Frequently Asked Questions (FAQs) on the Primary Response in Medical Emergencies (PRIME) Service

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1. FAQs on the PRIME Service

1.1. What is the National Ambulance Sector Office?

The National Ambulance Sector Office (NASO) is a joint office between Accident Compensation Cooperation (ACC) and the Ministry of Health (the Ministry). It is located as a business unit within the Ministry. It is jointly funded and governed by the two organisations, and is staffed by four full-time staff. The Group Manager role is a joint appointment, with reporting lines to both organisations.

It was first established in September 2008 and was confirmed by the Ministers of Health and ACC in June 2009.

NASO’s functions include:

- progressing the New Zealand Ambulance Service Strategy
- providing a single voice for the Crown on strategic and operational matters regarding emergency ambulance services (EAS)
- managing and monitoring funding and contracts from both parent agencies related to the delivery of EAS.


1.2. What is the PRIME service?

The Primary Response in Medical Emergencies (PRIME) service aims to provide timely access to clinical skills that have the potential to improve outcomes for medical emergencies (including injury) in rural areas.

The PRIME service aims to ensure high quality access to pre-hospital emergency care in areas where access to appropriate clinical skills are not available, or where ambulance service rural response times may be longer than usual.

The PRIME service works in conjunction with emergency ambulance services and is coordinated by their communications centres that receive 111 calls for ambulance and dispatch appropriate resources.

1.3. What does the PRIME service involve?

The PRIME service specification requires a PRIME response for 111 calls coded as a Category A (ie, immediately or potentially life threatening incident) by the medical priority dispatch system used in the communications centres.

While communications centres now use different terminology from that in the service specification, PRIME continues to be dispatched to incidents that are immediately life threatening (now called ‘purple’ incidents) and potentially life threatening (now called ‘red’ incidents).

1.4. Who provides the PRIME Service?

PRIME is provided by specially trained medical practitioners, nurse practitioners and registered nurses who assist ambulance services. It is a 24-hour a day, seven-day a week service where PRIME service providers are on an on-call roster.

PRIME providers are registered medical practitioners, nurse practitioners and registered nurses who have formal agreements with the PRIME administrator, St John, and ACC to co-respond to medical emergencies (including injury) in rural areas according to specified protocols.
1.5. What is considered to be a PRIME response?

A PRIME response is a potentially life threatening call (purple and red incidents) that has been received by the ambulance communications centre, either by 111 or other non-urgent telephone line into the communications centre. The ambulance communications centre then dispatches the PRIME service provider to the incident. If the call is not activated from the ambulance communications centre then it is not considered to be a PRIME response.

To qualify as a PRIME response, the PRIME practitioner must have:

- been dispatched
- responded to the incident, and
- seen the patient.

1.6. When was the PRIME service established?

The PRIME service was first established in 1998 in the South Island following a rural general practitioner’s (GP’s) advocacy to design a new integrated pre-hospital system. *Roadside to Bedside (1999)* provided a framework for a 24-hour clinically integrated acute management system, and its implementation plan required the PRIME service to be rolled out nationally.

1.7. Who provides the PRIME administrator function?

St John is the administrator of the PRIME service through a contract with the Ministry of Health. The contract is managed by NASO (National Ambulance Sector Office), and St John administers PRIME on behalf of ACC and the Ministry of Health.

1.8. What are the functions of the PRIME administrator?

The PRIME administrator performs the following functions:

- Formally agrees response regions and service coverage with PRIME service providers, in accordance with requirements outlined in the PRIME service specification, which is part of the contractual agreement between the Ministry of Health and St John.
- Keeps a record of all PRIME service providers and their designated response regions, monitors service coverage, and co-ordinates review of response regions, including any potential modified or new response regions.
- Organises and administers PRIME committees (as described in the PRIME service specification) and ensures that all PRIME service providers have opportunity for input into the Committees.
- Supplies expendable supplies and PRIME kits to PRIME service providers.
- Ensures that all PRIME service providers have knowledge of all local and regional plans, procedures, protocols, and communication linkages relevant to their role in an emergency response.
- Carries out other functions that may be specified in contract terms and conditions by the Ministry of Health.

1.9. What is the PRIME service specification?

The PRIME service specification is a joint Accident Compensation Corporation (ACC) and Ministry of Health document. It provides detailed information of the requirements for the delivery of the PRIME service. While the two agencies may have separate contracts or agreements for PRIME services, the joint service specification is used as part of any contracted PRIME service agreements.

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1.10. What is the responsibility of PRIME committees?

