurse-practitioners-a-healthy-future-for-nz.pdf

Ministry of Health. (2011). *Advance Care Planning: A guide for the New Zealand health care workforce.* Wellington: Ministry of Health. Retrieved on March 15, 2015 from: http://www.health.govt.nz/publication/advance-care-planning-guide-new-zealand-health-care-workforce

Ministry of Health. (2013). *Aotearoa NZ Health Survey: Annual update of key findings 2012/13.* Wellington: Ministry of Health. Retrieved on March 15, 2015 from: http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-survey-annual-update-2012-13-dec13-v2.pdf

Ministry of Health. (2014). Pacific health. Retrieved from http://www.health.govt.nz/our-work/populations/pacific-health

Minto, R. (2015). http://www.nursingreview.co.nz/news-feed/2015/primary-healthcare-in-need-of-a-paradigm-shift/#.Ve9gADYViUk

Morgan, O., & Baker, A. (2006). Measuring deprivation in England and Wales using 2001 Carstairs scores. *Health Statistics Quarterly*, *Autumn*(31), 28–33.

Munford, R., & Walsh-Tapiata, W., (2006). Community Development: working in the bi-cultural context of Aotearoa New Zealand. Community Development Journal 41 (4): 426-442.

Okada, A. (2008). *Knowledge cartography: Software tools and mapping techniques*. London, England: Springer.

Oxford Dictionary. http://www.oxforddictionaries.com/definition/learner/collaboration retrieved September 2015.

Pacific Canterbury Healthcare Report 2010-2011 (24th April 2012). http://www.cdhb.health.nz

Partnership Health Canterbury (2004). Services to Improve Access Plan.

Partnership Health Canterbury (2009). Access Project Overview (October 2009).

Pegasus Health Charitable Ltd. Annual reports. (2012, 2013, 2014).

http://www.pegasus.org.nz

Penfold, C. (2015). *Is the Partnership Community Worker project fulfilling its original intention?* UC Unpublished MHealSc Thesis.

Pollock, K. (2014). Public health: Social and ethnic inequalities, *Te Ara:Tthe Encyclopedia of New Zealand*. Retrieved from http://www.TeAra.govt.nz/en/diagram/31387/maori-health-te-whare-tapa-wha-model

Prewitt Diaz, J. O., & Dayal, A. (2008). Sense of place: A model for community based

psychosocial support programs. *Australasian Journal of Disaster and Trauma Studies*. ISSN:1174-4707. Volume 2008-1

Pulotu-Endemann, F, (1995). Fonofale Model. www.hauora.co.nz/resources/Fonofalemodelexplanation.pdf

Pulotu-Endemann, F. & Bush, J. (2000). *Making a Pacific Island difference in a mental health setting: Training workshop for people wanting to increase their understanding around Pacific Island mental health.* Auckland, New Zealand: Lotofale, Auckland Healthcare Limited.

Ragsdell, G. (2000): 'Engineering a Paradigm Shift?' An Holistic approach to organisational change management. www.emeraldinsight.com/journals.thm?articlid=1411058

Roberts, M. (2009). Consultation concerning novel biotechnologies: Who speaks for Māori? *International Social Science Journal*, *60*(195), 145–151.

Salmond, A. (2003). To the Social Policy Research and Evaluation Conference. *Social Policy Journal of New Zealand, 20*, 1-5.

Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in Nursing and Health, 23*, 334-340. Doi: 10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Stake, R. (2008). Qualitative case studies. In N.K.Denzin & Y.S. Lincoln (Eds.). *Strategies of qualitative inquiry* (3rd ed., pp. 119-150). Thousand Oaks, CA: Sage.

