HEALTH HUB PROJECT YEAR 2: PROGRESS REPORT - A 'NEW-TYPE' OF INTEGRATED, PATIENT-PARTNERED, AND COMMUNITY-ORIENTED POPULATION MEDICAL AND HEALTH CARE CENTRE

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The process to create and develop, in Palmerston North, the 'new-type' of integrated, patient-partnered, and community-oriented population medical and health care centre, called the Health Hub Project - HHPNZ, essentially is evolutionary and dialectical in nature. It comprises **thesis**, **antithesis** and **synthesis** processes and actions. Acquisition of an already established general practice, with potential for further development, was the initial ***thesis*** action of HHPNZ development. It provided the GP-framework of doctor and nurse practitioner, and general and specialist nurse experience and expertise required to build a solid foundation for all subsequent development and growth. The first ***antithesis*** component was, and continues to be, bi-modal:

(i) Ongoing, staff professional development and training (including disruption as necessary) to ensure that the attitudes, beliefs and views of all staff align fully and consistently with the concept of patient- partnered and community-oriented population health care in action; and

(ii) Uptake and progressive implementation of patient population segmentation, integrative practice, multidisciplinary teamwork and community outreach, which contemporary New Zealand and international population health policy and research advocate as the preferred form of population health care for the future, i.e. the ***antithesis*** of longstanding general practice and doctor-centric delivery of primary healthcare.

Synthesis is in the form of HHPNZ evolving and functioning overall as a multidisciplinary team of clinicians, nurses, medical and other health care professionals (e.g., social workers and counsellors) that nurses and doctors co-lead; supported by an evolving centralised information-technology administration system.

The second (positive***) thesis*** action ***is*** the emergence of two separate but linked patient support teams, in which all team members are expected and encouraged to function at, or near to, their full scope of practice:

(i) ***Integrated (multidisciplinary) clinical diagnosis teams*** work in pods to achieve optimal medical and healthcare outcomes - i.e., doctors, nurse practitioners, nurses, and other allied health professionals work in teams, as distinct from working in isolation[1]; and

(ii) ***Integrated (multidisciplinary) clinical care teams***, are implementing into practice long-term population health care solutions for patients, along with administrative coordination and support, that -

(a) Promote a culture of care and support both internally and widely in the community, through outreach,

(b) Are helping form a *community of practice,* making HHPNZ primary care services and resources accessible to the wider medical and health care community, i.e. to other GPs, medical centres, and hospitals, and

(c) Invites partnership and collaboration through (both disruptive and constructive) new ***antithesis*** processes with potential to further expand the scope and reach of HHPNZ as the evolving, inclusive new-type of, New Zealand designed population health care model for the future.

[1] In effect, working in teams is a ***risk management and risk mitigation strategy.*** They help to minimise the increasing number of complaints about doctor incompetency that Dr John Adams, Chair Person of the Medical Council of NZ, reported in *Medical Council News* (Issue 59, January 2014); and linked, possibly, to errors of diagnosis and treatment that commonly occur when doctors work alone and in isolation, often under pressure.