Investigating a Public-Private partnership model of Physiotherapy service delivery in a rural setting: a Constructive Inquiry

Emily Farquhar
Physiotherapist in Charge
Wagga Wagga Base Hospital
emily.farquhar@health.nsw.gov.au
(02) 5943 2450

Acknowledgements

The project has been completed as part of the New South Wales (NSW) Health Education and Training Institute (HETI) Rural Research Capacity Building Program (RRCBP). I would like to acknowledge the contribution of the following people to the project:

- The team at Back on Track Physiotherapy for their willingness to participate in the project and their ongoing dedication to provide services to patients in a rural area.
- The health professionals and managers who willingly shared their experiences and insights as part of the study.
- HETI for providing rural clinicians with such a valuable opportunity.
- My mentor, Dr Anna Moran, for the generous sharing of her knowledge and time and for her ongoing enthusiasm with the project.
- My research supervisor, David Schmidt, for his inspiration to participate in research in the first place, as well as his ongoing support, sharing of wisdom (as well as cartoons and music) and guidance throughout the project.
- Other HETI teaching staff, including Kerith Duncanson, who have provided invaluable support, guidance and inspiration.
- Murrumbidgee Local Health District staff, particularly the executive sponsors, Catherine Maloney and Virginia Mitsch; translational expert, Rosemary Garthwaite, Allied Health Managers Kate Kennett and Roanna O'Hara and the Wagga Wagga Base Hospital Physiotherapy team for their support.
- Catherine Maloney, Rosemary Garthwaite, Back on Track Physiotherapy and staff at both the Murrumbidgee Primary Health Network (MPHN) and the Hume Medicare Local who set up the partnership.
- My family for supporting me get through the project, reading draft documents and helping juggle child care arrangements- it does take a team.

Abbreviations

AHA	Allied Health Assistant
eMR	electronic Medical Records
FTE	Full Time Equivalent
HETI	Health Education and Training Institute
GP	General Practitioner
MLHD	Murrumbidgee Local Health District
NSW	New South Wales
PD	Policy Directive
MPHN	Murrumbidgee Primary Health Network
PPP	Public Private Partnership
RRCBP	Rural Research Capacity Building Program

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Abstract

Murrumbidgee Local Health District and a private physiotherapy business implemented a public-private partnership in four outer regional NSW towns to overcome longstanding gaps in physiotherapy service delivery. The physiotherapy business was contracted by the Local Health District to provide physiotherapy to hospital inpatients, aged care facility residents and outpatients.

A qualitative methodology, using a Constructive Inquiry design, was used to investigate the success of the model from the perspective of the partnering organisations. Individual interviews were conducted with 5 staff from each partnering organisation, including managers and clinicians. Data were analysed using Framework Analysis and synthesised using a Program Logic approach.

All participants described the model as being successful. Elements of success included improved access to local services, a coordinated effort to meet the needs of the community, a service that is financially viable and satisfied stakeholders. Mechanisms to successfully implement the service delivery model included the use of multiple (but consistent) resources, motivated stakeholders, the content of the contract and referral schedule (including a time-block procurement model), streamlined administration processes for contracting and accounting, the workforce model, processes for managing private therapists in a public setting, processes for communication and consistency of stakeholders. Participants described uncertainty of future funding as the main emerging challenge. Participants identified emerging opportunities to expand the model including increasing the frequency and types of services provided, expanding to other locations, other allied health disciplines and utilising telehealth.

This study demonstrates that a physiotherapy private partnership service model of service delivery can be a successful way to deliver services in a rural area. The mechanisms to successfully implement the model, described in this report, should be considered when setting up similar partnerships in rural physiotherapy or potentially other allied health disciplines.

Key Words: physiotherapy, allied health, public-private partnership, rural, contracting

Executive Summary

Recommendations

Managers and Clinicians

It is recommended that public-private partnerships (PPP's) be considered for physiotherapy, and potentially other allied health disciplines, to meet gaps in rural service provision. This study demonstrates that a physiotherapy PPP is a successful model for service delivery in a rural area. A partnership has the ability to connect multiple small amounts of health funding, through a variety of State, Commonwealth and private funding streams, to create a viable service in both the hospital and community setting.

To successfully implement a physiotherapy PPP the following mechanisms should be considered:

- the use of multiple (but consistent) resources,
- motivated stakeholders,
- the content of the contract and referral schedule,
- streamlined administration processes for contracting and accounting,
- the workforce model,
- processes for managing private therapists in a public setting,
- processes for communication and
- consistency of stakeholders.

It is recommended that opportunities to continue and improve the local physiotherapy PPP model should be implemented. This includes utilising a time-block procurement model, streamlining local processes for contracting and accounting, improving communication and improving processes to manage private therapists in a public setting.

Opportunities to expand the local physiotherapy services provided should also be explored. This includes expansion to include other towns (eg. Tocumwal), additional outpatient services, chronic disease management exercise groups and the use of telehealth.

Findings from the report may also be relevant for other contracted services, such as allied health and medical services.

Policy Makers

It is recommended NSW Health provide an exemption from utilising the contracting rates, outlined in the NSW Health Policy Directive PD2013_008 (Workforce Planning and Development, 2013) and more recently in Information Bulletin IB2018_36 (Workplace Relations, 2018) for all rural areas where there is "market failure" and gaps in service delivery exist. The information bulletin IB2018_36 states that the maximal payment rate is currently $224 per 3.5 hour session (Workplace Relations, 2018, p. 42). A permanent exemption from utilising these contracting rates would allow health services to offer more attractive remuneration to provide services in rural areas. This would allow negotiation of payment rates commensurable to other funding streams and considering the skills of the rural generalist clinician. It would also prevent delays in initial contract generation related to obtaining an approval, from NSW Health, for an exemption from procurement policy.

Context

There is difficulty recruiting and retaining physiotherapists in rural areas which often leads to reduced access to local services. A public-private partnership model can provide a solution to this service gap in outer regional areas.

Public-private partnerships (PPP) are emerging as a means of addressing health service delivery as well as health infrastructure shortfalls around the world (Sekhri, Feachem & Ni, 2011). Other models of allied health service delivery implemented in rural and remote Australia include multi-disciplinary primary health teams, private practices, outreach models, disease specific units, education services, telehealth and delegation models (Services for Australian Rural and Remote Allied Health, 2016).

Approach

A research project, underpinned by Constructive Inquiry methodology, was undertaken investigating the public-private partnership model between Murrumbidgee Local Health District (MLHD) and a private physiotherapy business, Back on

Track Physiotherapy. The partnership provides physiotherapy services in 4 outer regional towns in NSW (Berrigan, Finley, Jerilderie and Urana). Ten semi-structured individual interviews were undertaken with clinicians and managers working within or alongside the partnership. The data were analysed using Framework Analysis and synthesised using a Program Logic approach. All participants described the model as being successful. Elements of success included:

- improved access to local services,
- a coordinated effort to meet the needs of the community,
- a service that is financially viable and
- satisfied stakeholders.

The mechanisms to achieve success as well as opportunities for the future were analysed and described in the report.

Participants described uncertainty of future funding as the main emerging challenge.

Participants identified emerging opportunities to expand the model including:

- increasing the frequency and types of services provided,
- expanding to other locations,
- expanding to include other allied health disciplines and
- utilising telehealth.