Stirling, B. (2010*).* A comparative survey of Aotearoa New Zealand and UK social workers on the role of religion and spirituality in practice. *British Journal of Social Work, 40*(2), 602-621

Torstonson, S., & Whittaker, M. (2011a). Building community resilience in post-quake Christchurch. Christchurch, New Zealand: Council of Social Services in Christchurch and Healthy Christchurch. Retrieved from http://www.communityresearch.org.nz/research/supporting-community-resilience-in-post-quake-christchurch/

Treaty of Waitangi, 1840. Retrieved from http://www.treatyofwaitangi.maori.nz/

USA Dept. Health and Human Services (2009) http://www.hhs.gov

Viswanathan, M., Kraschnewski, J., Nishikawa, B., Morgan, L. C., Thieda, P., Honeycutt, A., Lohr, K., & Jonas, D. (2009). *Outcomes of Community Health Worker Interventions* [Report]. Rockville, MD: Agency for Healthcare Research and Quality U.S. Department of Health and Human Services. Retrieved from www.ahrq.gov

Wells, K., Battaglia T., Dudley D., Garcia, D., Green, R. (2008). Patient navigation: state of the art or is it science? Cancer. 2008;113:1999–2010. [PMC free article] [PubMed]

Warren, D. M. 1990. "Indigenous Knowledge Systems and Development." Background paper for Seminar Series on Sociology and Natural Resource Management. The World Bank, Washington, D.C. December 3, 1990.

World Health Organisation (WHO), (2011, 2002, 2006) http://www.who.int/topics/en/

Williams, D., & Mohammed, S. (2009). Discrimination and racial disparities in health:

Evidence and needed research. *Journal of Behavioural Medicine, 32*, 20–47.

Wise, G. (1998). Definitions: Community development, community-based education about the environment. In *An EPA/USDA Partnership to Support Community-Based Education* (pp. 1–29). Washington, DC: EPA/USDA.

Wright, S. (2013). Christchurch Re-Settlement report 2012-2013

Zweifel, C., & Wezemael, J. Van. (2012). Drawing as a qualitative research tool: An approach to field work from a social complexity perspective. *Tracey Journal: Drawing Knowledge, Drawing and Visualisation Research.*, (November). Retrieved from http://www.lboro.ac.uk/microsites/sota/tracey/journal/edu/2012/PDF/Christina_Zweifel-TRACEY-Journal-DK-2012.pdf

http://web.archive.org/web/20130608113910/http://www.show.scot.nhs.uk/publications/isd/deprivation_and_health/background.HTM

Appendices

Appendix A: New Zealand Deprivation (NZDep) Index questionnaire (2013)

Appendix B: Ethics approval

Appendix C: Information letter to participants

Appendix D: Consent form for participants

Appendix E: Survey to Pegasus Medical Practices

Appendix F: Interview questions for PCWs

Appendix G: Interview questions for organisations who refer clients to PCWs

Appendix H: Interview questions for to the Community Group Managers (NGO), the host organisations of the PCWs

Appendix H: Questionnaire for the NZDep Index (2013)

Appendix A: New Zealand Deprivation (NZDep) Index questionnaire (2013)

Questionnaire items for NZDep the eight questions for the five-point individual-level index of socioeconomic deprivation are shown below. The order of the eight questions is not important, although they are listed here in decreasing order of occurrence. The simple scoring system is described after the questions. A suggested lead-in to these questions is: "The following few questions are designed to identify people who have had special financial needs in the last 12 months. Although these questions may not apply directly to you, for completeness we need to ask them of everyone."

1 **B**uying **cheap food:** *in the last 12 months have you personally been forced to buy cheaper food so that you could pay for other things you needed?* (yes/no)

1 **Unemployment:** *NOTE: defined as no for those 65 and over, and for full-time care-givers/home-makers*; otherwise*: In the last 12 months, have you been out of paid work at any time for more than one month?* (yes/no)

2 **Being on a means-tested benefit; amended 2014: see NOTES below:** *In the 12 months ending today did you yourself receive payments from any of these three benefits: Jobseeker Support, Sole Parent Support or Supported Living Payment?* (yes/no)

3 **Feeling cold to save on heating costs:** *in the last 12 months have you personally put up with feeling cold to save heating costs?* (yes/no)

