



# **Community and Public Health Advisory Committee Meeting**

**Wednesday 20 July 2011**

**2:00pm**

**Marie Hosking Room  
Level 7, Building 14  
Greenlane Clinical Centre  
Epsom**

*Hei Oranga Tika Mo Te Iti Me Te Rahi  
Healthy Communities, Quality Healthcare*





# Community and Public Health Advisory Committee

## For discussion with Board

CPHAC Meeting Date:	
Feedback By:	
<b>DAP</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
<b>KPIs</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
<b>RISKS</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
3.	







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**KARAKIA**



## **Karakia**

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

## **Creator and Spirit of life.**

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind

As we seek to be of service to those in need.

Give us the courage to do what is right and help us to always be aware

Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.



**ATTENDANCE AND APOLOGIES**



**CONFLICTS OF INTEREST**



## Conflicts of Interest Quick Reference Guide

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Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction.
- Having a financial interest in another party to a transaction.
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it.
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction.
- Being otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

### IMPORTANT

If in doubt – declare.

Ensure the full nature of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at [www.legislation.govt.nz](http://www.legislation.govt.nz)) and “Managing Conflicts of Interest – Guidance for Public Entities” ([www.oag.govt.nz](http://www.oag.govt.nz)).





**ADHB BOARD AND COMMITTEE (CPHAC)  
INTERESTS REGISTER**

<b>NAME OF BOARD MEMBER</b>	<b>ORGANISATION</b>	<b>ROLE</b>	<b>FINANCIAL INTEREST</b>	<b>NATURE OF INTEREST</b>	<b>DATE OF LATEST DISCLOSURE</b>
<b>Lester LEVY (Chair)</b>	University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin & Taylor Waitemata District Health Board A+ Trust	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman Trustee			31 May 2011
<b>Jo AGNEW</b>	Senior Lecturer Nursing, Auckland University Casual Staff Nurse ADHB		Salary Salary		21 April 2010
<b>Peter AITKEN</b>	Pharmacist Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/ Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
<b>Judith BASSETT</b>	Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Susan BUCKLAND</b>	Writing, editing and public relations services  Medical Council of NZ  Occupational Therapy Board	Self-employed  Professional Conduct Committee member  Professional Conduct Committee member	Fees  Hourly fee  Hourly fee	Writer, editor and public relations services Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes Lay member of PCC to assess complaints and determine outcomes	7 August 2009
<b>Dr Chris CHAMBERS</b>	Employee, Auckland District Health Board Wife employed by Starship Trauma Service Clinical Senior Lecturer in Anaesthesia Auckland Clinical School Associate, Epsom Anaesthetic Group Member, ASMS Shareholder, Ormiston Surgical				20 April 2011

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Rob COOPER</b>	Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust Advisory	25 February 2011
	James Henare Research Centre, University of Auckland	Board Member	No fee		
	Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	Waitemata District Health Board	Member	Fee (to Ngati Hine Health Trust)		
<b>Lee MATHIAS</b>	Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting Director, company provides services to people with multiple physical disabilities especially cerebral Palsy Provider of business and professional services to midwives and other maternity services providers	31 May 2011
	Iris Limited	Director	Fee		
	Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited		

	Pictor Limited	Shareholder, Director	Fee	Biotech start-up focussing on diagnostic products Estate of late husband Provider of early childhood education services contracted to the MoE. Statutory Authority	
	John Seabrook Holdings Limited	Director	No fee		
	AuPairlink Limited	Governance Advisor	Fee		
	NZ Council of Midwives Tamaki Transformation Transitional Board	Council member Chair	Fee Fee		
<b>Robyn NORTHEY</b>	Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	16 December 2010
	Hope Foundation Northern Region	Board member	Nil		
	Ethics Committee	Member	Fee		
<b>Gwen TEPANIA-PALMER</b>	Waitemata District Health Board	Board member	Fee		18 May 2011
	Manaia PHO Ngati Hine Health Trust	Board member Chair			
	Te Taitokerau Whanau Ora	Committee member	Fee		
<b>Ian WARD</b>	Principal/Director C -4 Consulting Limited				4 May 2011

**CONFIRMATION OF MINUTES**  
**- WEDNESDAY 15 JUNE 2011**



# Community and Public Health Advisory Committee Minutes

<b>MEETING DETAILS</b>	
Time and Date	2:00pm, Wednesday, 15 June 2011
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom
<b>1</b>	<b>KARAKIA</b>
	The Chair declared the meeting open at 2:02 pm. Aroha Haggie led the meeting with the karakia.
<b>5</b>	<b>ACTION POINTS</b>
	<p><b>GAIHN</b></p> <p>Dr Ray Naden, Chair of GAIHN was in attendance. A paper on GAIHN was being prepared.</p> <p>Dr Naden was appointed Chair in November 2010. He advised that the idea was good and there was lots going on but it was not integrated and had little cohesion between parties on what they were doing together. The ADHB contract does not fit well with the alliance relationship between partners .</p> <p>A workshop had been held at the end of March to focus on savings and return on investment based on care and savings.</p> <p>The big area was growth of the need for acute hospital beds. A number of things could be done to manage that acute demand with a focus on avoidable hospitalisations and, for children, through better primary care..</p> <p>There are two key strategies, the first being prevention with a focus on frail elderly, medically illiterate and “did not attends” to avoid acute events through targeting individuals and assigning care coordinators to develop a health plan. The second was to address possible acute episodes earlier as not all acute needed to go to hospital. POAC was successful but quite patchy with different rates of admissions at practice level. Those that usually miss out were being targeted with programmes being developed to identify high risk people.</p> <p>There is support for primary care but it is not coordinated yet. A number of projects are in process e.g. , better access to diagnostics, e-referral project . but these are not connected well. A focus on prevention would reduce unnecessary admissions however the payment system does have some perverse incentives.</p> <p>There has been identification of the characteristics acute admissions in the last three weeks so that they could be targeted. The major diagnoses being cellulite, at risk families, CVD, chronic obstructive lung disease and frail elderly for example on six medications which increases the risk. This work is to be completed by 30 September and the first patients enrolled by 1 December. Risk factors identified by other organisations would also be assessed.</p> <p>Leadership for change was about hearts and minds not organisational structures and not one model fits all working with local networks that differ in different locations. The Health Navigator is the Whanau Ora approach used by Waipareira Trust. Where best practice is identified this would be shared. Enablers were electronic decision support to follow care pathways based on best practice with a focus on the journey of the person and what is best for the patient. Johan Vendrig is included in the group to assist integration.</p> <p>The paper next month would go to all regional DHB Boards and the PHO Boards. The Chair thanked Dr Naden for his informative address.</p>



	<p>a report awaited and involvement of the Health and Disability Commissioner.</p> <p>More practices were becoming involved in the removal of skin lesions and the service was being promoted to primary care. However, there are still not enough engaged practices to meet the target. Partly this was because of ADHB policy and management of blockages needed to be addressed. There are also there were some issues on the subsidy and accreditation of GPs. It was suggested that using a few practices with higher volumes may be a better strategy than dispersing work through many practices. There was some discussion on credentialing. The pharmaceutical project was trying to assess the financial impact, including the cost of prescribing and how savings are calculated. Work was being undertaken on the national Community Pharmacy contract.</p> <p>Gwen Tepania-Palmer left the meeting at 3:20pm.</p>
<b>9.1</b>	<b>Diabetes Annual Review and Management and National Health Target</b>
	<p>Gayl Humphrey, Manager Strategy Implementation and Louise Dickinson, Project Manager Long Term Conditions were in attendance.</p> <p>It was noted that the paper was detailed and informative. A lot of work was being undertaken and although the target would not be reached it was better than neighbouring DHBs noting that they had different targets. Achievement in the last month was 65% across all groups. The focus was on building quality improvement in primary care providing more education and pathways with coordinators assisting in data checks to get better results. Procure had a project team to improve data and address the complexity of having blood tests at the Community Laboratories instead of point of care testing. The framework in general practice would be based on the concept of chronic care management.</p> <p>The scoping for a community Specialist Diabetologist position would be to provide a tier 2 type service in primary care acknowledging the need for a specialist. The targets at regional level should be the same.</p> <p><u>Moved Lee Mathias; seconded Robyn Northey</u></p> <p><i>That the Community and Public Health Advisory Committee:</i></p> <ol style="list-style-type: none"> <li>1. <i>notes activities being undertaken to improve diabetes health outcomes for our population and as a consequence achieve our diabetes annual review and management targets;</i></li> <li>2. <i>notes ADHB's Diabetes performance is equal or greater than our neighbouring DHBs despite not achieving target;</i></li> <li>3. <i>notes ADHB's 2011/2012 targets remain as stretch targets with the goal to improve health outcomes for people with diabetes;</i></li> <li>4. <i>notes the scoping of a community diabetologist position with a paper to come back to CPHAC with recommendations;</i></li> <li>5. <i>agrees that Diabetes Update be on Board Agenda three monthly, and.</i></li> <li>6. <i>for a joint paper ADHB/WDHB to be provided as soon as practical.</i></li> </ol> <p><u>Carried</u></p>
<b>6.2</b>	<b>Planning and Funding Exception Reports</b>
	There were no exceptions this month.
<b>6.3</b>	<b>National Targets</b>
	<p>Immunisation had improved with a good increase in Maori and overall 90%, Maori 87% and Pacific 92%, noting that the target will be reached by 30 June. There would be a further challenge next year with the target being raised to 95% so practices with low rates would be targeted.</p> <p>It was noted, that for the generation of baby boomers, their initial immunisation may be declining and there may be a need for re-immunisation.</p>

7.1	<b>Improvement Activities</b>
	<p>The community provider for retinal screening had been contracted and system changes were being made to ensure recording in the community coincides with the in-house service with the community service to be functioning by the end of August which will rapidly address the backlog. In the meantime an interim mobile provider was being used and the wait had reduced to 6 weeks from 13 and catch up on some recalls. The new provider would be providing the service in evenings and weekends.</p> <p>Dental clinics had been opened at Balmoral and Stonefields. The Eden philosophy for rest homes was being rolled out to more providers.</p> <p>The next meeting would have an update on work for refugees and new migrants including information on a GP collective quality improvement project over 12 practices.</p>
8	<b>MAORI HEALTH ADVISORY COMMITTEE FEEDBACK</b>
	<p>There had been an informative presentation on the Tamaki Path of Health Careers project. If there were more applicants that met the criteria that could not be handled they were referred to standard resources. There was strong endorsement by the Maori Health Advisory Committee of the programme to lift the number of Maori and Pacific in the workforce and this would be provided to the Pacific Health Advisory Committee and a business case then to the Audit and Finance Committee to make a recommendation to the Board. The project was wider than Tamaki and sponsors would be sought as well as linkages to other organisations.</p> <p>The Committee had also received a Whanau Ora presentation from Ngati Whatua O Orakei.</p>
11	<b>GENERAL BUSINESS</b>
	<p><b>CPHAC Appointments</b></p> <p>The Chair had talked with Alfred Ngaro concerning Pacific representation and any suggestions should be addressed to the Chair.</p> <p><b>Consultation</b></p> <p>Waitemata District Health Board used Health Links with a quarterly report to CPHAC and a monthly meeting with the CEO.</p>
	<b>NEXT MEETING</b>
	<p>The meeting closed at 4:15pm</p> <p>The next scheduled meeting is for 2:00pm, Wednesday, 20 July 2011 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom</p>
	<p><b>CONFIRMED</b></p> <p><b>CHAIR:</b> <span style="float: right;"><b>DATE:</b></span></p>

**ACTION POINTS**

**- WEDNESDAY 15 JUNE 2011**



**Community and Public Health Advisory Committee  
Action Points from the meeting on Wednesday 15 June 2011**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
5	A paper on diabetes management would be provided to the next meeting.	Denis Jury	July
5	Verbal update on Assisted Reproduction Services	Denis Jury	July



# **PLANNING AND FUNDING PERFORMANCE**

- 6.1 Planning and Funding Summary Report**
- 6.2 Planning and Funding Indicators List and Exception Report**



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## Planning and Funding Summary Report

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### Glossary

B4SC	Before School Check
BSMC	Better, Sooner, More Convenient
CAYAD	Child and Youth Alcohol and Drugs
HEHA	Health Eating Healthy Action
GAIHN	Greater Auckland Integrated Health Network
GAIHN ALT	GAIHN Alliance Leadership Team
IDA	Iron Deficiency Anaemia
IFP	Interim Funding Pool
NHB	National Health Board
NHC	National Hauora Coalition

## 1 Lifting the Health of people in Auckland City

### 1.1 Planning

Both the Statement of Intent and the Annual Plan were submitted at the end of June to the National Health Board as finals. The documents resolved all outstanding issues as raised by the National Health Board in their feedback. However, subsequent to our submission on June 30, we received additional feedback from the National Health Board on several areas:

- Primary care wording in module 3 regarding the integration of data sources
- Issues of alignment with the GAIHN work plan (milestone dates)
- Issues of alignment with the National Hauora Coalition work plan
- Changes required to our Module 6 which covers service changes

These issues have all been resolved and the Annual Plan re-submitted.

The Statement of Intent will be available on the Auckland DHB internet site mid July. The Annual Plan will be released when we have received the Minister's approval.

In the meantime, a shorter version of the Annual Plan has been developed into a succinct business plan. The business plan brings the key deliverables for the year into one place for senior managers to refer to, and to track progress against.

### 1.2 Child, Youth and Women's Health

#### *Immunisation*

ADHB has exceeded the national and regional immunisation targets by 2%. Provisional data as at 1 July 2011 shows 92% coverage of 2 year olds fully immunised for all ethnicities (Maori 88%, Pacific 95%, New Zealand European (NZE) 92%, Asian 94% and Other 85%). This reflects an overall annual increase (from 30 June 2010) for this cohort of 5% (Maori 9%, Pacific 11%, NZE 7%, Asian 3% and other 1% reduction). This is a very pleasing result particularly as it reflects a significant reduction in the equity gap for Maori and Pacific.