Background

In this partnership, a private physiotherapy business was contracted by the Murrumbidgee Local Health District (MLHD) to provide physiotherapy to hospital inpatients, aged care facility residents and non-admitted patients. As part of the contracting arrangement, the private physiotherapy business was provided with facilities to treat patients through other funding streams, including funding from the Murrumbidgee Primary Health Network (MPHN) for specific programs, private health insurance, General Practitioner (GP) management plans, worker's compensation and client self-funding. The partnership has been in place for more than 3 years. Prior to implementation there was no physiotherapy service available in the towns.

Introduction

Public-private partnerships (PPP) are emerging as a means of addressing health service delivery as well as health infrastructure shortfalls around the world (Sekhri, Feachem & Ni, 2011). In rural areas of Australia, there is often difficulty recruiting and retaining physiotherapists (Russell, Chisholm, Humphreys & Wakerman, 2011; Pretorius, Karunaratne, & Fehring, 2015; Stagnitti, Schoo, Dunbar, & Reid 2006). Without a local physiotherapy service, patients choose between driving long distances to access a service or going without a service. This study investigated the use of a PPP between the Murrumbidgee Local Health District (MLHD) and a private physiotherapy business, Back on Track Physiotherapy, to provide physiotherapy services to meet the needs of the community in four small rural towns in New South Wales (NSW), Finley, Urana, Berrigan and Jerilderie. In 2016 the combined total population of the 4 towns was around 5000 people (Australian Bureau of Statistics, 2017).

The study evaluated success of the model. The report describes how success was defined by the staff working in the partnering organisations. It describes the mechanisms for achieving success and emerging challenges and opportunities. This report adds to the limited literature about rural allied health PPP's. This report is for health professionals, managers, those working in contracts and accounting, policy makers, workforce planners and researchers who want further understanding about PPP's to address gaps in rural service delivery. The partnering organisations can use the report to guide the implementation of opportunities for service improvement. The findings from the study can also be utilised when considering PPP's at other rural sites for physiotherapy and other allied health disciplines.

Background

There is difficulty recruiting and retaining physiotherapists in rural areas (Russell et al, 2011; Pretorius et al, 2015; Stagnitti et al 2006). In 2012, the supply of physiotherapists in Australia was highest in major cities (91.2 FTE (Full Time Equivalent) per 100,000 population) and lower in outer regional areas (47.5 FTE per 100,000) (Australian Institute of Health and Welfare, 2013). There is a higher turnover of allied health than nurses and doctors (Humphreys et al, 2009; Russell et al, 2011). Without a local service, patients choose between driving long distances to access a service or going without a service.

One strategy to improve access to public physiotherapy services is to look to private colleagues for solutions. Private physiotherapists appear more embedded in rural life and generally remain longer in rural areas than public counterparts (Keane, Lincoln, Rolfe & Smith, 2013). Around 11% of rural allied health clinicians work across public and private sectors (Keane, Smith, Lincoln & Fisher, 2011). Collaboration between the sectors to form public private partnerships has the potential to improve access, quality and efficiency in health care (Sekhri et al, 2011). Public private partnerships may provide another solution to problems with healthcare access in rural areas.

There is limited published research on public-private collaboration in physiotherapy. There were benefits for joint recruitment to public and private new graduate physiotherapy positions in a rural area of NSW, where the recruited physiotherapists worked part time for both the public and private organisations (Schmidt & Dmytryk, 2014). The benefits included attracting higher quality applicants, reducing attrition through social isolation, improved networking between the sectors and improved staff skill development (Schmidt & Dmytryk, 2014). Another study found that the overwhelming majority of surveyed private physiotherapists were in favour of having partnerships between public and private practice in rural and regional areas and of governments developing programs to facilitate such partnerships (O'Toole & Schoo, 2010).

Like physiotherapy, dentistry has clinicians working in public and private settings. Within dentistry, the utilisation of existing private dental practices for the delivery of subsidised dental care has the potential to improve service availability in rural and remote areas and improve oral health for the economically disadvantaged members of the community (Dudko, Kruger & Tennant, 2017).

The NSW Health Agency for Clinical Innovation places a high priority on developing flexible, evidence-based, patient-focused models of care which can be adapted to various settings including rural, regional and remote NSW (Agency for Clinical Innovation, 2018). When developing new models of care, Western Australia Health encourages fostering integration and continuity of care partnerships between government agencies, non-government and private organisations, multi-disciplinary professionals and home, community and hospital settings (Department of Health, 2014). An example of such a model is the single entry private-public integrated primary health service, including medical, nursing and allied health services, which has been able to successfully provide services in a rural area of Victoria (Buykx, Humphreys, Tham, Kinsman, Wakerman, Asais & Tuohey, 2012). The model combined fee-for-service Medicare-based income from the private medical practice with public funding from the community health service. The model was able to optimise the use of health staff and maximise community access to a range of health services (Buykx et al, 2012).

A private physiotherapy business and MLHD implemented a public-private physiotherapy partnership model of service delivery for patients in the outer regional towns of Finley, Urana, Jerilderie and Berrigan. Historically, MLHD had public funding available for inpatient and limited outpatient physiotherapy services but had been unable to recruit to the part time (2 day per week) position. The available funding enabled MLHD to contract the private physiotherapy business for services. Treatment rooms at the four sites were provided by MLHD for the physiotherapists to conduct private business from, in addition to the contracted public service, at no additional fee. Other funding streams utilised by the physiotherapists included funding from the Murrumbidgee Primary Health Network (MPHN) for specific programs, (General Practitioner) GP management plan funding, private health insurance, workers compensation and client self-funding. The pooled funding streams increased the total number of physiotherapy hours available, increased the presence of physiotherapy across all sites, and allowed for services in the larger site, Finley, across multiple days of the week. Prior to the implementation of this model there had been an outreach service provided by the physiotherapy department in a larger city that involved significant travel and there were often gaps in service delivery. The current public-private physiotherapy partnership has provided continuous services for more than 3 years.

The executive at MLHD are interested in innovative rural health service delivery models and collaborating to create an interconnected system of healthcare (MLHD, 2016). When implementing new models of care, rural researchers describe the need to conduct evaluation studies that investigate how key barriers and enablers for effective implementation interact in real-world settings, to guide the dissemination of successful models (Lyle, Saurman, Kirby, Jones, Humphreys, & Wakerman, 2017). This research evaluates a rural physiotherapy PPP model. Where possible, ideas for improvement will be implemented to enhance the service provided to rural patients. The findings will also be utilised to inform the implementation of similar models, to address issues of access to physiotherapy services, in other rural areas and potentially for other allied health disciplines. The findings may also be relevant for other contracted services.

Research Aims

The aims of this study was to:

- Investigate how success of a PPP model of physiotherapy service delivery in a rural setting was defined from the perspective of each organisation.
- Identify the enablers and barriers, and from these mechanisms, to success for each organisation.
- Explore emerging challenges and opportunities for this PPP.

Method

The study implemented a Constructive Inquiry approach. This qualitative approach blends Appreciative Inquiry with other research methods (Howieson, 2011), in this study Framework Analysis and Program Logic. Appreciative Inquiry was selected to recognise the organisational successes of this model of service delivery and provide steps towards furthering these successes in the future. With a focus on success, this approach helped maintain the potentially sensitive relationships between the stakeholders in the small rural towns.