4 **Help obtaining food:** *In the last 12 months have you personally made use of special food grants or food banks because you did not have enough money for food?* (yes/no)

5 **Wearing worn-out shoes:** *in the last 12 months have you personally continued wearing shoes with holes because you could not afford replacement?* (yes/no)

6   **Going without fresh fruit and vegetables:** *in the last 12 months have you personally gone without fresh fruit and vegetables, often, so that you could pay for other things you needed*? (yes/no)

7   **Help from community organisations**: in the last 12 months have you personally received help in the form of clothes or money from a community organisation (like the Salvation Army)? (yes/no)

Creating the NZDep index

(1) Add the 'yes' responses (any missing data are counted as 'no').

(2) Re-code the count of deprivation characteristics into the following five ordinal categories (relatively few people will have the largest number of deprivation characteristics): 1 no deprivation characteristics 2 one deprivation characteristic 3 two deprivation characteristics Notes: previous means-tested benefits were the Unemployment Benefit, Domestic Purposes Benefit, Independent Youth Benefit, Sickness Benefit, and Invalids Benefit. From 15 July 2013, these benefits became obsolete and were replaced by the three benefits now listed in question (3)Note; that it is not possible to have perfect consistency with the previous list of means-tested benefits. The unemployment cut off has been set at age 65 since 2007 in accordance with GRI entitlements, and as used in the national small-area indexes of deprivation NZDep2006 (created in 2007) and NZDep2013.

Appendix B: Ethics approval

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2014/09/LR

17 March 2014

Carol Penfold
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Carol

Thank you for forwarding your Human Ethics Committee Low Risk application for your research proposal "Is the role of Partnership Community Worker (PCW) meeting its original intention?".

I am pleased to advise that this application has been reviewed and I confirm support of the Department's approval for this project.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 13 March 2014.

With best wishes for your project.

Yours sincerely

Lindsey MacDonald
Chair, Human Ethics Committee

Appendix C: Information letter to participants

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Research Title**; Is the Role of the Partnership Community Worker (PCW) meeting its original intention?**

Information Letter;

My name is Carol Penfold and I am a Masters student in the School of Health Sciences, Canterbury University. I am conducting a research study as part of the requirements of my Master's degree.
I am studying the original role of the Partnership Community Worker (PCW) as at 2007, and am looking in particular at whether the current perception of those in the community that refer to the PCW role, and also the current perception of the PCWs themselves still match the original intention of the PCW role.
A recent submission to the 2012 Canterbury District Health Board Quality Improvement and Innovation Awards was entitled 'Partnership Community Workers; They Know What to Do.' In this publication it is stated that the original Partnership Community Worker (PCW) initiative was based on the community development model (Jones & Silva, 1991). Equity was the challenge for the PHOs for the main target population of Māori, Pacific peoples and those with low socioeconomic status and it was hoped that the role of the PCW would help to bridge the perceived gaps in access.to primary healthcare.
My research question is; '**Is the Role of the Partnership Community Worker meeting its original intention?**'
 I intend to interview the PCWs, their managers, GP practices and referring community organisations. My research on the feasibility of the PCW is not so much on a financial question but more on the perception of both the community and the PCW themselves as to what their role actually is as opposed to what the publications may present and how it can be transferred into a best practice model today.
It is hoped that the findings of the study will give a clearer understanding of the role of the PCW which will benefit both the referrers and the PCW workers. It is also hoped the study will provide a more up to date model for all involved to work from and with. I am looking to interview current and past PCWs, GP practices who refer to the PCW service, managers of

community groups (NGOs) who refer to the PCW service and managers of the NGOs who employ the PCW role.

Your involvement in this project will to be either interviewed by myself Carol Penfold or to complete a survey form which will be sent to you with a self-addressed envelope for your reply. The half hour interview will be digitally recorded by myself. You will not be required to participate in any follow up process. In the performance of the task there will be no risk to you in consenting to the interview or the survey form. You may receive a copy of the project results by contacting the researcher at the conclusion of the project.