PRIME committees are responsible for reviewing and evaluating the functioning of the regional PRIME system, recommending possible improvements to systems, communicating relevant information and recommendations to stakeholders, and providing peer support to PRIME service providers.

In the South Island PRIME committees are also responsible for liaising with the local Emergency Care Co-ordination Team (ECCT) to ensure the PRIME service is fully integrated into the pre-hospital emergency care network.

1.11. What are Emergency Care Co-ordination Teams (ECCTs)?

There are regional acute care networks based around the tertiary hospital services in Christchurch and Dunedin. ECCTs act in networking, monitoring and advisory roles to their regional emergency care system.

The service specification identifies that ECCTs are responsible for receiving reports from the PRIME committees and endorsing appropriate PRIME committee recommendations to district health boards (DHBs), ACC, the Ministry of Health, and other stakeholders.

1.12. What are ambulance communications centres?

Ambulance communications centres provide the telecommunication interface between 111 callers and the PRIME service provider. Communications centres dispatch PRIME service providers to the scene of medical emergencies in their response regions, based upon information received from 111 callers. PRIME service providers are dispatched according to agreed protocols.

1.13. What is used to determine a PRIME response region?

The PRIME service specification states that PRIME is provided in areas that are:

- at least 30 minutes standard driving time from a secondary hospital providing Level 3 or higher emergency department services as described in the Ministry of Health service specifications for Emergency Departments; and
- within an area where an advanced life support (now referred to as Intensive Care Paramedic) ambulance coverage is not available within 30 minutes.

Some flexibility is accorded in the definition of PRIME response regions. Factors including geography, population, seasonal climate, population changes, on-call practitioner rosters, and availability of ambulance resources, may be considered when defining PRIME response regions.

PRIME response regions will be agreed by the PRIME administrator with the Ministry of Health and ACC. PRIME committees will provide advice on any modifications to PRIME response regions or additional PRIME response regions. The PRIME administrator will be responsible for co-ordinating this advice and communicating it to the Ministry of Health and ACC.

1.14. How is the PRIME service funded?

The PRIME service is funded by the Ministry of Health (the Ministry) and Accident Compensation Corporation (ACC). There are three arms of funding provided:

- Administration of PRIME
- Medical-related responses
- Accident-related responses

[See sections 2 and 3 for details on spending for medical- and accident-related responses].

Administration of PRIME

Funding is provided to the PRIME administrator, St John, through an agreement with the Ministry of Health. The contracted amount for the 2015/16 financial year was $1.8 million (GST exclusive) and covers dedicated resource and management functions; contract management with PRIME service providers; supply of PRIME kits and replenishing their stock; PRIME committees and PRIME service provider training.
Medical-related responses

Through the agreement with the PRIME administrator, St John, the Ministry funds PRIME services for all eligible persons for PRIME services in rural areas who require emergency medical attention in the pre-hospital setting.

Accident-related responses

ACC is responsible for the funding of PRIME for eligible people who have suffered a personal injury in terms of ‘the Act’\(^2\) for which a claim for cover has been accepted, or is likely (in the PRIME service provider’s experience) to be accepted. Eligible people are those for whom the PRIME service starts within 24 hours of suffering a personal injury or within 24 hours of being found after suffering a personal injury (whichever is the later) and for whom the PRIME treatment is necessary.

1.15. **Who is responsible for providing equipment to PRIME service providers?**

The PRIME administrator provides one PRIME kit per clinic or other distinct physical location from where PRIME services are provided. PRIME kits are jointly funded by ACC and the Ministry of Health. It is the responsibility of the PRIME provider to insure the PRIME kit and contents.

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\(^2\) “The Act” means the Accident Compensation Act 2001 or its replacements, and any amendments; and the IPRC Regulations and any replacements or amendments.
2. FAQs for the Medical-Related Response Component of PRIME

2.1. How are PRIME medical-related services funded?

St John, as the PRIME administrator, funds 73\(^3\) primary care practices.

- 56 practices providing 24/7 coverage.
- 17 practices providing less than 24/7 coverage.

Funding is allocated to practices based on one of three levels of response volumes as follows:

<table>
<thead>
<tr>
<th>Funding received for 24/7</th>
<th>Number of prime sites in each category</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>response coverage</td>
<td>24/7 coverage</td>
<td>Less than 24/7 coverage</td>
</tr>
<tr>
<td>1-20 responses</td>
<td>$13,314</td>
<td>21</td>
</tr>
<tr>
<td>21-40 responses</td>
<td>$18,435</td>
<td>17</td>
</tr>
<tr>
<td>41+ responses</td>
<td>$23,555</td>
<td>18</td>
</tr>
</tbody>
</table>

For practices providing less than 24/7 coverage, the amount will vary based on actual hours covered.