Appreciative Inquiry, a strengths-based qualitative method, has four distinct stages, known as the "4D cycle (discovery, dream, design and destiny)" (Trajkovski, 2013, p.1225). Due to time constraints, this study explored only the first two stages: discovery and dream. However, findings from the study were reported back to relevant stakeholders and opportunities for improvement were explored and implemented outside of the scope of this research project.

The research was conducted by a MLHD physiotherapist with knowledge of, but no direct involvement in, the set up and management of the partnership. Further information about the researcher and the processes used by the researcher to engage in reflexivity are described in Appendix A.

Participants were purposively recruited via email invitation and telephone follow up, from an unrelated administrative officer. Individuals invited to participate in the study comprised employees of the MLHD and private physiotherapy business involved with setting up or working within or alongside the partnership and included managers as well as clinicians. Twenty eligible public or private staff were invited to participate in the study and 10 individuals consented to be interviewed. Five were employed by the private practice including 3 that had directly provided the clinical services being investigated. From the MLHD, 5 people were interviewed including staff from a range of management levels and covering the 4 towns being investigated. Staff that had been dismissed by either organisation for reasons of misconduct were excluded from the study, as it was thought they could unfairly influence the results. There were no staff excluded from participation due to being dismissed by either organisation.

Individual semi-structured interviews were conducted by the researcher with consenting participants. Individual interviews were chosen, rather than focus groups, as participants work across a range of locations and the difficulty meeting at one time was acknowledged. Eight face to face interviews were conducted in suitable private meeting rooms at the participant's worksite and 2 interviews were conducted by telephone. Participants were provided with a copy of the interview questions via an email from the researcher after they agreed to the interview. The interview questions were written by the researcher following discussions with the research supervisor and project mentor and considering the Appreciative Inquiry approach. The questions were trialled with a Local Health District executive staff member and then refined prior to submission for Ethical review. Appendix B describes the final interview questions.

Interviews were recorded using two audio recording devices and transcribed verbatim by the researcher or a transcription service. The duration of interview ranged from 15- 45 minutes. Data saturation was met evidenced by participants providing similar information. The transcriptions had identifying information removed by the researcher prior to analysis.

Framework Analysis was employed as the thematic analysis approach using Microsoft Excel. Framework Analysis chosen as the method for analysis as it is well suited to qualitative research where there are pre-set questions that need to be addressed and where the timescale is short (Srivastava & Thomson, 2009). The 5 key stages of Framework Analysis (Familiarisation, Identifying a thematic framework, Indexing, Charting, Mapping and Interpretation) were undertaken in a linear fashion and all data was collected before analysis begun (Battersby, Ask, Reece, Markwick & Collins, 2003; Ritchie & Spencer, 1994). The thematic framework for analysis related to the research questions and included defining success, barriers and enablers to success, as well as emerging challenges and opportunities.

Data extraction was undertaken by the researcher and then checked and analysed in conjunction with the project mentor, for researcher triangulation (Gale et al, 2013). Other triangulation strategies employed in the study design included examining the partnership from the perspectives of several employees from both the public and private sectors and across the 4 sites (Curtin & Fossey, 2007).

A logic model was selected to synthesise the data and visually display the findings. The logic model was used to provide realistic evaluation aimed at understanding "what works, for whom, in what circumstances" (Pawson, Greenhalgh, Harvey & Walshe, 2005, p.21). The logic model followed a similar approach to the logic model developed by Nancarrow, Roots, Grace, Moran, & Vanniekerk-Lyons (2013) and shows the relationships between drivers, context, mechanisms and outcomes. It clarified the meaning of success and built understanding of the relationships between actions and results.

The findings of the study were reported back to staff in both organisations who contributed to the local improvement plan. The findings can also be utilised when implementing a similar model elsewhere.

Ethical Approval was granted by Greater Western Human Research Ethics Committee on 27th June 2017 HREC Reference No LNR/17/GWAHS/41 (GWAHS 2017-033). Site specific assessment approval was granted on 4th August 2017 (LNRSSA/17/MLHD/19).

Findings

Part A: Discovery- Defining success

In responding to a line of enquiry about what success of the model looks like, participants described a successful model of care in terms of improving patients' access to local services; a coordinated effort to meet the needs of the community; a service that is financially viable; and satisfied stakeholders. All participants described the public-private model as being successful and described improved access to local physiotherapy services previously unavailable in the four towns.

Success is improving access to local services

The strongest theme describing success of the PPP model was in improving access to services for patients. This was mentioned by participants from both the public and private organisations. Being able to access local physiotherapy services within set timeframes was seen as a measure of success. Dimensions of access described in the literature include accessibility, availability, acceptability, affordability and adequacy (Penchansky & Thomas, 1981). The participants interviewed particularly described improved accessibility, with the local service available within reasonable proximity to the consumer. The PPP also appeared to improve the other dimensions of access.

"Success is where we have physiotherapy services where we didn't previously." (Public, interview 10)

"So access is a success. I guess anything, anything else from that is a bit of cherry on top." (Private, interview 7)

"Well I think the success of the model would be certainly that set key performance indicators are met in terms of timeframes, certainly for acute physiotherapy services." (Public, interview 8)

Success is a coordinated effort to meet the needs of the community

While it was considered a success to have a service at all, improved health outcomes for patients and meeting the needs of the community was considered by both organisations as a success factor. This included reducing time patients spend in hospital and decreasing falls. The private practice staff repeatedly described the importance of meeting their clients' needs.

"Better and quicker good health outcomes for patients". (Private, interview 9)

"I think we've been able to get people out of hospital sooner and less likely to re-present." (Private, interview 4).

"Improvement with our residents and decreasing our falls." (Public, interview 6)

"the success of the model is because it's about servicing those people who need it." (Private, interview 3)

Success is a service that is financially viable

Participants from both organisations described financial viability as a requirement for a successful partnership. The MLHD employees defined success in terms of being cost effective and ensuring resources are being used appropriately. The private practice required the service to be profitable overall.

"Well it needs to be cost effective. It needs to be that we're making use of the resources appropriately." (Public, interview 8)

"Obviously it needs to be a profitable thing for us to sustain." (Private, interview 5)

Success is satisfied stakeholders

Both organisations identified that there were multiple stakeholders to satisfy for success to be achieved. This included staff at various levels of the partnering organisations, as well as patients, communities and GP's.

"We have happy communities, happy general practices, general practitioners, hopefully facility managers." (Public, interview 10)

"The managers at (the private practice) … are happy with remuneration for services and (the MLHD) … are satisfied with their feedback from the partnership." (Private, interview 9)

One private practice participant considered workforce wellbeing and satisfaction when defining success. They also valued what the private practice staff had learned from being involved in the partnership.

"Staff members that feel satisfied with the service provision that they've provided and get a sense of wellbeing and satisfaction as a result of providing service which other people don't get access to … It's been a good experience from our perspective as a private provider to see the governance and the additional aspects of providing a service that we haven't been exposed to before … From a business perspective it's been positive. We've learned a lot." (Private, interview 4)

Recognition from patients was important to private practice staff providing the services.

"The clients on the ground are more than accepting and more than grateful so that's been really rewarding." (Private, interview 4)

Recognition from within the health community was also valued when describing success by one MLHD participant and was shown by presentation of awards and presenting at conferences.