I am thrilled with this result and it must be seen as a reflection of the integrated and focused team approach that has been applied to improving immunisation coverage over the past year by a wide range of stakeholders. These have included, in particular Planning & Funding, ADHB clinicians and managers, National Immunisation Register (NIR) staff, Immunisation Coordinators and PHO managers, the Immunisation Advisory Centre, the Office of the Children's Commissioner and Plunket.

The national immunisation target for 2011/12 is 95% of all 2 year olds fully immunised. This will be challenging. ADHB has a current decline rate at 2 years of 3.6% (55 children) so achieving 95% will mean locating almost all of the non-immunised non-declined children.

### ***Health Services for Children and Young People in Care***

ADHB Planning & Funding continues as the DHB representative on the national multi-sector working group developing and now implementing this programme. Child Youth and Families (CYF) will contract directly with DHBs for services. Comment is currently being sought on draft contract documents.

### ***B4 School Check programme***

Although the final programme performance has not yet been notified, as expected it will fall far short of meeting targets for the year. As previously reported the B4SC programme was transitioned to a primary care service delivery model from 1 January 2011 managed through a Service Alliance Agreement. Although it had been expected that performance would drop in the initial period following the transition, performance has been much poorer than expected. The key reasons for this have been reported on previously.

The Service Alliance Leadership Team (SALT) which includes ADHB as well as the senior managers from the four PHO providers has reviewed the service delivery model and agreed to extend the range of providers to include Well Child providers. Plunket have indicated a strong interest in becoming a provider in ADHB. They are the current B4SC provider in Counties Manukau DHB. It is also planned to make a number of systems changes to improve programme efficiency.

Discussions have been held with the other Auckland DHBs to explore the possibility of a adopting a regional service delivery model in the future. There is agreement to consider this.

### ***Fertility Services***

ADHB continues to participate in the project regarding contracting for fertility services for the Auckland DHBs. This project is led by Waitemata DHB.

### ***National Services***

ADHB has participated in a project led by the National Health Board (NHB) to scope the current services that will transition to NHB planning & funding management as agreed.

New service specifications and purchase unit codes have been approved for the four national paediatric services – clinical genetics, paediatric and congenital cardiac

services, paediatric and perinatal pathology and the paediatric and adult metabolic service.

Governance and operational structures will be communicated to DHBs shortly. Clinical Network arrangements with a formalised work programme for these new services are to be established over the next few months.

### 1.3 Health of Older People

#### ***Enhanced Home Based Support Services Project***

The case mix model has been completed and agreed as the funding base for 2011/12.

There remain some issues with the high and complex client group, with volumes still growing and assessments being more demanding than anticipated. This is being resolved currently.

Capital and Coast DHB have released a tender document requesting providers to deliver the ADHB model of care in Wellington. The ADHB Planning and Funding Manager is on the evaluation panel. ADHB have been asked to present the model again at this year's NZ Home Care Association in August.

#### ***Residential care***

Following a series of meetings the Edmund Hillary Dementia Unity has been signed off for opening subject to ongoing compliance with conditions.

#### ***Interim Funding Pool (IFP)***

Devolution has occurred as planned, although there has already been significant concern expressed about a number of children who appear to be at very high clinical risk without appropriate or ongoing support. This is being addressed as a matter of priority.

#### ***Other***

A tender document requesting additional dementia day care service is about to be released to secure replacement capacity for the Meadowbank Village service which is closing in December. There has been a high level of anxiety expressed from families and clinicians following the announcement of the closure.

### 1.4 Primary Care

#### **i) Implementation of Government's BSMC Primary Care Strategy:**

##### ***Regional Progress to Date:***

The Metro Auckland DHBs collectively continue to make significant progress with implementation of the regional components of Government's Better Sooner More Convenient Primary Health Care (BSMC).

##### ***Business Cases***

All three business cases contributed to the revision of Auckland DHB's annual Plan revision and have been working on finalising their implementation plans for 2011/12.

### ***Progress with PHO Consolidation***

The National Hauora Coalition and Waitemata PHO are two new PHOs that come into effect 1 July 2011. This means that the Metro Auckland region will have reduced its PHOs by over two thirds to seven PHOs. The National Hauora Coalition replaces Te Hononga PHO (which Total Healthcare Otara rolled into in April) which will continue as an NGO as an interim transition arrangement. There has been a slight delay in North Waikato in joining National Hauora Coalition and this is expected to be completed by October 2011.

ProCare operates across the entire metro region, Alliance Health + and National Hauora Coalition operates across Auckland and Counties Manukau DHB and then there is Auckland PHO, East Health Trust and Waitemata PHO operating within DHB boundaries.

This means Counties Manukau DHB will now have five PHOs in its district; Waitemata DHB will have two; and Auckland DHB will have four PHOs.

### **ii) ADHB Specific Progress to Date**

In addition to active involvement in the above regional work programmes ADHB PHO and Primary Care team work plan progress includes:

#### ***Progress with the ADHB PHO Alliance***

The last of the 'fast five' workshops will be held at the end of July / early August. This will then decide if this forum will continue in the future. A number of primary care issues with contractual difficulties will be put through the alliancing criteria to see what issues it should be dealing with in this way.

#### ***Progress with the Locality Planning***

A further draft of the Locality Planning model has been circulated for discussion. This will form a positions paper to the first combined ADHB and WDHB CPHAC. A core strategic steering group reflecting the main portfolios of interest –localities, primary care and long term conditions has been formed and will meet fortnightly. Implementation plans for the Locality Model and the Health Needs Assessment (HNA) are being produced. A community engagement methodology designed to increase skills and capacity amongst community members is currently being socialised with partner agencies. This has led to significant progress in intersectoral collaboration with NGOs operating in the two pilot ADHB localities and with Auckland council.

### **iii) Improve Primary – Secondary System Efficiency: The Regional Annual Plan projects**

#### ***Access to Diagnostics***

- 113 ADHB Practices trained and installed by 20 June 2011, with a steady incline in utilisation rates. There were 45 more requests generated this month compared to the same period last month.
- Pre-implementation pilot testing occurred at seven CMDHB practices and three ADHB practices in June.

- Review by the Projects Clinical Governance Group of the Clinical Triage Criteria is almost complete and will be forwarded onto the Regional Radiology Forum for endorsement and adoption.
- Regional e-Referrals project confirmed that Radiology is on their Phase 2 work plan, to develop the long term sustainable end-to-end Radiology solution. On this advice, the Access to Diagnostics-Radiology Steering Group re-confirmed that ProExtra Radiology is the interim solution until the regional e-Referrals Radiology is functional (due late 2012 / early 2013). A meeting between the clinical governance group and e-Referrals team was held in June.

### ***Minor Skin Surgery – Skin Lesions***

As of 31 May 2011, 760 volumes have been achieved, leaving a YTD variance of - 341. This is primarily due to the delayed implementation start date of 1 April 2011. As a remedial strategy, WDHB and CMDHB have continued to send out referrals to GPs under historical contracts. However, the number of minor surgery referrals sent to accredited GPs is steadily increasing across the region, and an improvement action plan has been formulated and was implemented during June. Clinical trust is seen as key, and a robust process for accrediting providers was needed to give secondary care confidence in sending out referrals. Consequently WDHB volumes are increasing since the scheme was introduced. CMHDB volumes have remained on target and ADHB have started to send out referrals from 1 April 2011. A number of other approaches to enhance uptake have been initiated as follows;

- The new clinical pathway has been widely advertised across the region so we expect to see an increased number of referrals. Details about the skin surgery scheme including the pathway, frequently asked questions, and a list of the contracted GPs has been loaded on to Health point.
- In addition, a central triage point has been established at each DHB to triage all skin cancer referrals and forward appropriate referrals to the accredited GPs. Referrals that are inadvertently sent to the wrong department are being redirected to the central triage point.
- A contract variation was agreed and sent to the Operations Managers at each DHB for issuing to their accredited GPs. This contract variation provides clarification of how GPs can claim for multiple lesions (>3 lesions) under the contract.
- The patient satisfaction survey was finalised and distributed to the Operations Managers at each DHB for sending out from 1 July 2011.
- The GP opinion survey was developed and due to be distributed from 1 July 2011. This questionnaire is designed to directly survey Metro Auckland GP's views on the regional initiative.

### ***Clinical Pathways***

- Implementation Process and project funding has been prepared in 2011-12 work plan
- Consultation process continues with all PHO and Primary Care clinicians, not just reference groups.

- Dyspepsia and - Iron Deficiency Anaemia (IDA) are now live.
- Sign off process complete

### ***Acute Demand / Primary Options for Acute Care (POAC)***

Monthly targets have been consistently met for volumes with an average of 1370 referrals per month (target 1250). (NB: referral numbers are at this date incomplete due to the reporting prior to the month end)

- DAP target of 5,000 additional POAC referrals (total 15000) for the year ending 30.06.11 is tracking with a provisional figure of 16435 referrals being received YTD
- YTD referrals are 10% above target and 39% above previous year volumes
- Preliminary analysis indicates that 87% of all referrals were managed in primary care without admission to hospital
- Average cost per referral across all DHBs is \$197 excl GST
- The average cost per referral for all regions is under budget, however total expenditure is over due to managed volumes

### ***After Hours***

Community Care Auckland (CCA) implementation group met the end of June deadline to deliver an After Hours service plan to the metro-Auckland DHBs. This is currently being analysed by the DHBs.

### ***Optimal Prescribing Project***

Data analysis for the first six months of the project has indicated budget savings of \$332k reimbursement cost for ADHB and \$642k reimbursement cost for CMDHB. These savings are only indicative as they have been based on the pharmaceutical list price.

### ***Maori Service Devolvement***

ADHB were not to devolve any services in this current year. WDHB and CMDHB have devolved \$600K of services from their internal teams to community providers. CMDHB have contracted for Smoking Cessation services while WDHB have contracted for Child and Youth Alcohol and Drugs (CAYAD), HEHA, with Well Child still pending. A paper was developed as part of this devolution process which included considering the broader implementation of Whanau Ora by the National Hauora Coalition. This paper has not been accepted by the Auckland and Waitemata GMs or Maori health teams. Ongoing discussions are occurring as to how services can continue to be devolved at a local level.

### ***Regional Health Targets***

All targets are on track for being met at the end of the year. Diabetes numbers are for March, April and May as June is not available yet. The regional diabetes management is expected to be reached when June data is available.

## iv) Summary of Annual Plan Targets

Initiative		Regional Volumes		Target to end June 2011
		Month (June)	YTD	
<b>Acute Demand / POAC</b> (NB: referral numbers are at this date incomplete due to the reporting prior to the month end)		1,568	16,492*  *provisional figure	15,000 cases
<b>Access to Diagnostics</b>	<b>DAP Target 1</b> <i>Measures elective plain x-ray and ultrasound referrals by GPs for diagnostic radiology to Non DHB Providers</i>	819	8,658  Includes diagnostic radiology procedures via POAC	4,500
	<b>DAP Target 2</b>	2,774 (referred via Clinical Triage Criteria)  2,543 (referred via "old" forms)	25,024  32,675  <b>Total= 57,699</b>	16,000+
<b>Skin Lesions</b>		115	760	1,200
<b>Pharmaceuticals CMDHB &amp; ADHB Project</b>  No update received at the time of reporting.		Tracking to plan. Process milestones are now on track with the exception of budget tracking and reporting due to complexity of Pharmaceutical Rebates from PHARMAC.		
Target		Target	Achieved	
Immunisations		90%	91%	
Diabetes Get Checked		55%	73%	
Diabetes Management		70%	69%	
CVD Risk Assessment*		80%	81%	
*=Estimated from Quarter Three 2010/11 MoH data				

## **v) Business Cases**

Active DHB involvement continues to support the three Business Cases in the development and the rollout of their respective Implementation Plans.

### ***GAIHN***

As reported previously, the GAIHN ALT has taken the decision to refocus GAIHN on a single goal to acute reduce demand and unplanned hospital admissions across Auckland. This moves the focus of GAIHN from the original business case intent somewhat to position the group as a change agent in the primary care sector for acute demand management and prevention. A work programme has been developed at a high level and there is work underway currently to add to this the necessary project and initiative detail, timeframes and resource requirements.

It is intended to present a paper to PHO and DHB Boards in July 2011 to seek endorsement of the direction and approval of funding and DHB staff resources. The paper is likely to include information about achievements to date, the change of direction and intentions from the agreed business case, an overview of projects and initiatives planned over the next 1-3 years to address acute demand with specific detail for the 2011/12 year, and the detail of funding and resource requirements.

### ***National Hauora Coalition (NHC)***

The National Maori PHO Agreement is now in place with an initial PHO register in May of 244,000 enrolled patients across five DHBs. Ngati Porou in Tairāwhiti DHB and North Waikato in CMDHB/Waikato DHBs did not meet the deadline (due to Iwi accord) and will join from 1 October. A further eight practices from Waitemata DHB known as the West Auckland Practice Network are also part of NHC but currently sit with ProCare following an agreement between NHC and ProCare.

The NHC has also been working on a proposed framework for the devolution of Maori service agreements, focused on integrated whānau ora services. Discussions are underway between DHBs and NHC to develop the initial concept into a workable model and proposal for formal consideration of DHBs. It is likely that an alliancing model will underpin the development of whānau ora integrated service specifications and template agreements by NHC on behalf of/for DHBs.

### ***Alliance Health +***

DHBs and the MOH are providing support to Alliance Health+ to establish effective management and governance processes to implement their business case and be a successful single regional Pacific PHO.

The ALT have recently reconfirmed their role, organisational arrangements, and resource requirements and a transition plan has been developed to focus on key requirements going forward.

## **2 Performance Improvement**

### **2.1 Community Pharmacy**

A proposal from the National Pharmacy Working Group has been made to issue a three and half year variation to the pharmacy services contract with a three year phased transition approach to be taken. This will allow time for the working groups to develop more detail for the long term conditions and aged residential care patient groups. The phased approach will include an amendment to the close control rules.

### **2.2 Oral Health**

The key activity in the oral health portfolio is the implementation of the Child and Adolescent Oral Health Business Case which is progressing according to plan. Avondale Intermediate will be completed on 13 July, and inspection is underway at Royal Oak, Wesley and Blockhouse Bay Intermediates.