For each financial year is based on actual volumes for the previous financial year.

2.2. What components make up the funding to PRIME service providers?

There are two components to the funding provided to PRIME service providers.

- A fixed base rate of $8,000 per annum (for 24/7 coverage) in recognition of the administration and availability costs of providing PRIME.
- A cost per medical-related response.

**Fixed base rate**

This payment is based on payment to a PRIME provider for the administration and availability costs of providing PRIME. The fixed base rate of $8,000 per annum remains the same regardless of the on-call volumes expected in a PRIME site.

**Cost per medical-related payment**

Medical-related response funding is based on the total contracted payment minus the fixed base rate component.

The funding provided for a medical-related response covers time on the call, travel and consultation fee.

2.3. What co-payments can be charged by practitioners for medical-related responses

No co-payment can be charged (ie, a fee charged to the patient) for medical-related responses although the old PRIME contracts do not specifically make this clear. The newer PRIME contracts have a clause that clarifies that no co-payment may be charged.

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\(^3\) As at 17 February 2016.
3. FAQs for the Accident-Related Response Component of PRIME

3.1. How are PRIME accident-related responses funded?

ACC contracts with 73 PRIME practices for the provision of accident-related responses. Practitioners are paid on a fee for service basis utilising ACC’s PRIME and Rural General Practice (Rural GP) contracts as well as Cost of Treatment Regulations (CoTR).

Under the PRIME contract providers are invoicing for the following service items:

<table>
<thead>
<tr>
<th>Service item</th>
<th>Service description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance Fee</td>
<td>Time spent on the call out – from receiving the call until return to home or place of work</td>
<td>$183.11 per hour</td>
</tr>
<tr>
<td>Travel Distance</td>
<td>Kilometres travelled to and from the accident scene</td>
<td>$0.73 per km</td>
</tr>
</tbody>
</table>

In addition PRIME Providers are able to invoice under the Rural GP contract for the actual treatment provided at the accident scene. If the client requires further treatment at the GP clinic, a second consultation may be invoiced to ACC.

There is some confusion around the intersection of the PRIME and Rural GP contracts. Feedback from the sector is that the PRIME contract does not reflect how providers are invoicing ACC for PRIME callouts.

ACC will recommend clarifying the funding mechanism for accident-related call-outs as part of the PRIME review.

3.2. What co-payments can be charged for accident-related responses?

In most cases practitioners are not able to charge clients a co-payment for accident-related responses. But the ACC PRIME contract allows them to charge a reasonable co-payment in exceptional circumstances. If a situation such as this arises, then the practitioner must submit a report to ACC with their invoice, detailing these exceptional circumstances.

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4 As at 17 February 2016.
4. FAQs specifically relating to the PRIME Service Review 2016

4.1. What is the reason for the PRIME Service Review 2016?

The PRIME service has not been formally reviewed since it was implemented in 1998. In response to receiving a range of ad-hoc feedback on the PRIME service for an extended period of time, the National Ambulance Sector Office (NASO) asked for formal feedback in March 2016. The purpose of asking for feedback was to understand the issues more clearly and to inform whether a formal review has required.

Considerable feedback was condensed into a summary document in May 2016, which was then distributed to key stakeholders and presented to the National Rural Health Advisory Group. Following discussion on the issues raised, it was agreed that a review was required.

4.2. What are the objectives, benefits and outcomes for the PRIME Service Review 2016?

The key objectives of this project are as follows:

- **Dynamic:** the PRIME service will be developed so that it can evolve to ensure that it is safe, effective and sustainable.
- **Balanced centrally and locally:** the PRIME service is structured so that it allows local autonomy, but has appropriate central control as required.
- **Aligned to the themes in the New Zealand Health Strategy 2016:** people-powered, closer to home, value and high performance, one team, and smart system.

It will be important to ensure any recommendations from the review align with the aim and purpose of the PRIME service.

The PRIME Service Review 2016 expects to realise the following key outcomes and benefits:

- PRIME continues to be relevant and adds value to rural ambulance services.
- PRIME practitioners feel well supported in their role.
- PRIME continues to meet its objectives in a sustainable manner.
- PRIME funding arrangements are well understood, with improved utilisation of available resources.