"We won the Integrated Care Award, the Health Secretary's Integrated Care Award in 2015. That's success." (Public, interview 10)

Part B: Discovery- Mechanisms for success

Responses to a line of enquiry about barriers and enablers to success, were coded to develop themes. These themes were synthesised using a Program Logic approach into mechanisms to achieving the participants definition of success. The mechanisms include the use of multiple (but consistent) resources, motivated stakeholders, the content of the contract and referral schedule, streamlined processes for contracting and accounting, the workforce model, processes for managing private therapists in a public setting, clear processes for communication and consistent stakeholders. The logic model is displayed in Table 1 and shows the relationships between drivers, context, mechanisms and outcomes and helps build understanding of the relationships between actions and results.

Table 1: Logic Model

Driver	**Context**	**Mechanisms** **Barriers**	**Enablers**	**Outcome**
		Mechanism - The use of multiple (but consistent) resources		
Access to local services, financial viability and satisfied stakeholders.	Availability of small amounts of funding through multiple streams, access to facilities/ treatment rooms and referral pathways in place eg. from hospital and GP.		The use of multiple resources for the partnership	Viable business opportunity for the private provider and access to local services not previously available
		Mechanism - Motivated Stakeholders		
Access to local services, meeting the needs of the community, financial viability, satisfied stakeholders, business leaders interested in innovative.	No public or private physiotherapy services available in the 4 towns for many years. A private physiotherapy business located in a nearby rural town was looking for opportunities to expand.		Public and private stakeholders were motivated for the partnership to be successful. The timing of the partnership aligned with where the business was looking at ways to expand.	Stakeholders able to work through the barriers to implement the PPP. The private provider was motivated to develop the business opportunity.
		Mechanism - The content of the contract and referral schedule to utilise a time block procurement model.		
Access to local services, financial viability, a coordinated effort to meet the needs of the community, satisfied stakeholders.	The contract outlined the specific referral schedule and indicators for referral as well as an hourly rate for service procurement model.	The impacts of an hourly rate for service procurement model (including difficulty accessing hospital inpatient physiotherapy services).	The content of the contract and referral schedule.	Improved access to local services for MLHD patients, time allocated for service development and staff education, improved compliance with mandatory training requirements and reduced transaction costs.
		Mechanism - The workforce model		
Improved access to local services and financial viability.	Physiotherapists with a range of clinical skills, AHA's employed by the private practice to carry out physiotherapy care plans and charged at a lesser rate than the physiotherapist. Nursing staff able to follow on recommendations for residential aged care facility clients and hospital inpatients between physiotherapy visits.		The workforce model (including skilled physiotherapists, AHA's and nursing staff to follow on recommendations between physiotherapist visits).	Physiotherapists skilled to see a variety within their caseload including inpatients and outpatients. Improved frequency of local services with AHA's and nursing staff able to carry out recommendations between physiotherapy visits. The use of the AHA for some tasks is more financially viable than utilising the physiotherapist.
		Mechanism - Streamlined administration processes for contracting and accounting.		

Financial viability and satisfied stakeholders.	Process of negotiating and renewing contracts has required significant administration and caused delay. Processes for collecting statistics, invoicing, checking invoices against medical records and payment has required significant administration and caused delay.	The administrative burden to oversee the contract and accounting (including the time taken to obtain a non-standard arrangement to procurement policy contracting rates, the lengthy process negotiate and renew contracts and processes for managing invoicing and accounts).		Reduced transaction costs and administrative burden making the PPP more financially viable and improving stakeholder satisfaction.
		Mechanism - Processes for managing private therapists in a public setting		
A coordinated effort to meet the needs of the community and a satisfied workforce.	MLHD processes for managing private therapists in a public setting were not clear.	Lack of clear processes for managing a private physiotherapist in a public setting and lack of understanding by all parties (including difficulty accessing computer systems and lack of identified personnel for operational and professional governance).		Physiotherapists have access to MLHD systems (including eMR and online mandatory training). Staff in both organisations are orientated to the partnership and have a clear understanding of the requirements. MLHD personnel identified for operational and professional governance, and are aware of their roles, including orientating new staff and monitoring compliance with contract.
		Mechanism - Processes for communication		
A coordinated effort to meet the needs of the community and a satisfied workforce.	Good communication between executive of both organisations however communication did not always follow through to all levels of both organisations.	Lack of processes to enable good communication.	Marketing the service in the community.	Good communication between partnering organisations, within individual organisations and with the community.
		Mechanism - Consistency of stakeholders		
A coordinated effort to meet the needs of the community and satisfied stakeholders.	There were many changes in staffing within both organisations over the 3-year period.	Lack of consistency of stakeholders (including changes in both public and private staffing).		Changes in staffing are probably inevitable, however comprehensive on-boarding and orientation for new staff at all levels of the organisations will improve the PPP.

The use of multiple (but consistent) resources for the partnership

A substantial enabler to success was the utilisation of a variety of funding streams, referral pathways and facilities to resource the partnership and increase the hours of physiotherapy service available across the four towns.

> *"Having the funding to continue to provide the service to those areas." (Private, interview 5)*

> *"Just the facilities available, so consistent use of the facilities." (Private, interview 7)*

> *"There has been a lot of referrals… there's a lot of patients that require treatment." (Private, interview 7).*

The use of a variety of funding streams increased the total hours of physiotherapy services available across the 4 towns.

> *"It's 0.4 FTE. It's two days a week. Nobody is going to work – well I shouldn't say nobody but very rarely are we going to get somebody who's going to work four short days, four 4 hour days a week to get a bit of a spread of the service and then if we're going to outreach and travel, so we lose it probably just as much as we would gain. So for 0.4 I do think this is the best model." (Public, interview 2)*

An opportunity to improve the facilities was described by one participant. It was also mentioned that the allocated room was sometimes taken for higher priority services.

"It used to be a bigger room and patients say, "Oh it was a lovely room before. It was nice and big," and now it's a bit – it's not cramped but it's a bit small and there's no window and the wall still hasn't been painted. It's still like under construction it looks like … and there's no proper desk to type on so for doing notes it's a bit – it's not nice to type notes on, plus the bed isn't working." (Private, interview 7)

"Sometimes I'd move room because there would be a call scheduled for another practitioner and so that room would be taken." (Private, interview 7)

The use of multiple resources, including funding streams, referral sources and infrastructure, allowed for the employment of 1 and at times 2 full time private physiotherapists, working across the 4 sites. Using MLHD funding alone would have allowed only 2 days per week covering the 4 sites. The pooling of resources created a viable business opportunity and then access to local services previously not available. Future changes to resources used in the partnership would impact on the business viability.

The Berrigan Shire Council's suggestions to improve liveability for older residents in their shire include the "coordination and cooperation between services to access funds, recruit and retain allied health specialists services (creating capacity and service viability across Nursing Homes, MPS, Hospital and Community Care Services)" (Berrigan Shire, 2013, p.20). Funding, adequate infrastructure and efficient information technology systems has been shown to be vital for primary healthcare implementation and sustainability (Wakerman, Humphreys, Wells, Kuipers, Jones, Entwistle & Kinsman, 2009). Although acknowledged as being difficult to implement, the pooling of funds, from the variety of federal and state funding programs, provided opportunities to aggregate funding to meet the community need for primary health care (Wakerman et al, 2009). The Multi-Purpose Services program provides an example of Commonwealth and state governments working cooperatively to provide aged care and hospital services in rural and remote areas (My Aged Care, 2018). In this Physiotherapy PPP the pooling of resources provided services across the continuum of care to address primary healthcare, aged care and also hospital based healthcare needs.