## **3 Live Within Our Means**

### **3.1 Month's Funding Issues**

A verbal update on any developing funding issues will be given.



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June 2011

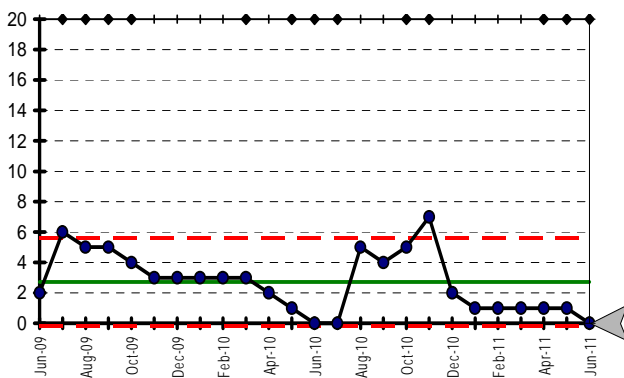
**Exceptions this month**

**H1. Payments Made Against Unsigned Contracts:** Final alterations to the service specification within the unsigned Home Based Support Agreement were signed off. This meant for June 11, no payments were made against Draft Agreements. However, a new case mix model has been developed for the four Home Based Support Services currently contracted to ADHB which will require each Agreement to be renegotiated. It is likely that these four Agreement will be in Draft (i.e. unsigned) for a minimum of one month durign the negotiation phase.

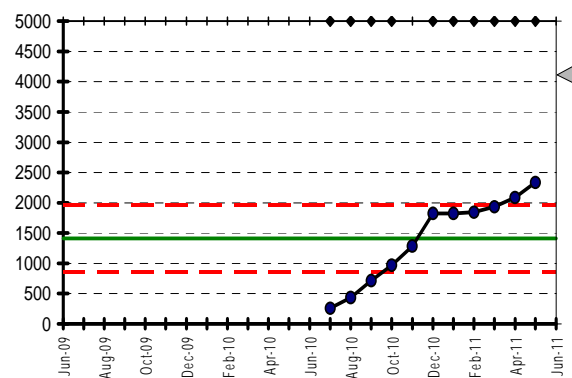
**L18. B4 School Checks Completed (cumulative target):** The B4SC programme transitioned to a primary care service delivery model in January 2011. While it was not expected that targets would be met with new and inexperienced providers performance has been poorer than expected and consequently the service model has been reviewed. An outcome of the review was a decision to pursue the option of Well Child providers also providing the programme in ADHB. This has been well received by Plunket and discussions are underway. The B4SC Service Alliance Leadership Team is confident that this along with other system and process changes will greatly improve performance.

**L42. Percentage of Mental Health Providers audited over three year cycle (starting 1 July 09 ending 30 June 12):** The Mental Health audits are tracking well against the target - 2010/11 has been a busy auditing year and the programme is approx. 10% ahead of schedule. ADHB expects 100% of Mental Health NGO providers to be audited by the end of the cycle.

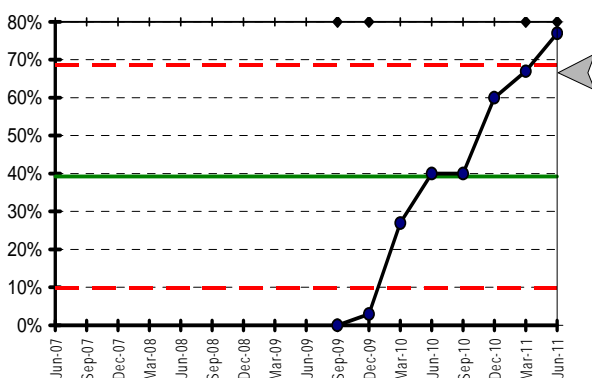
H1. Payments Made Against Unsigned Contracts



L18. B4 School Checks completed (cumulative target)



L42. Percentage of Mental Health providers audited over 3 yr cycle (starting 1 July 09)





# **IMPROVEMENT ACTIVITIES**

## **7.1 DAP Projects Report**



# Group Pack Report

Group/Committee: Community and Public Health Advisory Committees



## Goal Level Summary

DAP Projects - total projects: 25

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	18	18	3	3	1	8	2	0	14	2	1	17	0	0	17	0	0	1	1	0	0
2 Performance improvement	7	7	0	1	0	6	0	0	5	2	0	7	0	0	4	3	0	0	0	0	0
3 Live within our means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total #</b>	<b>25</b>	<b>25</b>	<b>3</b>	<b>4</b>	<b>1</b>	<b>14</b>	<b>2</b>	<b>0</b>	<b>19</b>	<b>4</b>	<b>1</b>	<b>24</b>	<b>0</b>	<b>0</b>	<b>21</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>12%</b>	<b>16%</b>	<b>4%</b>	<b>56%</b>	<b>8%</b>	<b>0%</b>	<b>76%</b>	<b>16%</b>	<b>4%</b>	<b>96%</b>	<b>0%</b>	<b>0%</b>	<b>84%</b>	<b>12%</b>	<b>0%</b>	<b>4%</b>	<b>4%</b>	<b>0%</b>	<b>0%</b>

## Goal: 1 Lift the Health of the people in Auckland City

### High Level Summary - total projects: 18

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan		Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red	
			Define	Measure																	Analyse
1.1 Reduce inequalities in health status	7	7	2	1	1	3	0	0	6	1	0	7	0	0	7	0	0	0	0	0	0
1.2a Improve outcomes for children and young people	2	2	0	1	0	0	1	0	2	0	0	2	0	0	2	0	0	0	0	0	
1.2b Improve outcomes for older people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2c Improve outcomes for mental health and addictions	3	3	0	0	0	2	0	0	2	0	0	2	0	0	2	0	0	1	1	0	
1.2d Improve outcomes for long term conditions	5	5	1	1	0	3	0	0	4	0	1	5	0	0	5	0	0	0	0	0	
1.2e Improve outcomes for Palliative care	1	1	0	0	0	0	1	0	0	1	0	1	0	0	1	0	0	0	0	0	
<b>Total #</b>	<b>18</b>	<b>18</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>8</b>	<b>2</b>	<b>0</b>	<b>14</b>	<b>2</b>	<b>1</b>	<b>17</b>	<b>0</b>	<b>0</b>	<b>17</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>17%</b>	<b>17%</b>	<b>6%</b>	<b>44%</b>	<b>11%</b>	<b>0%</b>	<b>78%</b>	<b>11%</b>	<b>6%</b>	<b>94%</b>	<b>0%</b>	<b>0%</b>	<b>94%</b>	<b>0%</b>	<b>0%</b>	<b>6%</b>	<b>6%</b>	<b>0%</b>	

### Objectives

Objective	Objective Owner	Comment
1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	<a href="#">Aroha Haggie (ADHB)</a>	Projects under this objective are progressing as expected. Significant support is being provided to these activities especially in the BSMC space to support the implementation of whanau ora and activities focused on reducing inequalities. Whanau Ora Outcomes Framework - We are experiencing some delays in the development of outcomes for the framework however we are seeking to align DHB:MAPO outcomes with those recently development in the primary care and BSMC business case space
1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	<a href="#">Hilda Faasalele (ADHB)</a>	A busy month of multiple HVAZ (Zone) HEHA and primary care/health screening activities and events. Many of the activities are collaborative events by Procure & Alliance Health+ HVAZ staff - supported by the ADHB Pacific team. The HVAZ Self Management Education (SME) was rolled out by jointly appointed (ADHB/CMDHB) Pacific SME Nurse. Two churches have begun the SME 6 week Course - successful engagement was shown by all participants (mostly elderly) returning every week and participating fully in the programme. Training of ADHB Pacific Best Practice Education Programme has had approx 85 staff participating this month with more sessions planned. Secondment of Pacific team member providing secretariat support to the newly established AH+ Clinical governance Group. Provider Arm Pacific Events included a Pacific Celebration of International Nurses Day with a Pacific Nursing Grand Round 'Talanoa Session' attended by over 60 people. This was organised and facilitated by the ADHB Pacific Nurse Leadership Group.
1.1.3 Increase access to services for culturally and linguistically diverse populations	<a href="#">Denis Jury (ADHB)</a>	Increased utilisation of online cultural competency training modules and interpreters by both primary and secondary care has continued over the last four months -good progress.
1.1.4 Support disabled	<a href="#">Denis Jury (ADHB)</a>	IFP occurred 1 July 2011 as planned with regional agreement around management and risk share arrangements. With regard to disability work is

## 47

people and improve their access to health care and support services		focussed on aligning work in the context of the WDHB / ADHB common DISAC Committee.
1.2a.1 Achieve immunisation targets	<a href="#">Denis Jury (ADHB)</a>	ADHB overall immunisation rate was 92% at year end. Great work, especially with the significant improvement with intervention rate for Maori.
1.2a.2 Improve the oral health of children	<a href="#">Denis Jury (ADHB)</a>	Construction of clinics and service development continues according to plan -Avondale Intermediate clinic to be completed by Mid-July.
1.2b.1 Home-based support services and restorative homecare initiatives	<a href="#">Denis Jury (ADHB)</a>	Casemix work completed and agreed to be used as base for 2011/12 year
1.2b.2 Quality improvement in residential care	<a href="#">Denis Jury (ADHB)</a>	Strong support from providers generally for the EDEN programme and developmental continues with a small group providers -currently also extending the concept to dementia care provders. Number of complaints decreased compared to last financial year.
1.2c.1 Increase effectiveness across primary, secondary, tertiary services for mental health and addictions	<a href="#">Denis Jury (ADHB)</a>	Good progress with all projects.
1.2d.1 Strengthen community participation and action for long term conditions	<a href="#">Denis Jury (ADHB)</a>	Long term condition management has been diredted at diabetees and CVD, and in particular the ongoing development of a number of initiatives at practice level (for example the practice coordinators as previously discussed. The ongoing LTC work is being collaboratively with WDHB and will be part of the joint localities paper on the agenda for the August WDHB / ADHB CPHAC.
1.2d.2 Integration of services across primary and secondary care for long term conditions	<a href="#">Andrew Coe (ADHB)</a>	Five new clinical pathways being progressed across the region, with the Dyspepsia pathway now fully implemented. The Auckland Region diabetes network continues developing their implementation plan.
1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	<a href="#">Andrew Coe (ADHB)</a>	The CVD risk assessment target of 80% has been met in the third quarter.
1.2d.4 Support whanau and self resilience for long term conditions	<a href="#">Aroha Haggie (ADHB)</a>	Initiatives progressing as expected under this initiative
1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	<a href="#">Andrew Coe (ADHB)</a>	All projects progressing well, with clients in the primary care programme now at the planned levels and implementation of Liverpool pathway currently ahead of schedule.

## Exceptions

			On	On	Expected
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Project	Coverage	Phase	Time	Budget	Outcome	Sponsor Review
Increase access and capacity to community diabetic eye screening	National	Improve				The work to enable the wider community screening programme to be operationalised is continuing with clinical and project teams working closely together to ensure that the system meets the work flow, data requirements and new structure. Customisation discussions with the vendor for the software component of the project is in progress as is the regional alignment for the solution to ensure that a regional system is developed and meets the regional needs. The support from the community provider to enable the volumes to continue to be screened is operating well and the additional capacity offered is helpful while the sustainable solution is being constructed.
Māori Service Development	Regional	Define				The original project intention was to devolve \$600k of services (largely health promotion and public health) from metro-Auckland DHBs and the Ministry of Health (MoH) to Iwi and Maori providers by 30.12.10. This target date was too ambitious and was revised to 28/02/2011 for the identification of services across the DHBs to be devolved and construct a devolution framework. A number of services from CMDHB and WDHB were tagged for devolution and these are so far; • CMDHB: Smokefree RFP has been awarded to Raukura Hauora o Tainui. Total contract price is \$240k PA • WDHB: CAYAD contract has been let, value \$176PA. Well Child contract awaiting MoH decision, therefore RFP process on hold The draft devolution framework was due to CMDHB by 06/05/11. The original timeframes have already passed but the tools for future devolution work are in place and \$416K worth of services should be devolved before the financial year end.

Legend: Red - , Orange - , Green -

## Goal: 2 Performance improvement

### High Level Summary - total projects: 7







	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
<b>High Level Strategy</b>																					
2.1a Efficient and effective Primary health care	2	2	0	0	0	2	0	0	2	0	0	2	0	0	1	1	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	4	4	0	1	0	3	0	0	2	2	0	4	0	0	2	2	0	0	0	0	
2.1c Improve quality of hospital care while improving productivity	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0	
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
2.3 Improve Clinical Quality and Professional Governance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
2.4 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
2.5 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
2.6 Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
<b>Total #</b>	<b>7</b>	<b>7</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>6</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>2</b>	<b>0</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>0%</b>	<b>14%</b>	<b>0%</b>	<b>86%</b>	<b>0%</b>	<b>0%</b>	<b>71%</b>	<b>29%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>57%</b>	<b>43%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	

### Objectives

Objective	Objective Owner	Comment
2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	<a href="#">Andrew Coe (ADHB)</a>	ADHB continues participation at national, regional and local level regarding primary care planning and implementation. In addition, ADHB & WDHB Primary care planning and funding merged in May 2011 and as a result primary care planning activity is being strengthened across these two districts. Joint localities paper to the combined August CPHAC.
2.1b.1 Improve access and efficiency of service delivery for primary–secondary system	<a href="#">Andrew Coe (ADHB)</a>	Overall there has been progress made in all projects although some time delays and unrealistic stretch targets mean that not all will fully achieve all targets by year end. Remedial plans and improvement activity is underway where needed. An after hours proposal, as agreed, has been received from Community Care Auckland (CAA) and is currently being considered by the DHBs.
2.1b.2 Reduce acute demand	<a href="#">Andrew Coe (ADHB)</a>	POAC at year end was ahead of target by 1435 cases. The Primary Options (POAC) RFP has closed and service implementation discussions are underway with the preferred provider. GAIHN has refocused its direction around acute demand and will overtime lead initiatives and projects in this area. A number of regional projects - clinical pathways, access to radiology diagnostics, optimising prescribing and POAC are proposed to be transitioned to GAIHN next year.

### Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review

Skin Lesions	Regional	Improve				Project is now back on track. Contracting arrangements are currently being finalised and transition plan from ADHB provider to GP's is being developed.
Pharmaceuticals	Regional	Measure				Optimal prescribing – to improve medicines safety for patients and to improve prescribing quality of providers through a multi-faceted approach which utilises bulletins, analysis and prescriber level data through GP cell groups to encourage peer review and pressure to inform 'best practice' prescribing. By adopting 'best practice' prescribing efficiencies can be made through the quantity and type of medications prescribed and the reduction in polypharmacy in the elderly. The project was originally envisioned to save at least \$1.5million of pharmaceutical expenditure in the 2010 / 2011 financial year which would be divided equally with the project. This was a joint project with CMDHB and involves Procure and East Health Trust. The project's programme of interventions is progressing well and is gaining traction with GPs. There has been difficulty in agreeing on a methodology for calculating savings as it is a complex process which involves pharmaceutical rebates which are unknown and there are so many external factors that can impact on pharmaceutical spend. The project is on budget, ADHB has contributed \$300K to the project which is expected to be covered by the pharmaceutical savings made (once a methodology is agreed). However the target of \$1.5 million in savings may have been too ambitious as highlighted above external factors can impact and plans for reduced costs or additions to the schedule which have fallen through will have impacted on the original savings estimated. Regardless of the savings the project is improving the quality of prescribing and so is improving clinical practice and optimising community pharmacy budget.

Legend: Red - , Orange - , Green - 

## Goal: 3 Live within our means

High Level Summary - total projects: 0

No Projects entered against this goal



**FEEDBACK FROM  
MAORI HEALTH  
ADVISORY COMMITTEE  
AND  
PACIFIC HEALTH  
ADVISORY COMMITTEE**



## **PAPERS**

- 9.1 Migrant Health**
- 9.2 GAIHN Proposed Work Plan 2011-13**
- 9.3 Community Pharmacy Contract Renewal**
- 9.4 After Hours Proposal for Auckland Metro Region**



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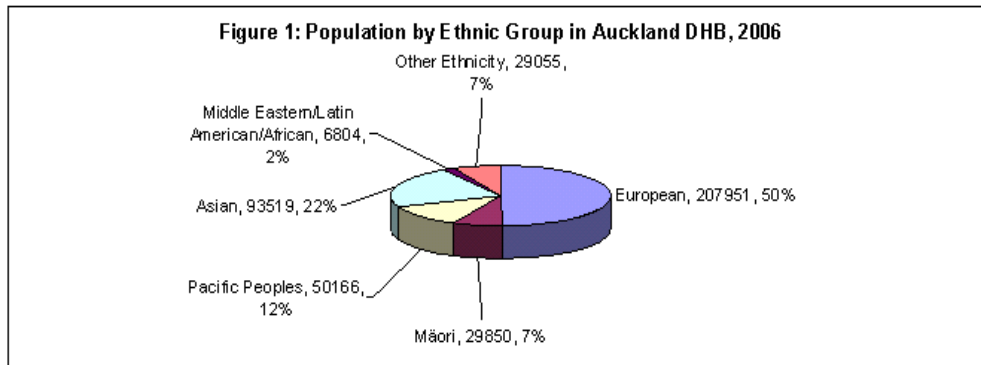


# Community and Public Health Advisory Committee Briefing Paper

Date	Wednesday 20 July 2011
To	Community Public Health Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: <a href="mailto:denis.jury@adhb.govt.nz">denis.jury@adhb.govt.nz</a>
Author	Sarah Marshall, Planning & Funding Manager, Ext 26650 smarshall@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	<b>Migrant Health</b>
<b>1</b>	<p><b>Purpose</b></p> <p>This is an Information Paper presenting an overview of the migrant population in Auckland District Health Board, their health needs, service funding and delivery.</p>
<b>2</b>	<p><b>Recommendation</b></p> <ul style="list-style-type: none"> <li>• <b>Endorse</b> the approach taken to provide health services to the Auckland District Health Board migrant population.</li> </ul>
<b>3</b>	<p><b>Population Demographics</b></p> <p>Auckland is one of the most culturally diverse cities in the world and this diversity is projected to increase. The number of new migrants living in the region more than doubled between 1991 and 2006. In 1991 there were 74,000 people who were overseas at the time of the previous census (1986). In 2006 this group numbered 169,000 people (Statistics New Zealand, 2011). Of the 50,700 New Zealand adult non-English speakers, over 65 percent live in Auckland.</p> <p>There are 233 ethnic groups living in the Auckland District Health Board (ADHB) locality. People who identify as Asian, African, Middle Eastern and Others comprise 31% of the ADHB population. Asians are the largest and fastest growing group, 22% identified as Asian in the 2006 census. There are two larger sub-groups - Chinese (41,000) and Indians (30,000) and several smaller ones including Korean (5,000), Japanese (2,800), Filipino (2,300), Sri Lankan (2,300), Taiwanese (1,700) Thai (1,300) Vietnamese (900), Cambodian (500) and others. Over 40 percent of all migrants to the Auckland region between 2001 and 2006 were born in Asia (Statistics New Zealand, 2011). Asians are a diverse group of people from different ethnicities, cultures, languages, religions and socio-</p>

economic backgrounds. There may be limited contact between communities.

Middle Eastern, Latin American and African (MELAA) are another sizable population in the ADHB, numbering 18,585 in the 2006 census. The largest subgroup is Middle Eastern (n=10,692), followed by African (n=4,806) then Latin American (n= 3,087).



Where-as migrants choose to move in order to improve their future prospects, refugees have to move if they are to save their lives or preserve their freedom. The United Nations 1951 Convention Relating to the Status of Refugees defines a refugee as “any person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country”. As part of its international humanitarian obligations and responsibilities, New Zealand has accepted refugees for resettlement since World War II. It is one of only nine countries in the world that takes a regular quota, 750 refugees per annum. Uniquely, it accepts the neediest cases. Refugees also come to New Zealand as family sponsored migrants. Asylum seekers are people who seek refugee status at the border, or when their temporary visa expires. A significant proportion of refugees come from Middle Eastern and African countries and a smaller but growing proportion come from Asia. Approximately 30% of New Zealand’s annual refugee quota is resettled in the ADHB locality. The total number of refugees living here is 20,000 representing half of the estimated population of 40,000 living in the Auckland regional (Solomon, 1999).

It is difficult to draw clear distinctions between refugees and migrants. From the legal category of ‘refugee’, the term ‘forced migrant’ has evolved, but with respect to how the terms are used there is often little distinction drawn between categories of forced migrants which include refugees, asylum seekers, humanitarian migrants, migrants from refugee-producing countries and economic migrants (Mortensen, 2010).

#### **4 Population Health Needs**

Migration accounts for patterns of disease distribution and influences population health. Due to selection biases, the health of first generation migrants is often better than the host population but over time this effect weakens. The longer a migrant lives in the host country, the poorer their health is. High rates of cardiovascular disease and diabetes is an important common concern for Asian,

Middle Eastern and African populations living in ADHB.

#### *Health Needs of Asian Populations*

The diversity of ethnicities that comprise the 'Asian' category can obscure the health needs of disparate groups and contribute to knowledge gaps. Although the Asian population living in New Zealand appears to fare better than Europeans on many indicators including life expectancy and avoidable mortality, averaging masks the significantly worse health status of Indian compared to Chinese Asian populations (Gala, 2008).

The following time trends in the health of New Zealand's Asian population are evident (Scragg, 2010).

1. Despite being more educated than other New Zealanders; Asian people have lower incomes and are more likely to live in more economically deprived localities than Europeans and are therefore more constrained in their ability to live a healthy lifestyle compared to Europeans.
2. The prevalence of obesity has significantly increased among Asian adults due to lower levels of physical activity and lower daily intake of fruit and vegetables, compared to Europeans.
3. An increased length of residence in New Zealand is correlated with health adversity related to alcohol consumption, tobacco smoking and obesity.
4. South Asian people have increased prevalence's of treated hypertension, high blood cholesterol and diabetes, compared with Europeans.
5. Asian people are not accessing the health services to the same degree as non-Asians.

#### *Health Needs of Middle Eastern, Latin American, African Populations*

A recent health needs assessment of MELAA people living in the Auckland Region shows oral health, cardiovascular disease and diabetes as contributing to high rates of ambulatory sensitive and potentially avoidable hospitalizations. The leading cause of ambulatory sensitive hospitalisation in all MELAA ethnicities was 'angina and chest pain' (Perumal, 2011).

Muslims from Africa and the Middle East have very low rates of physical activity, particularly the women. Barriers for Muslim women's physical activity include religious values and requirements, feelings of being unsafe in the public, cost, transport, childcare, and feelings of social isolation and fear. Their health risks from sedentary lifestyles are amplified by diets which are typically high in fat and low in fruits and vegetables and contribute to high rates of obesity.

#### *Health Needs of Refugees*

Very few refugees emerge from their pre-migration experiences without enduring or witnessing some form of physical or psychological trauma. Long-term physical and psychological sequelae are a common feature of the 'refugee experience'. People from refugee backgrounds arrive in New Zealand with high rates of infectious diseases, disabilities and chronic health problems. Psychological

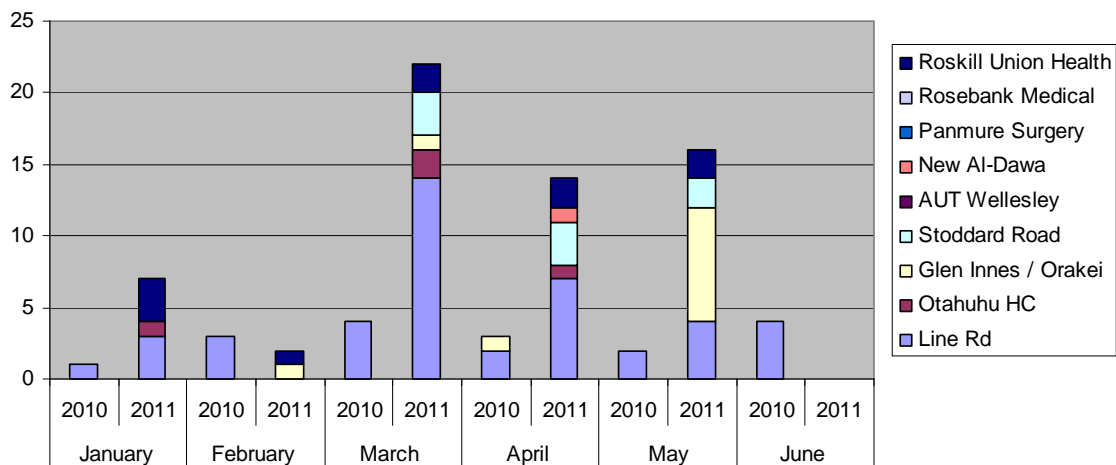
	<p>problems are common. Experiences of violence and sexual assault, multiple grief's and loss, and the trauma of resettlement may lead to Post Traumatic Stress Disorder. Feelings of guilt, shame, mistrust and anger, psychogenic amnesia, isolation, psychosomatic conditions and depression may manifest. An improved sense of safety can lead to a short term improvement but many experience ongoing emotional problems.</p> <p>In 2009, 95% of refugees were enrolled in Primary Health Organizations. The population is known to have high and complex health needs (Chan, Peters, Reeve, Saunders, 2009). Evidence from primary health care services suggests that there is a high utilization of GP services by refugees presenting with minor health issues. High hospitalisation rates in ADHB's refugee population are related to oral health problems in children and adults, tuberculosis and cardiovascular disease.</p>
5	<p><b>Mainstream Responsiveness to Migrant Populations</b></p> <p>The social cohesion of an ethnically super-diverse city is contingent on both state and society accepting migrant's rights to cultural difference (Penninx, 2000). Settlement is a two-way process between existing communities and new arrivals. Lack of mainstream responsiveness causes migrants to rely on community and ethnic services raising issues around small providers' ability to provide quality services and cope with increasing demand by a rapidly growing population.</p> <p>A responsive mainstream health system improves migrants' access to quality health care, provides early intervention and reduces avoidable hospitalizations. An unresponsive health system may create and/or perpetuate health inequalities. From a health sector perspective, responsiveness is influenced by variables such as the workforces' familiarity with the way health problems present; their degree of cultural awareness, knowledge and skills required to respond to prevailing needs; communication abilities and the services' ability to meet the higher operational costs of providing health care. From migrant and refugee perspectives, barriers to accessing health sector services include unfamiliarity with western, biomedical models of health; lack of knowledge about health and disability services and their entitlements; language barriers; lack of cultural sensitivity from service providers and family / cultural contexts that influence patterns of health-seeking behaviour.</p> <p>While ADHB health service providers are responding to increasing numbers of migrant service users, attention to migrant health issues remains weak at the national policy level and there is minimal direction to DHB's on their responsiveness to migrant populations. Local initiatives that target migrants are funded from multiple sources. Although Population Based Funding (PBF) does not factor migration into funding calculations, the cost of ADHB's responsiveness to ethnically diverse and non-English speaking populations is compensated because the higher costs of treating higher numbers of higher-need Indian Asians are outweighed by the lower costs rates of treating less afflicted larger Chinese and 'other' Asians (Arulambalam, 2011). Outside of PBF, a small amount of Refugee Primary Health Care funding is available in District Health Boards (DHBs) with the largest refugee populations. It aims to support the</p>