Participation is voluntary and you have the right to withdraw at any stage without penalty. If you withdraw I will remove information relating to you prior to my thesis being submitted to the University of Canterbury.

The results of the thesis may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: your identity will not be made public without your prior consent. To ensure anonymity and confidentiality no identifying names will be used in the thesis. You may be identified as GP practice1, GP practice 2, 3, 4, or PCW 1, PCW 2, 3,4,5, etc. or Community Group 1, or Community Group 2 etc. The data will be securely stored for 5years at the UC and will then be destroyed. The data will only be accessed by myself, and my supervisors. A completed thesis is a public document and will be available through the UC library.

This project is being carried out as a requirement for my Masters in Health Sciences degree under the supervision of Ray Kirk and Blair Stirling who will be pleased to answer any concerns you may have about participation in the project.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch. human-ethics@canterbury.ac.nz.

If you agree to participate in the study, you are asked to complete the consent form and return in the self-addressed envelope provided to you. I will then contact you to arrange a time for a 30minute interview which may take place at a mutually agreed destination e.g. café, workplace. I have attached a list of questions for you to consider. I am available to answer any questions before you commit to a half hour interview. I am also open to you sending in your thoughts to the questions by email.

Please txt or email me at;
cdpenfold@gmail.com
021713419

Kind regards and thankyou for your time

Carol Penfold

Appendix D: Consent form for participants

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Consent Form

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Researcher; Carol Penfold, cdpenfold@gmail.com

'Is the Role of the Partnership Community Worker meeting its original intention?'

Consent Form for (G.P. practices, PCW's and Community Group (NGO) managers.)

I have been given a full explanation of this project and have had the opportunity to ask questions.

I understand what is required of me if I agree to take part in this research.

I understand that participation is voluntary and I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.

I understand that any information or opinions I provide will be kept confidential to the researcher Carol Penfold or her supervisors Ray Kirk and Blair Stirling and that published or reported results will not identify the participants or my place of work. I understand that a thesis is a public document and will be available through the UC library.

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I understand that all data collected for the study will be kept in a locked and secure facilities and /or in password protected electronic form and will be destroyed after 5 years.

I understand the risks involved in taking part in the study and how they will be managed if required.

I understand that I am able to receive a report on the findings of the study by contacting the researcher at the conclusion of the project.

I understand I can contact Carol Penfold at cdpenfold@gmail.com or Ray Kirk ray.kirk@canterbury.ac.nz for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)

By signing below I agree to participate in this research project.

I, ------------------------------(please print your full name)

consent to take part in the above study.

Signature ---------------------

Date ---------------

Please insert the completed consent form into the return envelope and post back to the researcher by May 31st 2014.

Thank you for your time,

Carol Penfold

Low Risk Application Form

Appendix E: Survey to Pegasus Health Medical Practices

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Researcher; Carol Penfold, cdpenfold@gmail.com

Survey form questions for all the Pegasus Medical Practices

- Are you as a medical practice aware of the Partnership Community Worker (PCW) role?

    Yes/No   (please circle the one you choose)

- In the last 12 months how often has your practice used the PCW service?

    0-5 times   5-10 times   10 or more times   (please circle the one you choose)

- How did your practice first learn of the PCW service which supports your practice/patients? (Please tick one option.)

    1. PCW personal promotion?
    2. Partnership/Pegasus Health email or promotional material?
    3. Written fliers or cards?
    4. Other; if so please explain

- For what purpose have you used the PCW service? (Please tick all used.)

    1. Transport to medical appointments e.g. Diabetes Clinic
    2. Work and Income support
    3. Housing New Zealand support

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4. Allied Health e.g. Opticians
5. Hospital appointments
6. Food parcels
7. Others, please name

- Did the PCW meet the expectation you had for your patient?

  Yes / No   (please circle the one you choose)

- Would you recommend the PCW service to other medical practices?