Motivated stakeholders

Participants from both organisations described stakeholders being motivated for the partnership to be successful. One participant mentioned the timing of the partnership aligned with a time where the private business was looking at ways to grow.

"It was probably quite good timing initially when we were emerging as a clinic and we were always happy to look into expanding our services." (Private, interview 4)

Participants described the persistence, patience and perseverance displayed by executive from both organisations to set up and continue the partnership. They also described a shared understanding of what was required for both parties in the partnership.

"So his (the private practice manager) patience and perseverance… There was a lot of red tape involved and I guess you've got to be persistent." (Public, interview 10)

All stakeholders demonstrated extraordinary commitment to making the partnership succeed. They were able to work through the barriers to implement and continue the partnership. All stakeholders demonstrated a strong commitment to delivering physiotherapy services to the communities. It appeared that the private physiotherapists were not only involved in the partnership for financial gain, but were passionate about providing a community service.

The workforce model

The workforce model was identified by both organisations as an enabler. The workforce model included the use of appropriately skilled physiotherapists and utilising AHA's and nursing staff to carry out recommendations between visits. It was identified that the physiotherapists needed to be able to provide a variety of hospital and outpatient services, which was different to a usual private practice model of working.

"The requirements of some of those regional center's might be a little bit different to what we see here in our (private practice) clinics." (Interview 5, Private)

Physiotherapy staffing characteristics identified as enablers included being from a rural background and staff being willing to be flexible with scheduling times to provide ad hoc services.

> *"A lot of the success initially was that our service providers could be quite flexible and that we would often either stay back later or work during lunch or just shuffle the day around to make that possible." (Private, interview 4)*

> *A lot of our staff … grew up rurally anyway so I think that that's helpful. (Private, interview 4)*

Nursing staff were also able to carry out physiotherapy recommendations between physiotherapist visits. This enabled an increased frequency of exercise and continuity of care.

> *"The nursing staff have sort of, they know what to do, so that the physio can continue while the physiotherapist is not here." (Public, interview 6)*

The private practice employed an AHA, who was able to carry out the care plans delegated after the initial physiotherapy assessment. This AHA model was set up to increase the frequency of service and was charged at a lesser rate than utilising the physiotherapist.

> *"The actual physiotherapist comes in, does an assessment, and it's the allied health assistant who does the day to day." (Public, interview 1)*

> *"So particularly useful for some of the aged care residents." (Private, interview 4)*

In the ideal world many participants described opportunities for increasing the utilisation of AHA's.

> *"Ideally I would like to see an allied health assistant in every facility who could then link outreach services, either our own or contracted." (Public, interview 10)*

> *"I think that they'd be facilitating pulmonary rehab groups. They may assist with cardio pulmonary groups. They could be facilitating telehealth consults for women's health, men's health with more of our expert staff." (Private, interview 4)*

Compared to utilising a therapist, the AHA model may be able to provide a more cost effective and productive service (Brooks, Robinson &Ellis, 2008) and allows the physiotherapist to focus on the patients with more complex needs (Duckett, 2005; Lizarondo, Kumar & Skidmore 2010).

The content of the contract and referral schedule

There was a perception from one MLHD participant that the way the contract was set up, including referral schedules, would enable appropriate service provision, outline responsibilities of the partners and ensure appropriate service within the facilities. Referrals were only to be made by managers to avoid the physiotherapist making their own referrals and picking their own public patients.

> *"There were very specific descriptors in there, that outlined the type of clients that we would refer to the service and that the cluster manager, the facility manager was responsible for actually making those referrals. What we wanted to avoid was the situation where the physio might sweep through the ward and go, "I'll see this patient, this patient, this patient." (Public, interview 10)*

The hourly rate for service procurement model had the physiotherapist reviewing patients after referral and invoicing for the time allocated to the patient. Due to the ad hoc nature of MLHD hospital inpatient referrals, an identified barrier was the difficulty scheduling time to see these patients, particularly time to see on the same day as referral. Participants described a barrier of obtaining access for inpatient physiotherapy, particularly at one site. A lack of understanding of the model of care compounded frustrations felt by staff from the partnering organisations.

> *"We go through periods where we don't get a lot of referrals and so we have other clients that we see and build our book and then we'll get a run of referrals from the health service that need to be seen and we don't have time on that given day to see them." (Private, interview 4)*

"I now don't see allied health assistants and physios on the ward all that often. I'm receiving feedback now … that, the nurses phoning and being told that there is no appointments. They're fully booked with their outpatients and there's no time to review any patients on the ward…. I know that has to be the toss-up between a business model because what if I don't have anyone in hospital who needs physio and they've left appointments?" (Public, interview 2)

One participant mentioned that the funding reportedly available from the MLHD, when the partnership was set up, had not been realised. This is likely due to limited MLHD patients being reviewed as well as difficulties with invoicing and accounting. One MLHD participant recommended that the allocated physiotherapy budget should be spent on therapy services.

"If I went back through that contract stuff, I don't think we've ever hit – we haven't got anywhere near budget." (Public, interview 4)

"I think we have an obligation to fully spend that funding." (Public, interview 10)

Private practice participants described an opportunity to change to a time-block procurement model. This would give certainty of time for service provision as well as time for service development and MLHD staff education. This contracting model was proposed to reduce the transaction costs and administrative burden for both partners.

"I would probably be suggesting a block of time and if that time isn't necessarily used for face to face interventions it could help to develop other projects such as pulmonary rehab or assisting with the cardio rehab program, upskilling nursing staff, upskilling AHAs more … if there's not acute inpatients to be seen we might be able to do some project development." (Private, interview 4)

Alternatively, in the ideal world, staff at the MLHD identified the advantage of being able to flex up and down with demand.

"Flexible in the sense of being able to flex up to meet more, an increase in demand." (Public, interview 8)

"*The beauty of this model, if you leave it fairly flexible, is that the physio can move their hours around as they need to, so it could be really busy in (Town 3) one week and not very busy in (Town 2), and they'll go where the work is." (Public, interview 10)*

The hourly rate procurement model for service provision following referral, outlined in the contract, appeared to limit the services the MLHD received. The private providers scheduled patients in advance, which often meant there was no time available for MLHD referrals. It was not financially viable to leave time blocks vacant and then have no patients referred. Moving forward, it is recommended to trial a consistent, weekly, time-block procurement model. This should give certainty of time for inpatient service provision as well as time for service development, mandatory training and MLHD staff education.

The NSW Health policy directive PD2013_008 states "Direct employment of therapists as permanent employees is the preferred option" (Workforce Planning and Development, 2013, p.3) but recognises that engagement of sessional therapists may be required, particularly in regional and rural NSW. Outlined in this document, a session consists of a maximum of 3 1/ 2 hours and there is a maximum allocation of 4 sessions per week. The durations mentioned in this policy directive need to be considered when negotiating the time-blocks.

Streamlined administration processes for contracting and accounting

The administrative burden involved in contract management and accounting was identified as a barrier by executive from both organisations. The lengthy process to negotiate and finalise the initial contract and to provide contract extensions made it difficult to plan for staffing and service provision from within a small business.

"It's taken a long time for anything to happen because we're waiting for other people and so from our perspective, from a scheduling and a staff management, it was a little bit challenging because we were expecting something to start on one date yet that kept getting pushed back." (Private, interview 4)

The lengthy process to ensure compliant procurement strategies, and the time taken to obtain approval for an exemption from the NSW Health policy directive PD2013_008 (Workforce Planning and Development, 2013), was a significant barrier initially.