	<p>provision of comprehensive primary health care services to the refugee population. ADHB receives a similar amount of funding to other DHB's in the region despite having twice the number of refugees in it's population. Healthy Eating Healthy Action (ADHB) policy is orientated to high risk Maori and Pacific populations and Ministry of Health funding flows accordingly, though there is a need for HEHA initiatives targeting Asian and MELAA populations. In 2009-11, a one-off fixed term HEHA initiative targeting South Asian populations living in the Mt Roskill locality was funded by ADHB. There are no HEHA initiatives that specifically target Middle Eastern and African populations who are also high risk, but the recent discovery by Perumal (2011), that the leading cause of ambulatory sensitive hospitalisation in all MELAA ethnicities was 'angina and chest pain' (Perumal, 2011) will provide good evidence that there is a need for these.</p> <p>Gaps in migrant health policy are mitigated to some degree by settlement policy. The Auckland Regional Settlement Strategy (ARSS) and Auckland Settlement Action Plan (ASAP) is a Department of Labour led initiative that evolved from the Auckland Mayoral Forum in 2003 and was a signature project within the Auckland Sustainable Cities Programme. It is aligned to the New Zealand Settlement Strategy. The ARSS and ASAP were approved by Cabinet in November 2006, aiming to create a strong sense of national identity, encourage diverse peoples to live and work alongside each other in their communities, and contribute towards building a strong Auckland economy. Goal 4 of the Auckland Settlement Action Plan is "better physical and mental health for refugees and migrants". A joint Budget bid to Cabinet by the Auckland region DHB's and the Ministry of Health, to deliver the Goal 4 initiatives, resulted in sustainable funding of \$1,765,000 per annum being voted to the Auckland region DHB's from July 1<sup>st</sup> 2008.</p> <p>In 2011 ADHB has been represented in a second Department of Labour lead intersectoral process to develop the New Zealand Refugee Resettlement Strategy (NZRRS). Cabinet endorsement for the Strategy will be sought in August 2011. Outcome 3 of the NZRRS seeks "healthy and independent lives" for refugees. The Ministry of Health are engaged in the initiative and are working closely with Auckland region DHB's on the strategy and action plan.</p>
<p><b>6</b></p>	<p><b>Migrant Health Services</b></p> <p>While migrants and refugees are able to access all ADHB services, there are subsets of services that specifically target them (See Table 1, page 6). The Refugee Health Collaborative is a quality improvement project, funded by Refugee Primary Health Care funding, which aims to increase the satisfaction of refugees using primary health care services and reduce their rates of potentially avoidable and ambulatory sensitive hospitalizations. Using a modified version of the Breakthrough Series Collaborative methodology, it orientates primary health care providers to enrolled refugee populations and their health needs while supporting practices to develop sustainable systems and processes to deliver quality wrap-around services to refugees. The project is working with 9 Primary Health Care Practices with 50+ refugees enrolled, across four Primary Health Organizations. It draws on and links Practices to resources in the wider health</p>

and social sector services including those offered by schools e.g. nurses, social workers; Housing New Zealand, Work & Income and various Non Government Organizations.

The number of staff completing competency training and the use of interpreting services are key performance indicators of participation in the Refugee Health Collaborative. There has been a significant uptake in the utilization of primary health interpreting services (Graph 2) and uptake and completion rates of cultural competency training, by staff, has also increased.

**Figure 2: Rates of Interpreting Service Utilization by Practices Participating in the Refugee Health Collaborative**



Clinical target areas of the Refugee Health Collaborative include immunization rates and before school checks for children; mental health (including drug and alcohol) and sexual health for youth; antenatal care, breast and cervical screening, mental health, cardiovascular disease and diabetes care for women, mental health, cardiovascular disease and diabetes care for men; oral health and mental health for people of all ages.

The Collaborative approach involves a 6 weekly CME/CNE forums covering topic areas relevant to refugee health, a set of change principles which underpin best practice in each topic area, practical examples of change ideas that practices can implement to achieve change, shared learning with peers, applying learning to their own practice through rapid testing of change ideas, use of specific improvement measures to monitor the impact of the change and ensure that the change is an improvement.

What is required of participating practices?

- Involve the practice team in various aspects of the programme
- Identify practice champions to lead the process
- Put aside dedicated time to work on the programme – variable around 2 hours/week
- Attend and actively participate in the CME/CNE learning sessions
- Hold regular team meetings with dedicated time to discuss improvement initiatives

- Submit at least one PDSA cycle per month
- Submit data on a monthly basis

**TABLE 1: SERVICES TARGETING ADHB MIGRANT / REFUGEE POPULATIONS**

- Refugee Health Collaborative<sup>#</sup>
- ADHB Interpreting Service ≈ and Primary Health Interpreting Service\*
- Community Child Health and Disability Service, Child Disability Cultural Support Workers\*
- Community Mental Health Service, Transcultural Mental Health Services ≈
- Auckland Diabetes Centre, Clinical Nurse Specialist, South Asian Diabetes ≈
- Positive Aging Initiatives for Indian and Chinese Elders ≈
- Planning & Funding Manager, Health Equity including Refugee, New Migrant and Asian Populations ≈
- CALD Workforce Cultural Competency Training (WDHB provided) \*
- The Vulval Clinic ≈
- Community Child Health and Disability Service, Refugee Health Promotion♣
- Auckland Regional Public Health Service, Refugee Health Service♣
  - Health screening & assessment
  - Transition Nurse
  - Health Promotion
  - Hosts the New Zealand Refugee Health Website
- New Zealand AIDS Foundation♣
- New Zealand FGM Programme♣
- Mobile Mental Health Services for refugees ≈
- Pan Auckland Nutrition and Physical Activity Programme♣

**PROJECTS TARGETING ADHB MIGRANT / REFUGEE POPULATIONS**

- Community Coach Training Programme (completed) ≈
- The Mt Roskill Healthy Eating Health Action Project (completed) ≈
- Health Needs Analysis of Middle Eastern, Latin American & African populations living in the Auckland Region\* (Perumal, 2011)
- Health Needs Analysis of Asian populations living in the Auckland Region\* (initiating)
- Asian Health in Aotearoa in 2006-2007- Trends since 2002-2003\* (Scragg, 2010)
- Update of the Ministry of Health Refugee Health Website ≈
- Affinity Muslim MH project ≈
- Sponsorship of Conferences run by Auckland University School of Population Health, Centre of Asian Health Research & Evaluation\*

**KEY**

- \* ADHB Auckland Regional Settlement Strategy Funding
- # ADHB Refugee Primary Health Care Funding
- ≈ ADHB Population Based Funding
- ♣ Ministry of Health Funding



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## Community and Public Health Advisory Committee Briefing Paper

Date	Wednesday 20 July 2011
To	Community and Public Health Advisory Committee
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Functional Group	Planning and Funding Functional Group
Subject	<b>Greater Auckland Integrated Health Network (GAIHN) Work Programme 2011 -13</b>
<b>1</b>	<p><b>Glossary</b></p> <p>ALT Alliance Leadership Team  DHB District Health Board  ED Emergency Department  GAIHN Greater Auckland Integrated Health Network  GFP GAIHN Funding Pool  GRP GAIHN Resourcing Pool  NRHP Northern Region Health Plan  PHO Primary Health Organisation  POAC Primary Options in Acute Care  Q Quarter (of the year)  ROI Registration of Interest  SCP Smoking cessation Programme  ToR Terms of Reference</p>
<b>2</b>	<p><b>Purpose</b></p> <p>The purpose of this paper is to seek endorsement of the metro-Auckland DHBs for the 2011 – 2013 Greater Auckland Integrated Health Network's (GAIHN) focus on the goal of <i>'Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions'</i>, the associated work programme, and how it is intended to be funded.</p>
<b>3</b>	<p><b>Recommendations – that the Auckland Board:</b></p> <ol style="list-style-type: none"> <li>Note the change in GAIHN focus from the previously approved business case</li> <li>Endorse GAIHN's new principal focus on management of acute demand,</li> </ol>

	<p>and on reducing inequalities through all of its activities with a particular emphasis on child health, and the suite of work streams outlined in the 2011-13 work programme</p> <ol style="list-style-type: none"> <li>3. Note that the GAIHN Alliance Leadership Team (GAIHN ALT) has agreed to a stage gate process across the work programme, as a mechanism to manage work progress and risk, and approve resource allocation</li> <li>4. Note that the 1st quarter of the GAIHN Work Programme is to be funded through currently available funds</li> <li>5. Note that ALT will present a detailed work programme at the end of the first quarter (the 1<sup>st</sup> stage gate) and seek funding for this programme and its implementation for Quarters two, three and four</li> <li>6. Note the indicative budget allocation requirement in 2011/12 for ADHB of \$450k</li> </ol>
4	<p><b>Introduction</b></p> <p>The purpose of this paper is to seek endorsement of the metro-Auckland DHBs for the 2011 – 2013 Greater Auckland Integrated Health Network's (GAIHN) focus on the goal of '<i>Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions</i>', the associated work programme, and how it is intended to be funded.</p> <p>This paper seeks to summarise the salient points for DHB Boards in terms of the Work Programme goals and costs. It therefore does not provide comprehensive information or a level of detail about the work programme; for this please refer to the attached appendix.</p>
5	<p><b>GAIHN Business Case and Work Programme</b></p> <p><b>GAIHN Business Case</b></p> <p>The GAIHN Business Case approved by the Minister of Health in 2010 sets out the following outcomes and goals, for achievement over a three year period:</p> <p><b>GAIHN Outcomes:</b></p> <p>Better health outcomes, better patient experience, and better use of money through transformational change</p> <p><b>GAIHN Goals:</b></p> <p><b>Reducing health inequalities:</b> GAIHN aims to halve current inequalities wherever it intervenes in priority areas outlined below:</p> <ol style="list-style-type: none"> <li>1. <b>Acute demand growth:</b> Sustainably reduce acute demand growth to zero</li> <li>2. <b>Chronic conditions:</b> 5% reduction in acute hospital days for people with chronic conditions</li> <li>3. <b>Elective services:</b> Actual treatment threshold equivalent to clinically acceptable threshold across major elective services areas</li> </ol>

4. **Prevention:** Achieve national health targets for immunisation, cancer, and cardiovascular risk screening

The GAIHN Alliance Leadership Team has now agreed to focus attention on one principal goal - reducing acute demand, and the implementation of work streams to deliver this goal.

#### **GAIHN Focus and Work Programme 2011-13**

Unsustainable growth in acute demand for hospital services is one particularly significant issue where community and primary health care services can have a positive impact. This area of focus has had a large influence on the development of the Greater Auckland Integrated Health Network (GAIHN) programme 2011-2013. GAIHN recognises the scale of the challenge ahead and the need for a 'whole of system' approach to address regional issues and to find solutions that are aligned with the directions as set out in the Northern Region Health Plan (NRHP).

The 2011 -2013 GAIHN Work Programme goal is:

**“Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions”**

A key emphasis in the GAIHN approach is on empowering the alliance partners to manage a greater proportion of people's health care needs in community settings. GAIHN is also committed to a second area of focus on reducing inequalities through all of its activity with a particular emphasis on better health of children.

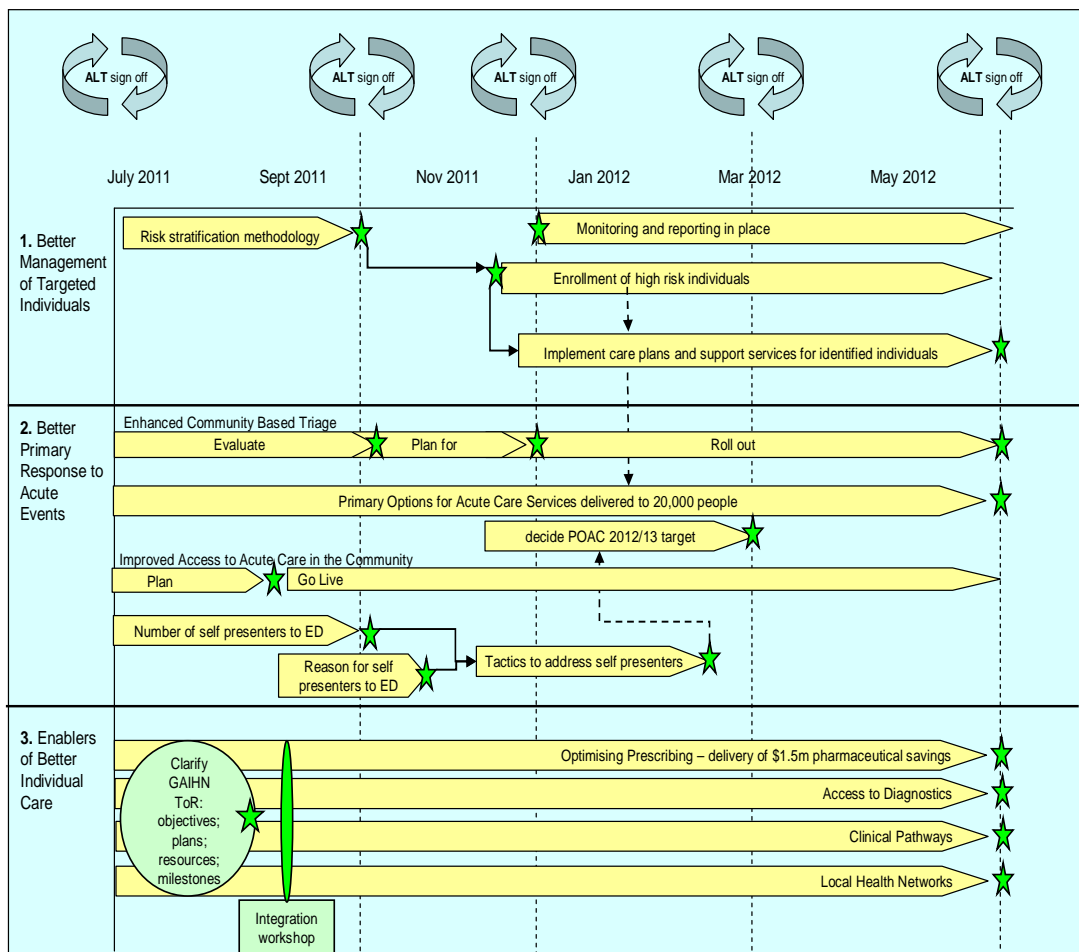
To attain the GAIHN goal, a programme of work has been developed for the next two to three years. The fully integrated programme of work comprises seven aligned work streams as follows:

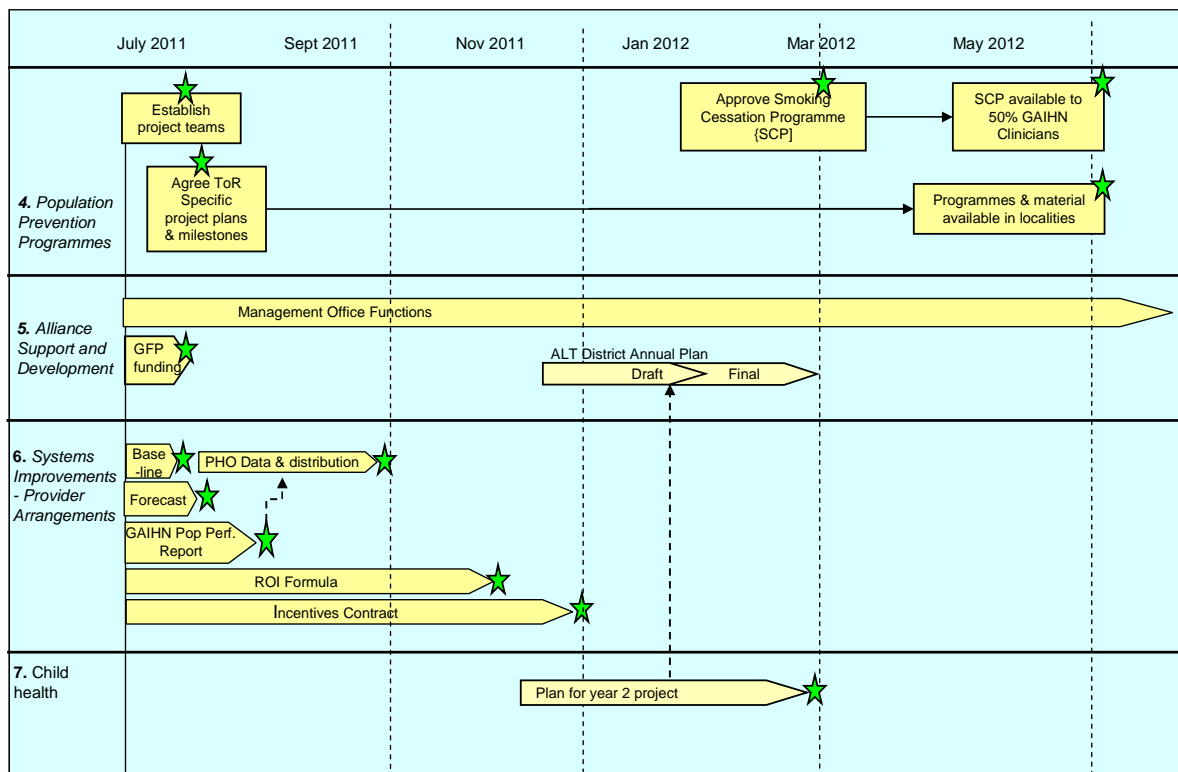
1. Better Management of Targeted Individuals
  - Identification of individuals at high risk of an acute event
  - The teams we use to manage those individuals
  - The model of care we endorse
2. Better Primary Response to Acute Events
  - Building capacity with a focus on selected community options for care
3. Enablers of Better Individual Care
  - Information management ('e-Practice')
  - Linkages
  - Specialist support for community-based patient-centred care
4. Population Prevention Programmes
  - Programmes to enhance community awareness and better self/whanau care

- 5. Alliance Support and Development
  - Programme management and support
- 6. Systems Improvement (Provider arrangements)
  - Incentives and contracting
- 7. Child Health Improvement Project
  - Broader improvement initiatives

The phasing of the seven work streams and associated stages of projects is shown in the overview of the GAIHN programme, as follows:

**Overview of the GAIHN work programme 2011-2012**





### Control Process

The Programme control process includes stage gates or key decision points for the work programme as a whole and for each work stream. This is to enable effective monitoring and management of projects and planned activities, and provide a decision point for the approval of funding from the proposed GAIHN Resourcing Pool.

The stage-gate concept is that the ALT will receive a request for approval of each main stage of project work and the release of funding to meet the staged work resource requirement. ALT will sign-off the funding for specific work streams or project stages on receipt of an appropriate case for funding.

The first of these stage gates is the end of Quarter One (September) 2011, at which time PHO and DHB Boards will be provided with detailed project plans and budgets and a proposal for funding the GAIHN Resourcing Pool (GRF) to resource the ALT approved projects for the remainder of 2011/12, that is Quarters two through four (subject to ALT approval at each stage).

### Funding the Work Programme

#### Funding Framework

The philosophy of the GAIHN resourcing approach is that alliance partners commit to providing a level of up-front annual resourcing to a pool.

The GAIHN Resourcing Pool (GRP) is predominantly based upon a 'top-down' indicative funding envelope with resources (personnel and funds) to come from each of the GAIHN partners. This envelope is to be determined by:

- An enrolled/domiciled population formula
- Equitable District Health Board (DHB) and Primary Healthcare Organisation (PHO) partner contributions.

The following set of principles for the Resourcing Pool are proposed by GAIHN:

### **Principles Regarding Contributions to the GAIHN Resourcing Pool**

Contributions to the GFP will be based on the following principles:

1. Ensuring equity between DHB and PHO partners' contributions
2. Contributions based on an enrolled/domiciled population formula
3. ALT will agree an indicative partner contribution (in \$ terms) to be allocated to the GRP at the beginning of each financial year
4. ALT will manage the expenditure of the GRP
5. ALT will approve funds for projects at key milestones subject to sign off of approved plans
6. Individual project expenditure will be accounted for in a transparent manner
7. Any interest accrued by the GRP will be credited to the GRP
8. Partner organisations will have the option of paying their contribution as
  - a. the full agreed maximum contribution in funds and subsequently billing GAIHN for time spent by staff on GAIHN projects or
  - b. paying a net amount to the GFP consisting of the agreed contribution minus an agreed amount for in kind support (staff time).

A central GAIHN Resourcing Pool (GRF) of \$6.8M for a two year period is currently proposed, funded by the GAIHN partners on a population basis. In 2011/12, operational and project costs are currently assessed as \$3.9M – but available funding has reduced this first year to \$3.2M. No additional funding is required in the first quarter of the year as the Programme will be funded from these available funds.

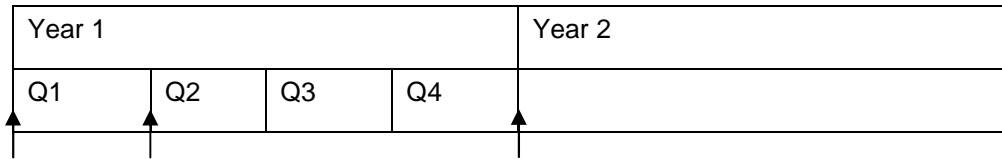
Current work indicates an ADHB population share of funding of \$450k in 2011/12, although this is subject to a formal proposal at the end of the first quarter.

This funding will be managed by the Alliance Leadership Team (ALT), through the stage gate process, following annual approval by Partner Boards of the detailed work programme and specific funding.

This sum includes GAIHN operational costs and project costs, however it should be noted that further detailed work is required on each of the project budgets, and as such no funding approvals are being sought at this time. Costs listed in the GAIHN Programme 2011-2013 Final Report, in some cases, include service delivery and project management costs which are already being paid by DHBs. Also for some projects, such as Access to Diagnostics, the costs should not be attributed evenly to all of the DHBs.

DHB Boards can expect further detailed project costs and budgets, including a break-down of 'cash' and 'in-kind' resource requirements, to be presented in a

specific funding proposal at the end of the first quarter. This request will be for the remainder of 2011/12, that is for project and operational activity in quarters two, three and four. This process is outlined in the diagram below.



ALT approves final work programme and Partner Boards briefed

Proposal to partner Boards for funding to the end of Q4

Year 1 report to partner Boards and proposal for Year 2 funding

### Conclusion

This paper has provided a summary of the GAIHN focus and work programme for 2011-13, and an indication of the funding framework and requirements for this programme. As noted above, the key focus for GAIHN is now acute demand management and reducing unplanned hospital events. A secondary focus is on reducing inequalities and in particular in the area of child health.

A central Resourcing Pool managed by GAIHN ALT is intended, into which GAIHN partners contribute funding per annum. Partner contributions are on a GAIHN enrolled population basis and equally divided between PHOs and DHBs.

Further detailed work is required to finalise the GAIHN project budgets. It is intended that this will be completed during the first quarter of this year, and that specific funding proposals for the GAIHN Resourcing Pool will be put to Partner Boards once this work is completed.



# *10*

## **CONFIRM**

**10.1 Action Points for next CPHAC Meeting**

**10.2 CPHAC Feedback to Board**

**Use Forms at beginning of Meeting Pack**

# *11*

## **GENERAL BUSINESS**



# *12*

## **APPENDICES**

### **12.1 GAIHN Programme 2011-2013**



# Greater Auckland Integrated Health Network

## Programme 2011 - 2013



Final Report 1 July 2011



## Executive Summary

The need for change to current health delivery mechanisms is well understood and supported in the greater Auckland region.

Unsustainable growth in acute demand for hospital services is one particularly significant issue where community health services can make a difference. A second significant issue is reducing health inequalities. These areas of focus have had a large influence on the development of the Greater Auckland Integrated Health Network (GAIHN) programme 2011-2013.

The GAIHN 2011-2013 work programme in this paper outlines how GAIHN partners will play their part in helping to shape, promote and implement changes to current models of care across the whole continuum of health service delivery. GAIHN recognises the scale of the challenge ahead and the need for a 'whole of system' approach to address regional issues and to find solutions that are aligned with the directions as set out in the Northern Region Health Plan (NRHP).

The GAIHN goal is:

**“Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions”**

A key emphasis in the GAIHN approach is placed on empowering the alliance partners to manage a greater proportion of people's health care needs in community settings.

GAIHN is also committed to ensuring that it maintains a second focus on reducing inequalities through all of its activity with a particular emphasis on better health of children.

To attain the GAIHN goal, and to address the second area of focus, a programme of work has been developed for the next 2-3 years. The fully integrated programme of work comprises seven aligned work streams.

### The GAIHN work programme 2011-2012 and seven work streams

1. Better Management of Targeted Individuals
  - § Identification of individuals at high risk of acute event
  - § The teams we use to manage those individuals
  - § The model of care we endorse
2. Better Primary Response to Acute Events
  - § Building capability with a focus on selected community options for care
3. Enablers of Better Individual Care
  - § Information management ('e-Practice')
  - § Linkages
  - § Specialist support for community-based patient-centred care
4. Population Prevention Programmes
  - § Programmes to enhance community awareness and better self/whanau care
5. Alliance Support and Development
  - § Programme management and support
6. Systems Improvement (Provider Arrangements)
  - § Incentives and contracting
7. Child Health Improvement Project
  - § Broader improvement initiatives.

A 'route map' has been developed for the full programme of work and this indicates the phasing of the different project stages within each of the seven work streams. The route map also provides a high level overview of the links and inter-relationships between the various GAIHN work streams and projects.

There are strong linkages between GAIHN projects and other work taking place in the region and a significant relationship between the GAIHN work programme and locality work being led by the three Auckland DHBs. Sound governance arrangements have been put in place to ensure that the seven GAIHN alliance partners can keep the work programme on track. The governance arrangements are supported by a charter setting out the principles for alliance partners to work together.

Partner commitments provide an indication of the scale of funding potentially available for the work programme. This is predominantly based upon a 'top-down' indicative funding envelope with funds to come from each of the GAIHN partner contributions. This envelope is set by:

- § An enrolled/domiciled population formula
- § Equitable District Health Board (DHB) and Primary Healthcare Organisation (PHO) partner contributions.

This 'top down' approach suggests an indicative budget of slightly greater than \$3,894,600.00 2011/12.

'Bottom-up' planning of the work programme has ensured that the overall work programme is capped within the indicative funding envelope and that the work plan enables identification of discrete stages of project work. These stages of work will ensure sound programme management principles can be applied to the phased release of funds provided by alliance partners. The intent is that alliance partners will contribute to a GAIHN Resourcing Pool (GRP) which will be managed by the GAIHN Alliance Leadership Team (ALT).

The GRP will be accessed in a 'Stage-Gate' manner. GAIHN Resourcing Pool funding approvals will occur upon achievement of prior project stage key milestones and on presentation of a specific case for subsequent project funding to the ALT.

The securing of funds to the GRP is a critical step between the Establishment Phase of GAIHN and the Implementation Phase, planned to commence 1 July 2011. Delays securing the GRP funding, or lack of clarity regarding the total annual budget committed will affect the scheduling and progression of the planned work streams.

The immediate resourcing requirement is to ensure that each project is populated by the right people to ensure its success. Sufficient funds will be in hand at 1 July to enable the GAIHN Programme to continue for the first three months. For Q2 – Q4 GAIHN partners will be asked to contribute resources ALT approved projects, within the overall funding ceiling.

**GAIHN is seeking**

- § Alliance Partner commitment to the overall programme of work and phased resourcing as outlined in the table above.
- § Approval of project management resourcing to enable the first three months of GAIHN work to be put in place
- § Approval to continue with existing projects commenced in 2010/11 year.

**GAIHN Estimated Budget Spread 2011/12 (23/6/11)**

<b>2011/12 FY Work stream</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>Funding Requirement For 2011/12</b>
WS 1	45,000	66,000	66,000	43,000	220,000
WS 2	60,000	90,000	80,000	50,000	280,000
WS 3	261,900	559,100	559,100	489,000	1,869,100
WS 4	0	22,500	45,000	82,500	150,000
WS 5	197,625	197,625	197,625	197,625	790,500
WS 6	100,000	182,000	169,500	98,500	550,000
WS 7	0	10,000	10,000	15,000	35,000
<b>Total</b>	<b>664,525</b>	<b>1,127,225</b>	<b>1,127,225</b>	<b>975,625</b>	<b>3,894,600</b>



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## Issues and Context

The NRHP provides evidence and convincingly states that continuing to deliver health services as we do now is not sustainable<sup>1</sup>. The region plan emphasises the fact that we need to build a foundation now that will enable us to progressively deliver services in a fundamentally different way over the next five years.