4.3. What are the deliverables for the PRIME Service Review 2016?

The review will provide recommendations on the following:

- PRIME funding arrangements to ensure it is equitable and effective.
- An effective structure to administer PRIME including: the role of the PRIME administrator; communication; PRIME committees; PRIME sites; the role of rural service level alliance teams (SLATs); and improved data collection and analysis.
- Clinical governance including: roles and responsibilities; nurse standing orders; clinical audit; quality assurance; dispatch of PRIME and scene management.
- Training and syllabus: ensuring content and delivery are fit-for-purpose and content is regularly reviewed and updated.
- Supplied kit and equipment including: standard-issue equipment; principles for any changes and updates; clear understanding of how items can be changed and at whose expense; medicine requirements; and safety.
The review **will not** provide recommendations on the following:

- Increase in funding for the PRIME service: additional funding is outside the scope of this review and – in general – the collective recommendations must not increase the existing funding envelope. The exception to this is that the Steering Group Chair may agree to include additional recommendations for increased funding, provided that (a) exclusion would limit the robustness of the review, and (b) there is a strong case that it presents a good investment for government given its priorities at the time. However, there is no expectation that any recommendation for increased funding would be realised.
- Technology (electronic patient report forms, PRIME app).
- Workforce issues (outside of those specifically identified above).

**4.4. What approach is the PRIME Service Review 2016 taking?**

Within the above scope, the project will have five workstreams, which were defined by the Steering Group:

1. Funding arrangements
2. Administration
3. Clinical Governance
4. Training and Syllabus
5. Equipment, Kit and Medicines.

Each workstream will have a workstream lead appointed, with a working group made up of representatives from each of the following:

- St John
- Emergency Care Coordination Teams (ECCTs)
- PRIME committees
- PRIME practitioners
- Rural service level alliance team (SLAT).

In addition to the above members, the working groups can involve other stakeholders as necessary to inform their work, without the need for Steering Group approval.

Each of the five working groups will develop recommendations based in the key issues defined by the Steering Group. These recommendations will be considered by the Steering Group, with final approval for any recommended changes being provided by the Ministry of Health and ACC.

**4.5. What organisations are represented on the PRIME Service Review 2016 Steering Group?**

The Steering Group has representation from the following organisations:

- National Ambulance Sector Office (NASO)
- The Accident Compensation Corporation (ACC)
- The Ministry of Health (Ministry)
- New Zealand Rural General Practice Network (NZRGPN)
- St John
- Royal New Zealand College of General Practitioners (RNZCGP)
- College for Primary Health Care Nurses (CPHCN).
4.6. What is the expected timeframe for the PRIME Service Review 2016?

The high-level milestones and deliverables are outlined in the following table:

<table>
<thead>
<tr>
<th>High-Level Milestone or Deliverable</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each workstream has been formed and started its aspect of the review</td>
<td>End of July 2016</td>
</tr>
<tr>
<td>Each workstream develops recommendations</td>
<td>End of October 2016</td>
</tr>
<tr>
<td>Recommendations from each of the workstreams is compiled to form a draft Review Report</td>
<td>Mid-November 2016</td>
</tr>
<tr>
<td>Draft Review Report is approved for consultation by the Steering Group</td>
<td>Mid-November 2016</td>
</tr>
<tr>
<td>Consultation period with stakeholders (five weeks)</td>
<td>November / December 2016</td>
</tr>
<tr>
<td>Review Report compiled</td>
<td>Over January 2017</td>
</tr>
<tr>
<td>Final Draft Review Report approved by PRIME Review 2016 Steering Group</td>
<td>Mid-February 2017</td>
</tr>
<tr>
<td>Consultation period with key stakeholders</td>
<td>Late February 2017</td>
</tr>
<tr>
<td>Review Report approved by PRIME Review 2016 Steering Group for submission to Ministry of Health and ACC for consideration</td>
<td>Mid-March 2017</td>
</tr>
<tr>
<td>Final decisions made on Review Report findings (Ministry of Health and ACC)</td>
<td>End of March 2017</td>
</tr>
<tr>
<td>Stakeholders informed which recommendations have been accepted, and next steps</td>
<td>April 2017</td>
</tr>
</tbody>
</table>

4.7. Who can I contact to discuss the PRIME service review?

Liz Parker (Ministry of Health) is the Project Manager for the PRIME service review. Liz can be contacted as follows:

   Email: liz_parker@moh.govt.nz
   Phone: 04 816 2147
   Cellphone: 021 221 9523.

Information on PRIME is also available on the following websites:


   Accident Compensation Corporation: http://www.acc.co.nz/for-providers/contracts-and-performance/all-contracts/PRD_CTRB112774