> *"We had sought prior approval from the Ministry to be exempt from that where we've got these service gaps… It was exhaustive, it was a huge business case." (Public, interview 10)*

The administrative burden, and delays, for contracting and accounting was clearly described by participants. A non-standard arrangement to the NSW Health policy directive PD2013_008 was required to allow MLHD to contract at a rate higher than the maximum payment rate outlined in the policy directive (Workforce Planning and Development, 2013). The maximum rate outlined at the time of the initial contract was Level 2, Year 4 salary under the NSW Health Professionals (State) Award. A higher rate was negotiated to be commensurable to other funding streams and create a viable business opportunity. It is noted that the latest information bulletin, IB2018_36 (Workplace Relations, 2018), states that the maximal payment rate has increased and is currently $224 per 3.5 hour session (Workplace Relations, 2018, p. 42). Despite this, it is recommended that a permanent exemption, from the contracting rates in PD2013_008 and IB2018_36 be provided for rural areas where there are significant service delivery gaps. A permanent exemption from utilising these contracting rates would allow health services to offer more attractive remuneration to provide services in rural areas, would allow negotiation of payment rates commensurable to other funding streams and considering the generalist skills of the rural clinician. A permanent rural exemption, for areas where there are significant service delivery gaps, would also help avoid delays in initial contract generation and service commencement, related to obtaining approval for an exemption.

On site managers and current service providers reported they had not seen the contract and there was limited local understanding of the expectations within the contract.

> *"I haven't seen the contract… Unfortunately, contracts are high, done at the executive level, not a local level." (Public, interview 1)*

Inaccuracies in statistic collection and invoicing as well as lengthy MLHD checking processes led to barriers to payment. Participants also reported delays in payment and significant time spent following up accounts.

> *"This was probably something that I was unaware of at the time in setting up the contract, was the exhaustive arrangements that are undertaken by the administrative offices on site to validate the invoices when they come in… plus our whole invoicing and payment arrangements for health in general are so clunky that actually makes us quite difficult to do business with." (Public, interview 10)*

> *"I think we do have from time to time a number of errors which have happened with our stats. And what ends up happening is that we just withdraw the charge associated with those stats … I reckon there's been times where we've spent more time as an organisation going over our invoice and stats than the time we've attributed to service provision from a physio perspective." (Private, interview 4)*

> *"Sometimes the latency in the payment for services has been quite extended which for a small business means cash flow obviously is a concern." (Private, interview 5)*

Accounting delays appeared to be caused by processes of checking invoices against the eMR, multiple approvers, general delays in payment and a lack of understanding of the model and contract by MLHD staff. More streamlined processes could include changing to a time-block model for procurement and payment as well as quarterly audits of documentation rather than reviewing every service event in eMR. The complexity of paying for physiotherapy services is not isolated to this PPP. In March 2018 the Transport Accident Commission streamlined the process of treating their clients by removing administrative barriers and speeding up payments for physiotherapy services, after recognising the process was too complicated (Mitchell, 2018). Streamlining the administrative processes for contracting and accounting should reduce transaction costs, therefore making the process more financially viable as well as improving stakeholder satisfaction.

In the ideal world, the accounting process would be simpler and one MLHD participant recommended simply paying on receipt of an invoice and only auditing quarterly.

> *"We should just pay on receipt of an invoice and we can audit periodically, even if we audited a sample quarterly that should be sufficient." (Public, interview 10)*

In the ideal world, one participant identified that costs for the service would be reduced.

> *"I suppose they could drop their fees." (Public, interview 1)*

Processes for managing private therapists in a public setting

Participants described a lack of clear processes for managing a private physiotherapist in a public setting and lack of understanding by all parties. Ongoing uncertainty as to who is responsible for managing the service, ensuring the service is delivered according to the contract and ensuring it is meeting the needs of the facility was identified as a barrier. Offsite executive appeared unlikely to have the time or the on the ground information. Onsite managers had limited experience with the model, partially due to a recent district management restructure, staff turnover and lack of specific orientation to the model.

> *"I was really embarrassed to find that the physios have been using a nurse's login, whoever's there and documenting, because they don't have access because they're not an employee… these are the things that were never set up." (Public, interview 2)*

> *"It's not clear who's responsible for managing the service. It's a little bit murky and that's not ideal." (Public, interview 10)*

Difficulty obtaining computer access and access to electronic medical records (eMR) was identified as a barrier. It was identified that staff from both organisations were unaware of the processes to obtain access.

> *"The actual physios, because they are contracted by (the MLHD) and not employed, they don't get a Stafflink number, which means, from eMR's perspective they can't get a log on." (Public, interview 1)*

> *"I still haven't got access to eMR… we didn't know what was happening with it so I was using (the AHA's) … So, we went through that process and then that was slow. So, it was slow to start and then slow to go through and then no one was really sure where it should be sent and then, but we sent it through and then I still haven't heard back … probably a couple of months" (Private, interview 7)*

Outpatients are not written up in the eMR, instead on the private practice's own front desk system. This may have caused problems for reconciling invoices.

> "*There hasn't been a lot of post-acute care clients, but in terms of the health service reconciling that, they base it on notes in the eMR and so on post-acute care there won't be any notes on eMR because we write them on our service." (Private, interview 4)*

The private practice were required to install their own internet and phone line and bring their own computers for private outpatients. Unreliable internet service and therefore access to patient files and booking systems was reported as a barrier when seeing private patients.

> *"We had internet issues as well which can be a bit frustrating… So sometimes the system would crash and we couldn't access notes and things like that, couldn't access referrals or scans and things like that." (Private, interview 7)*

Though there was an expectation staff comply with mandatory training requirements, they were not provided with access to the online mandatory training system.

> *"I think when it comes to our policies and procedures where we wear that cost is in making sure that all of (the private practice) staff have access to our mandatory training and all of that. So they still need to cover off all of our mandatory training procedures to be able to work in our facilities." (Public, interview 10)*

New South Wales Health PD2013_008 states that "Sessional contractors shall be required to attend mandatory training required by the Public Health Organisation and shall be paid as per the contractual sessional rate of payment for attending such training" (Workforce Planning and Development, 2013, p. 9). In this study the clinicians did not have access to the

online training platform and payment for training was not considered in the accounting processes. It is recommended that the contract between the partnering organisations be amended to include payment for mandatory training.

In the ideal world, 1 participant recommended that there would be additional training for private physiotherapy staff.

> *"Getting access to indigenous training and other professional development opportunities for staff attending out there would be great." (Private, interview 4)*

Participants from MLHD identified opportunities for the private physiotherapists to provide MLHD staff with education and in-services. Due to the lack of services available in the small rural town they described the requirement for local staff to be able to assist across a range of disciplines. Payment for the time taken to lead in-services was not included in the contract but would be part of the usual role of a MLHD employee.

> *"Whether or not it would benefit the physio doing any education as far as whether we could do something like as an in-service type thing. Maybe that might be something that we could look at." (Public, interview 6)*

In the ideal world, there would be a position in the district nominated to manage and ensure compliance with the contract, possibility related to the discipline stream, with operational and professional governance.