   Yes/ No   (please circle the one you choose)

- Is the PCW role meeting your original expectations?

  Yes/No/Maybe/Didn't have any expectations/Not sure what it was supposed to be

  (Please circle the one you choose)

- What is your overall impression of the PCW service?

   Not impressed; 1 2 3 4 5 6 7 8 9 10 very impressed (Please circle the one you choose)

- Briefly how would you describe the PCW role to others?

Thank you for your support to continue to improve and support the role of the PCW

(These questions will be asked either in person by the researcher or left for the appropriate person to fill in and return along with the completed consent form.)

Carol Penfold

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Appendix F: Interview questions for PCWs

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Interview questions for the PCW's (approx. 30minutes long interview)

- Tell me about your induction process. How long? Who with? Etc.

- How would you describe your ongoing training and education including cultural training\

- What does your supervision consist of? (Group, individual, external?)

- How do you find being placed in a community organisation, NGO? Advantages? Disadvantages? Benefits? Supports? Frustrations? Isolation?

- Have you ever considered what it would be like to work together with the other PCW's in one hub? E.g. Pegasus HQ (advantages being more professional time together, as opposed to perhaps professional isolation)

- What is your professional relationship with your allotted medical practices? (checking viability of useful engagement across the medical practices)

- How do you think the medical practices perceive your role as a PCW?

- What is your overall impression of your role now that you have been in it….? (looking at changes over time, possibly misunderstood role)

- How could your job description be structured differently to reflect the reality of your practice?

- How do you explain your role as a PCW to others in your life?

- Who do you perceive your 'boss' to be? Your NGO manager or your Pegasus manager?

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Are there any other comments you would like to make regarding the PCW role?

These questions will be asked in person by the researcher Carol Penfold. All PCWs will be given a copy of these questions along with an information sheet and a consent form prior to the interview which will possibly take place in a mutual setting .e.g. over a cup of coffee.

Appendix G: Interview questions for organisations who refer clients to PCWs

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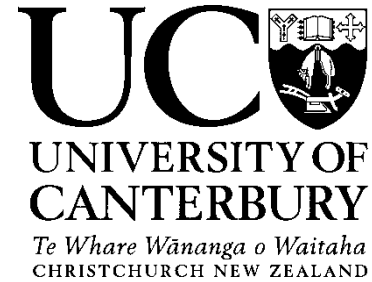University of Canterbury
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Researcher; Carol Penfold, cdpenfold@gmail.com

Interview questions for the Organisations/ Community Groups who refer to the PCWs

- How did you first hear about the PCW role?

- Describe your initial contact with a PCW

- What is the main reason that your organisation chooses to refer to a PCW?

- How do you explain the role of the PCW to your clients?

- How do you describe the PCW role to others? (E.g. Other NGOs, Govt. Dept.) In the community?

- Does the PCW role meet your organisations initial expectations?

- How do you see the PCW role developing in the future?

- Are there any other comments you would like to make about the role of the PCW?

These question will be asked in person by the researcher Carol Penfold

Appendix H: Interview questions for to the Community Group Managers (NGO), the host organisations of the PCWs

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Researcher; Carol Penfold, cdpenfold@gmail.com

Interview questions for the Community Group Managers (NGO) of the PCW's

- What is the main reason that you as a manager of an NGO chose to employ a PCW?

- How would you describe your links between you as the Manager of an NGO and the PCW management in Pegasus?

- Are you clear of which parts of the PCW role are your responsibilities and which parts are the responsibilities of the Pegasus management?

- How does your organisation support the needs of the PCW?

- How do you describe the PCW role to others? (e.g. other NGO's in the community)

- How do you see the PCW role developing in the future?

- What cultural aspects of the role do you encourage for your workers?

- Is the PCW role meeting your NGO's initial expectations?

- Are there any other comments you would like to make about the role of the PCW?

These question will be asked in person by the researcher Carol Penfold

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