Key issues supporting this conclusion are that:

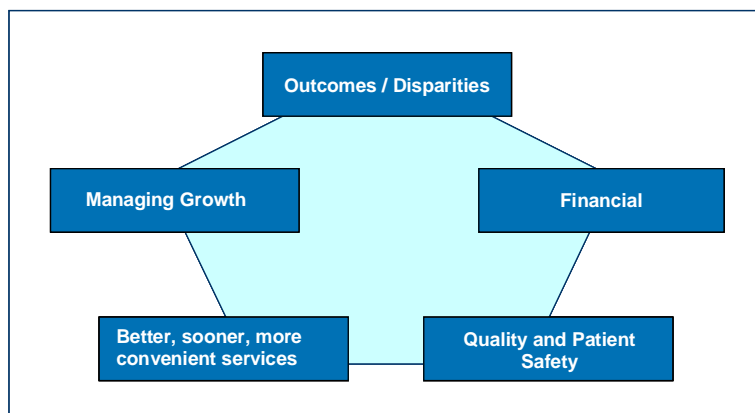
- § Over the next 20 years the population in the Northern region will grow by around 500,000 which exceeds the current population of any other DHB and will account for two out of every three additional people in New Zealand (NZ)
- § Our population is getting older and the burden of chronic diseases is increasing – in diabetes alone we estimate that an additional 40,000 people will be diagnosed with diabetes over the next 10 years
- § Our projections show that if we continue to deliver services as we currently do, each year we will need an additional 75-100 beds just to accommodate demographic growth. We will add \$30-40m to our cost base and need around \$300m of additional capital.

Collectively, these issues are putting large pressures on hospital resources, facilities and staff to meet need. These pressures will increase with time.

A high emphasis is placed on reducing health inequalities in the Northern region. Child and youth health is identified as a priority for development in 2011/12. New Zealand outcomes for child and youth health and safety are amongst the worst in the Organisation for Economic Co-operation and Development (OECD). Infant mortality is a significant contributor to premature death and is avoidable. There are large inequalities in child health outcomes between ethnic groups and across deprivation groups.

The NRHP has identified five key drivers for change impacting on the delivery of health services. The plan places emphasis on the role of community-based care in addressing the issues arising from these change drivers.

### Northern Region Health Plan five key drivers for change



<sup>1</sup> Refer Northern Region Health Plan for context and drivers of change in the Northern Region. See Appendix A for extracts relating to demand growth and other challenges

GAIHN understands the scale of the challenge ahead and the need for a 'whole of system' approach to address the regional issues. We recognise that:

- § The above issues are important due to the anticipated scale of growth in both demand and cost of future health services in the greater Auckland region
- § That reducing this growth will require focus on high needs populations and non-hospital care
- § There is a need to achieve improved health outcomes for children, that segment of our population who stand to benefit the most.

Unsustainable growth in acute demand for hospital services in the greater Auckland region is the key driver for the GAIHN work programme. Potential solutions to this issue must be aligned with the directions as set out in the NRHP to ensure aligned and consistent approaches across organisational boundaries.

## The GAIHN Goal, Focus and Approach

The GAIHN goal is:

**“Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions”**

This goal:

- § Is a priority due to:
  - The disruption it causes to the individuals admitted and
  - The disruption it causes to elective health care, most noticeably patient waiting times
  - The high and rising costs of emergency admissions compared with other forms of care.
- § Requires an approach that moves beyond small scale projects. Evidence suggests that adopting comprehensive admission avoidance programmes comprising multiple evidence based strategies is most likely to influence behaviours and effect change.

Implementation of change with respect to the GAIHN goal will particularly help the region to address three of the NRHP five key drivers, namely:

- § Managing Growth
- § Financial
- § Better Sooner More Convenient (BSMC) services

A second area of focus for GAIHN arises from its commitment to reducing health inequalities through all of its activity with a particular emphasis on child health. It is envisaged that over time this emphasis will impact on reducing health inequalities and better health for children.

**Improving Child Health Outcomes and Equity** is a focus because:

- § New Zealand outcomes for child and youth health and safety are amongst the worst in the OECD.
- § There are large inequalities in child health outcomes between ethnic groups and across deprivation groups
  - Maori and Pacific children are 70% more likely to die in infancy than others

- Children make up over a third of Auckland's Maori and Pacific populations (compared to 16% for other population groups)
- § Access to antenatal care and early intervention is protective of a wide range of poor health outcomes. Investment in interventions now will pay future dividends in terms of the health of our population.
- § Reducing infant mortality and morbidity, improving immunisation rates, with a focus on vulnerable children and a family approach, will contribute to the objective of reducing inequalities; particularly in the health of Maori and Pacific families.

Implementation of change with respect to child health outcomes and equity will particularly help the region to address the following of the NRHP five key drivers:

- § Outcomes
- § Disparities
- § Quality and Patient Safety.

During the first year all GAIHN initiatives will focus on achieving the goal of avoiding unplanned hospital admissions and planning how to extend the programme with respect to better health for children.

This emphasis reinforces, and is consistent with, similar focus and actions by other parties in our region. It will:

- § Reinforce changes in service delivery along the whole continuum of care and across organisational and DHB boundaries
- § Result in a regional whole of system approach; reflecting the work detailed in the NRHP, District Annual Plans (DAPS), and the other BSMC primary care business cases.

Due to the nature of the GAIHN goal and second GAIHN area of focus, we expect to see the impact of initiatives occurring in quite different time periods. We expect to see an impact from the initial focus on reducing unplanned admissions in the short to medium term while success against the second area of focus, that of reducing inequalities and better health for children, will continue to develop over a longer term.

GAIHN's approach to address the GAIHN goal will be to:

- § Identify individuals at high risk of acute events likely to lead to avoidable acute admissions
- § Develop better responses in primary care and the community to acute events when they occur
- § Better management of people at risk of acute events as a complication of LTC which have not been optimally managed.

The health of our older people will likely provide one priority because:

- § Older people represent a large and growing cohort of demand for our health services
- § Implementation of alternative models for delivery of care to older people, particularly those with chronic conditions, has the potential to improve the efficiency and cost effectiveness of health service delivery, avoid the need for expensive capital investment in hospital based services and improve patient experience.

However LTC are not only encountered in our older people, there are younger people who also currently require acute interventions for LTC. For these individuals prevention of acute exacerbations leading to hospitalisation would be significantly improved by a combination of:

- § Best clinical practice
- § More proactive anticipatory care
- § A greater emphasis on self management support with clear crisis plans as well as documented care plans.

Long Term Condition Management is a focus because 45% of avoidable admissions, attributable to primary care management<sup>2</sup>, arise from people with:

- § Cardiovascular disease (CVD) (21%)
- § Respiratory disease (18%)
- § Diabetes (6%).

This proportion of avoidable admissions would be even higher if one counted non-infective exacerbations of COPD.

Better management of these conditions will also significantly reduce disparities. Long term conditions contribute to 75% of premature deaths; and therefore health inequalities.

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<sup>2</sup> Using Ambulatory Sensitive Hospitalisation definition attributable to primary care management

## Patient stories

To understand what impact attainment of the GAIHN goal could mean to people in our region consider the following four patient stories.

### Patient Story One

<p>Mark is a 33 year old professional and father of two who collapsed at work losing consciousness briefly. He does not smoke, is usually well and has no known medical history having not visited a GP for at least five years. He is not enrolled in a primary care practice.</p>	<p>Mark's colleagues call an ambulance which transfers him to the hospital emergency department (ED) where he is assessed as Triage category five and waits nearly two hours to be examined by a doctor. ED is busy so he then waits another four hours on an uncomfortable trolley, breaching the six hour waiting time target, before being discharged home with no specific treatment and a suggestion to follow-up with his GP (which he doesn't have).</p>	<p>Mark's colleagues call the community telephone triage service who arrange for an ambulance. After ruling out apparent cardiac causes for the collapse and ensuring he is stable, the ambulance transfers him, through a Primary Options pathway, to a local Accident &amp; Medical (A&amp;M) Clinic where in a continuation of the Primary Options pathway he is assessed within 10 minutes of arrival and placed under observation. After two hours of observation with no further episodes he is discharged home. He is provided a list of primary care practices in his locality and nominates one for his follow-up care. The practice is informed of Mark's choosing them, and sent a summary of his acute event.</p>
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### Patient Story Two

Patient Story Two	Current Scenario	Future Scenario
<p>Pulusea is a five year old boy who has been in and out of hospital for the last few months with respiratory infections. His mother reckons he's never well for five minutes before they're back to ED. Pulusea lives with his parents, two surviving grandparents and three siblings in a three bedroom house in Tamaki. He shares a room with his 3 siblings who are all older than him (7, 10, 12). They have a car at home but it doesn't have very much petrol in it and money is tight. It's 8pm and Pulusea has been coughing and wheezing for the last couple of hours.</p>	<p>Pulusea's mother leaves his siblings in the care of their grandparents and drives him to Starship ED. He is given a nebuliser which helps his breathing and a prescription for some antibiotics. He is discharged home but his mother doesn't fill the prescription and he is back in ED two days later.</p>	<p>Pulusea's mother leaves his siblings in the care of their grandparents and drives him to Starship ED. The system identifies that this is Pulusea's third visit to ED in a short space of time which triggers his nurse to enrol him in the 'GAIHN high risk' programme. Pulusea is registered on the programme and a notification sent to the primary care practice with which Pulusea is enrolled. The next day, the practice discusses Pulusea and decides to ask the Pacific Community Support Service to contact the family. The Pacific Health Worker reports back to the practice. They decide to make a full assessment of the family's health needs. They agree a plan with the family which includes an assessment for improved insulation and heating of their home and arranges a nurse visit with the Pacific Health Worker to check on adherence to medication and further education re crisis plan. Pulusea's mother is assured that she will be seen urgently on the same day if she calls the practice.</p>

## Patient Story Three

Patient Story Three	Current scenario	Future Scenario
<p>Mr Ngata is a 45 year old Maori man who has an addiction to Coke, he presents to his GP with acute gout of less than 12 hours duration. Enquiry reveals he is a smoker and examination and investigation show an elevated blood pressure, and a raised glucose. He also has Tophi when examined.</p>	<p>GP treats his gout with a combination of non steroidal anti-inflammatory drugs, and colchicine and books another appointment for Mr Ngata to attend for education after follow up tests. Mr Ngata fails to attend for follow up and is not heard about again until the discharge summary arrives saying he has been discharged from ED with another acute attack of gout. He is told to see his GP to start allopurinol in one month's time but does not attend. He is still drinking large amounts of coke.</p>	<p>GP sees him then ensures he sees the Practice Nurse who provides further education re gout and why it's important to stop the "fizzy drink". Discusses strategies for weaning off the coke, including an immediate swap to Coke Zero. She reinforces the way to take the medication and the need to return for different medication to prevent a further attack and provide him with written information. She also gives simple advice on diet and lifestyle. She draws bloods, including HBA1C and arranges a <b>free</b> follow up appointment to see her. She arranges a "text to remind" message to be sent to him the day before his appointment. The nurse has had post-graduate training in long term condition (LTC) management including a module on gout. He attends follow up and the nurse does a CVRA using Predict and provides further advice re diabetes with written information. She uses an electronic template to create a care plan with agreed goals that he takes with him but that he can also access on-line. The GP provides a prescription for allopurinol and statin which the nurse explains how he should take. She refers him to the local Community Health Hub where he is seen within two weeks by a community health worker (CHW) who arranges a follow-up visit at home. He also sees a clinical pharmacist who provides ongoing education and detailed information re his medication and why he needs to keep taking these. The CHW coordinates a lifestyle programme and recommends he attends the Maori Men's group. All clinicians and the CHW can access his notes through a portal and are able to update his care plan with relevant actions and education given. All of this is imbedded in his notes and a summary sent to the GP with a link to the guideline for management which can be imbedded into his notes.</p>

## Patient Story Four

Patient Story Four	Current Scenario	Future Scenario
<p><b>Maori - Cook Island Maori Family</b> 69 year old Father (with obesity, COPD, osteoarthritis, gout, and hyperlipidaemia); 45 year old Mother with Diabetes, obesity, low vision; 2 daughters aged 10 (Chronic Otitis Media) &amp; 13 (Asthma &amp; cerebral palsy) and a Son aged 9 years (Asthma &amp; eczema).</p> <p><b><u>Total ED visits for family members in past 12 months = 26; Total GP Visits = 12 (different GPs)</u></b></p> <p>Father is elderly – only income being National Super (second marriage and family). Mother has become blind and is very frustrated at her dependency. Parents know the need for lifestyle changes but need motivation. Often not seeking medical care when required due to cost.</p>	<p>Family had been attending multiple practices because, with their frequent attendance, the bad debts were piling up. This made them reluctant to attend. The practice(s) and ED responded acutely each time but no proactive agreed plan was put in place to improve the situation.</p>	<p>The GP became aware of this high use of ED through the GAIHN acute demand project where a coordinator had been nominated and had contacted the family realising the extent that other family members also used ED. The family were enrolled in a programme that meant they did not have to pay to attend the GP (so long as they attended there family doctor or the agreed deputising A&amp;M) and they were given an 0800 Triage number to make contact 24 hrs. A plan was put in including reviewing medication and crisis plan for the children’s asthma and his gout and COPD. He and his wife were seen monthly by the practice nurse (and the GP if necessary) and a plan of care was monitored to ensure they could be kept out of hospital. Mother with Diabetes and loss of sight is now more independent and not relying on their oldest daughter as an escort. Diabetes nurse at practice has been involved resolving this and has liaised with the Blind Institute organising practical aids, and teaching. Diabetes now better managed. General health of father is much the same, however his attitude has changed and family are coping better with only two ED attendances in past year for the entire family and 24 attendances at the practice (mostly planned). There has been less acute presentation all the family and the children’s acute illnesses are now dealt with more promptly. Whole family now more aware of the health issues (weight and diabetes) that the family face and are involved supporting one another, and taking more responsibility. Mother is now more motivated and has begun computer skills course. Father has retrained and is employed working part-time in Mental Health. He is also completing Community Worker training. Everyone agrees that in the next year, if the family continue to progress, they could be removed from the GAIHN intensive care programme.</p>

## Programme of Work

A programme of work has been developed to progress the achievement of the GAIHN goal over the next 2-3 years. This programme has a planned commencement date of 1 July 2011.