> *"Ideally you would have a position within the district who managed these contracts… to make sure that it is, they're delivering according to the contract and we're getting the service that we need… Look I reckon that if we had full-time discipline leads, physio, OT, whatever, that had operational and professional governance for the district, then that is a role that could be not necessarily physically done by those guys but actually managed through the discipline stream." (Public, interview 10)*

Many barriers were described relating to physiotherapists not being directly employed by MLHD and a lack of understanding as to who was responsible for managing these therapists. Another physiotherapy public-private partnership in NSW directly employed the physiotherapists to both organisations and therefore did not report these features (Schmidt & Dmytryk, 2014). That partnership also demonstrated that the sectors can work together to improve education opportunities in a rural area (Schmidt & Dmytryk, 2017).

It is recommended that clear processes be identified to manage private therapists in a public setting including outlining staff responsible for onboarding and orientation as well as operational and professional governance. When implementing new models of primary health care in rural and remote areas a key element to enable change was the establishment of governance and operational processes to manage the complexity of the multiple organisations being involved, and sustaining the changes over time was enabled by local governance processes informed by service activity and impact data (Lyle et al, 2017).

Processes for communication

Good communication between the partnering organisations, multiple stakeholders and clients was identified as an enabler in the partnership. It was identified that face to face communication was not always possible so electronic medical records (eMR) and telehealth enabled communication when staff were not at the same site.

> *"Good communication between the staff and the service. That's obviously vital, so good communication but also good feedback from both sides." (Private, interview 7)*

> *"Well they are here on separate days, but with the beauty of eMR, it's very easy to get an understanding of who is doing what." (Public, interview 1)*

The use of telehealth for communication and meetings, rather than travelling to meet face to face enabled reduced travel time.

> *"There have been lots of meetings that we've had to do. I think there were some Skype ones or just over the phone rather than face to face and to make that sustainable for us… You're using technology to help that I think has been really important." (Private, interview 5)*

One participant identified that marketing the service to the community had led to the positive public perception of additional facilities in the rural community.

> *"They've got their own signage … and they have uniforms and so forth, I think it gives the public perceivement [sic] of an extra facility to assist the community." (Private, interview 9)*

Additional advertising in the community was also recommended. Awareness is suggested as an additional dimension of access (Saurman, 2016) that would be improved with further marketing.

> *"Probably not enough notification to the community regarding the physio and exercise vitality, because a lot of people just don't know. If you could get it out there more that the service is there, I think that would help." (Private, interview 9)*

Lack of processes to enable good communication was identified as a barrier across all levels of the organisation and with the partner organisations. This was particularly highlighted when the management and clinical staff providing the services changed. Participants identified that communication appeared to occur at the executive level but did not always follow through to all levels of the organisation, including the site level.

> *"Well the communication was a bit scattered between different levels of the organisation and stuff so no-one was really sure of all the details." (Private, interview 7)*

> *"I think the feedback that I get and the feeling that I get from Cluster Managers is they don't quite understand everything and they are, rightly so, only interested in what services are being provided to their patients and aged care residents." (Public, interview 10)*

In the ideal world one participant recommended regular meetings with management.

> *"Probably structured regular meetings, whether they're on telehealth, between us and the site manager." (Private, Interview 4)*

Private practice staff described uncertainty about who to contact regarding payment of accounts. The process of who to communicate concerns to also remained unclear.

> *"Knowing who to contact about the accounts … I just often feel bad for the person on the other end of the phone that I'm hassling, who it might not necessarily be their job about the accounts that haven't been paid, or chasing them up or the discrepancies in the account." (Private, interview 3)*

Communication with the clinicians between visits was identified as a barrier, although it was acknowledged they were likely busy with other appointments. The private practice staff also acknowledged that it could be difficult to contact the private practice directors, who also have a clinical caseload themselves.

> *"If the physio's seen the patient the day before and now they're not on site and one of the clinicians wants to clarify something, that contact is really difficult." (Public, interview 2)*

> *"So the fact that our directors are hands on in the clinic a lot of time, making communication during clinic hours actually quite challenging from our perspective." (Private, interview 5)*

One physiotherapist also described the difficulty obtaining support and advice.

> *"Sometimes access to advice from other people, you know sometimes you want it a bit quicker… it's hard to access people sometimes." (Private, interview 7)*

Staff from both organisations identified opportunities to improve referral and handover processes, which were different at each site, and include face-to-face verbal, paper based and phone call.

"Currently we don't refer to (the private provider) through eMR, we do with all the other allied health. We have to make a phone call. It would be good if we could get them onto the referral pathway on eMR." (Public, interview 1)

Clear processes to enable communication between partnering organisations, within individual organisations and with the community was identified as a mechanism to achieve success. Good communication should lead to a coordinated effort to meet the needs of the community and satisfied stakeholders.

Consistent stakeholders

Lack of consistent stakeholders was described by participants as a barrier. This related to turnover of staff in both the public and private settings and lack of orientation.

"Turnover of site management probably has been a bit of a struggle." (Private, interview 3)

"So again, being introduced to this model after it was all set up, not a great handover or anything like that." (Public, interview 2)

Recruitment and retention to rural positions was identified by both organisations as a barrier.

"Workforce would be a barrier and trying to recruit to that position has been hard." (Private, interview 3)

Orientation of new staff was identified as an opportunity.

"I guess orientation could be a bit more complete with the stats and paperwork and stuff." (Private, interview 7)

In the ideal world one participant recommended an orientation checklist including the requirements for new staff.

"Having something set up initially to make it easier to rotate a physio through there and in regards to the HR (Human Resource) requirements and even if there was a checklist that these are the things that we have to do and provide. That's your checklist, this is the person you need to hand it to." (Private, interview 4)

Despite changes in physiotherapy staffing, the private physiotherapy business had been able to provide a service for 51 weeks per year for more than 3 years. The private practice director was a constant during the period and the business remained committed to providing the service. It has been identified previously that private physiotherapists generally remain longer in rural areas than their public colleagues (Keane et al, 2013). The longevity of this business within the community can similarly be recognised. With staff turnover the need for orientation to the service at all levels of both organisations was identified.

With the complexity of rural allied health recruitment and retention, it has been recommended to avoid a one size fits all approach and instead being creative and adopting an integrated, collaborative, inter-sectorial and sustained approach (Durey, Haigh & Katzenellenbogen, 2015). This PPP model is one such approach.

Part C: Emerging challenges

In response to a line of enquiry about emerging challenges, consistency of funding was identified as the main emerging challenge. Potential changes to the funding model, particularly from the MPHN, were thought to affect the viability of the current model and particularly the AHA component.

"Given that a lot of our funding for our allied health assistant comes from the PHN (Primary Health Network) with exercise groups, is that it's going to be hard to transition across without that because of the amount of work required by the AHA isn't enough to prompt travel out there." (Private, interview 4)

An opportunity to increase GP referrals under GP Management Plans was identified as a way to sustain the model with potential funding changes.

"The other way to sustain some of those primary care services though is to work with local GPs to be referring people under a GP management plan and accessing the service using MBS (Medicare Benefits Scheme) items for chronic disease management." (Public, interview 10)

Inconsistent funding may threaten the partnership and other opportunities for revenue need to be explored to maintain viability.

Part D: Dream- Emerging opportunities and the ideal world

In response to questioning about emerging opportunities, all participants identified opportunities to expand the services provided in the model. This included increasing the frequency of physiotherapy service provision; expanding to other locations within the MLHD; expanding the model to include community clients, outpatients and chronic care group programs; expanding to include other allied health disciplines and telehealth and continuing to be innovative.

All participants mentioned an opportunity to increase the frequency of services, particularly in inpatients and aged care facilities.

"We would like them more often." (Public, interview 6)

As far as inpatients go I think a lot of benefit if there's more hours with physios there." (Private, interview 9)

Public staff were keen to see the model expanded to other locations in the MLHD.

"Ideal world I would definitely have (Town 5) in the provision, physio and allied health services." (Public, interview 2)

Participants mentioned opportunities to expand the model to include community clients, outpatients, home visits and chronic care group programs.

"*They don't do home visits so there's a real gap for clients who can't come in, palliative and things like that." (Public, interview 2)*

"I think pulmonary rehab's a big opportunity." (Private, interview 4)

"I certainly think that we need to be referring more people into the program, expanding, so if we look at community dwelling older people, if we look at the chronic disease management stuff, if we look at falls prevention in the community."(Public, interview 10)

The private participants mentioned the opportunity to travel and provide services as a team of allied health services.

"There is a great need for physiotherapy and probably other allied health services too… there might be the ability to link up with some other health providers and take a team of people out there for a day." (Private, interview 5)

Both public and private participants discussed options with expansion into telehealth.

"For potentially specialised services that we can't offer, we can't get the specialised therapist to those areas, then I think there's definitely telehealth." (Private, interview 5)

"Where you might only have one or two patients, there may be opportunities to look at telehealth set-ups" (Public, interview 10)

In the ideal world innovation would continue. When implementing innovative developments in rural and remote Australia, it has been shown that managers were able to attract staff by conveying a sense of excitement about a new model (Wakerman et al, 2009). It appears that innovation was one of the drivers for the physiotherapy business being involved.

"It would continue to be innovative and look at other ways to provide service out there." (Private, interview 4)

It is recommended that the emerging opportunities be explored locally and implemented where possible.

Strengths and Limitations

To the best of the author's knowledge, this is the first qualitative research investigating a contracting model of public-private partnership in physiotherapy. It provides evidence informed guidance for local improvements as well as a valuable contribution to the literature when considering public private partnerships at other sites.

A strength of the study was that it was conducted by a researcher with inherent knowledge of the local health systems. A limitation of the study was that it was conducted by a novice researcher. This was overcome by the input from supervisors, mentors and workshops with the HETI RRCBP. Another limitation of the study is that only half of those invited to participate were interviewed and therefore participants may represent a more motivated view. Given the researcher's role in the organisation, participants may have responded more positively. The findings from this study relate to a specific public-private partnership in 4 outer regional towns in NSW and the findings may be transferrable to similar rural areas and other allied health disciplines. Further research could include the perspective of the patients as well as a further economic evaluation, as these areas were outside the scope of this study.

Conclusion

This study has demonstrated that a physiotherapy PPP model of service delivery is a successful way to deliver physiotherapy services in an outer regional area. Elements of success included improved access to local services, a coordinated effort to meet the needs of the community, a service that is financially viable and satisfied stakeholders.

The study has demonstrated the mechanisms to successfully implement the service delivery model. These mechanisms include use of multiple resources, motivated stakeholders, content of the contract and referral schedule, streamlined administration processes for contracting and accounting, the workforce model, processes for managing private therapists in a public setting, processes for communication and consistency of stakeholders.

The study described an emerging challenge of consistency of funding and described future opportunities including expanding the model. With consistent funding, a PPP model could be expanded into other areas of health service delivery to achieve access to services in rural areas.

Recommendations

Local clinicians and managers

- Public-private partnerships be considered in other rural areas for physiotherapy as well as other allied health disciplines, (particularly when there are multiple small amounts of funding and facilities available). The mechanisms to successfully implement the service model, described in this report, should be considered.
- NSW Health and MLHD specific administrative processes for contracting and accounting be streamlined to make it timelier and easier to do business. The invoice checking process should be simplified (eg. the MLHD should trial paying on receipt of an invoice and auditing eMR records periodically (eg. quarterly) rather than every record).
- The MLHD should trial contracting in a consistent, weekly, time-block procurement structure rather than an hourly-rate for service model. If there are no referrals, the allocated time should be spent on mandatory training, service development and MLHD staff education activities.
- There should be documentation of clear processes to manage private therapists in a public setting including orientation processes for new staff in the partnering organisations. This includes processes to obtain contingent worker identification numbers, eMR access and training, and access to online mandatory training.
- It is recommended that there is a clear expectation of the mandatory training requirements for sessional physiotherapists and an understanding that they are to be paid at the contractual sessional rate to complete this. This requirement should be included in the contract and compliance monitored.
- Specific staff, such as health facility managers or discipline-specific leads, should be identified as being responsible for managing the contract and for operational and professional governance. This includes staff nominated to monitor compliance with the contract and assist as new issues arise. A contracts manager could also look for opportunities for new PPP's where there are service gaps.

- All relevant health facility managers and cluster managers are provided with orientation about the content of contract and the services being provided in their facilities. Contracted physiotherapists are provided with orientation about the content of contract and the requirement for the services being provided by the various funding streams (eg. location of documentation and reporting requirements).
- Communication be improved by regular meetings between partnering organisations and further orientation.
- Communication about the services provided and the referral processes be communicated to GP's, nursing staff, allied health and the broader community.
- Referral processes be streamlined (including the possible use of eMR orders (contingent on eMR access) at all sites for inpatient referrals) and the local contract amended to allow referrals from clinicians, rather than only cluster and facility managers.
- Statistic collection processes be streamlined (including possible use of eMR reports (contingent on eMR access) for this).
- Local opportunities for improvement described in this report be implemented by the partnering organisations where appropriate including:
    - expanding the model to include other towns,
    - more outpatient services,
    - chronic disease groups
    - and the use of telehealth.

Policy Makers

- NSW Health allow an exemption, from the contracting rates outlined in the NSW Health Policy Directive *"Engagement of Therapists on a Sessional Basis PD2013_008",* for all NSW rural areas where significant gaps in service delivery exist.

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Appendices

Appendix A: The researcher

In accordance with qualitative research, the researcher engaged reflexively with her own assumptions. The researcher is a female physiotherapist employed at MLHD who has worked as a clinician, manager and advisor in public settings for most of her career of more than 15 years. The researcher had worked only for a short time in a private physiotherapy practice setting. The researcher had limited contact with the participants of the study prior to its commencement, however was employed at the time of the interviews as the part time MLHD Physiotherapy Advisor. The researcher had previously completed an honours quantitative research project and received further training in research methods and techniques to conduct this study from her mentor and through the HETI RRCBP. To engage in the process of reflexivity, the researcher remained aware of the impact of her personal experiences, views and knowledge. She discussed these issues with her research mentor and supervisor and also recorded notes on these issues and reflected on their impact in her reflexivity research journal.

Appendix B: Interview questions

The best of what is:

1. What is your understanding of the Murrumbidgee Local Health District and Back on Track Physiotherapy public-private Physiotherapy service delivery model?
2. What has been your experience of the model?
3. What do you think success of this model looks like?
   Prompts: a. Define success for your organisation.
4. Has the model been successful?
5. What has contributed to this success?
   Prompts: a. What are the enablers?
6. What has held back success?
   Prompts: a. What are the barriers?

The best of what could be:

7. Can you describe any emerging challenges and opportunities?

Action to achieve the ideal:

8. In an ideal world, what would the model look like?

Additional questions will be asked to help clarify responses.