### The seven work streams

The fully integrated programme consists of seven aligned work streams to deliver initial benefits against the GAIHN goal. These work streams provide a suite of projects focussed on areas where GAIHN partners have an ability to enhance the system through the delivery of primary care. The seven work streams are:

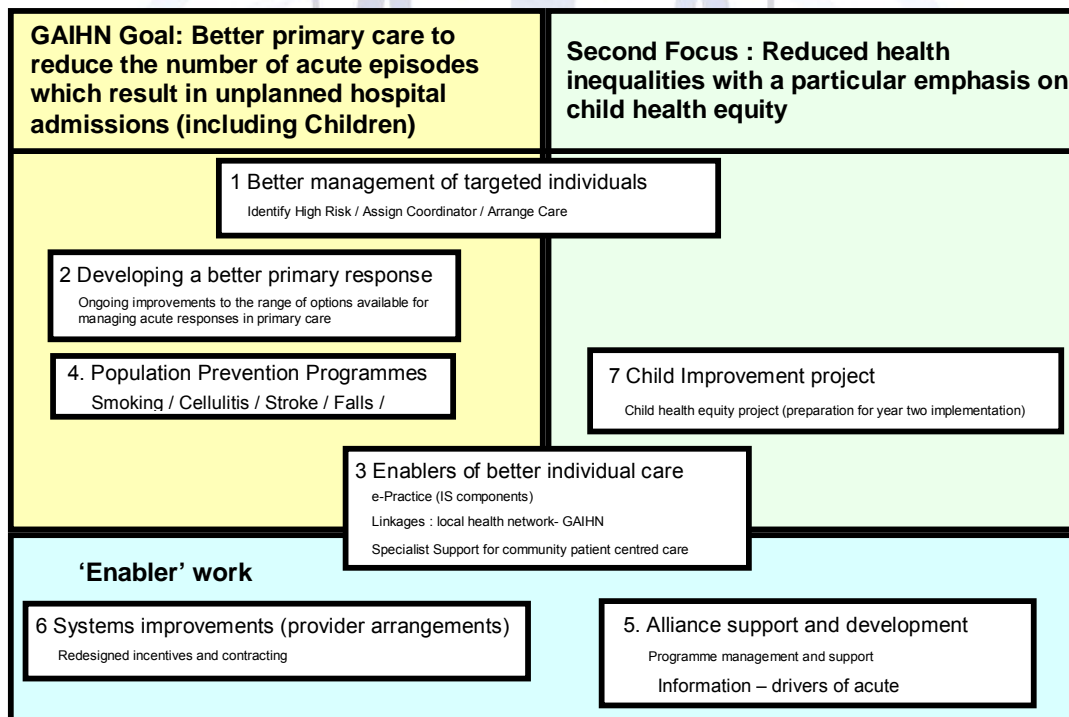
1. Better Management of Targeted Individuals
2. Better Primary Response to Acute Events
3. Enablers of Better Individual Care
4. Population Prevention Programmes
5. Alliance Support and Development
6. Systems Improvement (provider arrangements)
7. Better Health of Children.

Detail relating to each of these work streams is provided below.

Some of the seven work streams are service delivery focused, others are more generic; enabling system development or support.

The alignment of each work stream to the GAIHN goal and second area of focus is indicated in the diagram below.

#### Work stream alignment to the GAIHN goal and second focus area



Although year one of the plan primarily relates to reduction of unplanned admissions, some of the work stream project work is intended to prepare for the second GAIHN area of focus. This year one planning work will enable the Child Health Improvement project to commence in July 2012.

This work programme, with seven aligned work streams, replaces the previous GAIHN plans and will be managed regionally. Regional working groups will be established where consistency and standardisation are required. However, implementation will take place locally through 'Local Health Networks' (LHN).

## Overview of the seven work streams

### 1. Better Management of Targeted Individuals

The identification and management of individuals (both enrolled and non-enrolled) at high risk of acute events is key to preventing potential hospital admissions. These individuals will include, for example:

- § Frequent attendees at hospital emergency departments (ED)
- § People with poorly controlled (sub-optimally managed) LTC in particular those with cardiovascular and respiratory conditions and in the longer term diabetes.

To make a difference, this work stream must focus on:

- § How to identify individuals
- § The teams we use to manage those individuals
- § The model of care we endorse.

#### Key stages milestones and deliverables for work stream one (provisional)

- § Agree risk stratification methodology (and tool development) by September 2011
- § Identify targeted individuals at high risk of an acute event and assign to practices by 28 November 2011
- § Assign primary care coordinators by November 2011 who will plan and arrange the care programme to reduce the likelihood of acute events
- § Support the primary care provider in providing an individual care programme for their enrolled high-risk patients
- § Enrol 2500 patients by March 2012
- § Care plans and support services in place for >5,000 targeted individuals by June 2012
- § >10% Reduction in number of admissions; and bed days usage of targeted individuals.

GAIHN anticipates a potential target of 15,000 patients over a full year. With enrolment commencing in December 2011 to reach this rate of enrollees by June 2012, we will need to build to enrol 45 patients per day. This is on average one patient enrolment per week for each GAIHN practice, though these are unlikely to be evenly distributed. It is likely that enrolments will build gradually so we would expect 2500 enrolments by the end of March 2012 and 5000 by end of June.

## 2. Better Primary Response to Acute Events

This work stream is concerned with building the capability of the primary/community sector to manage acute episodes through planning and implementing improvements to a range of options. These include:

- i. Triage – includes face to face and telephone based e.g. 111 for emergencies; General Practice (medical home); Homecare Medical Ltd and Health Line; and triage within Hospital ED; Accident & Medical (A&M) clinics.
- ii. Broadening of Primary Options for Acute Care (POAC) (e.g. diversion of Ambulance to A&M at no/minimal cost to patient; use of POAC to keep people in aged residential care rather than admit; increased referral to POAC from ED etc).
- iii. Same day and urgent access to medical home
- iv. After hours availability
- v. Better management of self presenters to ED
- vi. Others as necessary.

The essential components here are that all patients should have ready access to their usual practice or deputising agency. The aim would be to reduce the number of patients who present to ED without having undergone some form of community-based triage. More patients will have access to a broader range of options to deal with acute events and subsequent management in the community (so reducing the number who need acute hospitalisation).

### Key stages milestones and deliverables for work stream two

- § Complete data analysis and volumes to establish baseline for 'self presenters' to ED July 2011
- § Review outcome of MMH study "What brought you to ED today?" to identify the reasons and possible solutions to ED self presentation – August 2011
- § Appropriate range of triage services agreed and available by September 2011
- § Ability to measure and report percentage of patients presenting to ED who have had prior triage by November 2011
- § Telephone triage service(s) holds after-hours plans for each GAIHN practice by November 2011
- § Public education/media campaign and resources available to promote use of triage services as alternative to ED – November 2011
- § Broadening of POAC - description of the range of alternative community options for acute care available and in place by December 2011 for piloting before year end.
- § Draft 2012-13 DAP content finalised including POAC volumes by January 2012
- § Final 2012-13 plan for the development of community options for acute care signed off by ALT February 2012
- § Increasing POAC volumes by 20% from 15,000 to 18,000 by June 2012

## 3. Enablers of Better Individual Care

This work stream has a number of projects that are essential for the success of GAIHN. However, all but three of these projects are not directly controlled by GAIHN. Key enablers are the information systems to support best practice and 'joined-up' care including 'e-Referrals' and 'shared care planning' with clear linkages to the 'Clinical Pathways' and 'Access to Diagnostics' projects. The infrastructure to support a locality approach through development of 'Community Health Hubs' is also key and is described further below.

- a. e-Practice:** Integrating the multiple initiatives relating to electronically enabled best practice including:
- i. Access to Diagnostics
  - ii. Clinical Pathways
  - iii. Optimising Prescribing
  - iv. E-Referrals
  - v. E-Shared Care Planning
  - vi. Advance Care Planning.
- b. Locality infrastructure** including the accessibility of specialist services and infrastructure to support ensuring effective linkages with LHN e.g. Community Health Hubs (CCH)
- c. Specialist support:** Ensuring that the specialist support services needed to support enhanced primary care are developed including:
- i. Specialist services required in clinical pathways
  - ii. Access to Diagnostics
  - iii. Nursing Development Project
  - iv. Community Specialist Clinics
  - v. Advanced Care Planning
  - vi. Optimising Prescribing Project (clinical pharmacist support).
- d. New models of care:** Where appropriate, develop new organisational guidelines for models of care for people with LTC in support of work streams 1 & 2 above.

#### Key stages milestones and deliverables for work stream three

- § Development of an integrated overview of all of the activities relevant to e-enabled primary care practice by September 2012
- § Advocacy Plan (if relevant) including options for development of integrated e-practice by November 2011
- § Ensuring continuity with Local Health Network development
- § As part of work stream 3a, investigate electronic solutions and complete a business case for preferred options by March 2012
- § Access to diagnostics – Radiology: Agree an appropriate target for waiting times for routine imaging and report performance against the target for Metro Auckland DHBs from January 2012
- § The volume of DHB-funded GP-requested diagnostic radiology procedures performed in the community will increase by 10%, on 2010/11 volumes by June 2012.
- § Regional Clinical Pathways Project - Project scoped to ensure a direct focus on supporting the delivery the goal and evaluation of the work to date and plan for full implementation at the clinical encounter by August 2011
- § 6 pathways (could be subject to variation by ALT) fully implemented including the four pathways developed in 2010/11 by June 2012
- § Pharmaceuticals, Optimising Prescribing: Improved medicines safety through reduced poly-pharmacy by June 2012
- § Simpler medication regimens especially for patients with multiple long term conditions
- § Less risk of harm through unnecessary medications left in homes through addressing prescription wastage
- § Develop new organisational guidelines for models of care for people with long term conditions where they support work streams 1 & 2: New models of care including self management models are trialled in selected localities by June 2012
- § New organisational models of care guidelines adopted as the standard for implementation across Metro Auckland by June 2012.

#### 4. Population Prevention Programmes

This work stream is focussed on programmes to enhance community awareness and better self/whanau care to prevent or respond to acute events. These campaigns will ensure consistent advice and messages are sent to the public for a wider scale engagement with the community in order to improve health status:

- a. Smoking cessation in primary care and awareness of existing services available
- b. Cellulitis, prevention/early intervention campaign
- c. Education re early intervention in Stroke & TIA
- d. CVD Risk assessment & Diabetes Annual Reviews
- e. Falls prevention (as per Regional Health Plan)
- f. Others.

##### Key stages milestones and deliverables for work stream four

- § Stock take of Smoking Cessation services completed by August 2011. Plan for extended services by October 2011
- § Resources for patients available at practices November 2011
- § Service directory for smoking cessation made available to practices October 2011
- § Review evidence re Cellulitis prevention campaign (note that past Glen Innes Pilot was successful) by September 2011
- § Design publicity and resources for targeted suburbs/localities with high incidence of cellulitis admissions by November 2011
- § Work with Heart Foundation to promote CVD risk screening and “know your numbers” by January 2012
- § Aim for 80% CVD risk assessment coverage of high risk groups by June 2012.

#### 5. Alliance Support & Development

These functions are provided by the GAIHN Management and include:

- § Alliance contracting
- § Communications and engagement
- § Funding and partner capability building.

##### Key stages milestones and deliverables for work stream five

- § Hitting milestones for this plan and also completion of 2012-13 planning documents in time to inform GAIHN alliance partners draft plans for 2012-13; (Initial indicative recommendations by December 2011 or specific detail for inclusion in plans by March 2012).

## 6. Systems Improvement (Provider Arrangements)

This work stream is about systems level changes to support providers to achieve the GAIHN goals. In particular the use of information and health intelligence to manage variability and incentivise improvement will be key. It also includes the contracting environment to ensure that the right incentives are in place to enable the necessary changes. The first two of the projects below are GAIHN led initiatives but the others are DHB led as they have broader implications than just GAIHN:

- a. **Information project** developing a better understanding of the drivers of acute demand and how this may be reported at practice level in a meaningful way useful for driving change
- b. **Redesigned incentives and contracting** – is about re-thinking the existing contracting methodology so that remuneration systems and non-pecuniary incentives appropriately reward the effort of higher performing providers and ensure the appropriate sharing and management of risk
- c. **Workforce development** (currently not under consideration within the direct scope of this plan but GAIHN will work with DHBs and professional bodies to support workforce development and ensure service continuity particularly in localities with vulnerable populations).

### Key stages milestones and deliverables for work stream six

- § Performance baseline established for acute demand by July 2011
- § Performance forecast counterfactual established and agreed by August 2011
- § GAIHN population performance reporting established by September 2011
- § PHO datasets and regular distribution established by October 2011
- § Practice level reporting in place by November 2011
- § Return on Investment formula established and agreed by December 2011
- § Incentives contract agreed by March 2012
- § Roll-out of education and training plan once the detailed work programme for intervening has been determined.

## 7. Child Health Improvement Project

The improvement of child health will initially be considered through the focus on acute demand and will be implemented via work streams one to six in the 2011-12 year. In 2012-13 we are seeking a more ambitious approach to improving health of children. Growth in demand for hospital services for 0 – 4 year olds is not a major driver in the Auckland metropolitan region with mostly lower than average avoidable hospitalisations compared to national figures. However there is still considerable disparity in admission rates between different groups in the community (ethnic, socio-demographic, etc) and there is a lot that can be done for preventing child admissions particularly for the following conditions: cellulitis, asthma, dental conditions and dehydration (gastroenteritis).

During 2011-12 a team will be charged with doing more detailed work based on the Reducing Inequalities Clinical Alliance Team work done over 2010 – 11. The objective will be to come up with a plan for inclusion in DHBs DAPs and PHO

Annual Plans by December 2011. A more detailed, fully scoped, implementation plan for sign off by all GAIHN partners will be produced by March 2012.

This team will consider non-accidental injury prevention and early detection as well as a focus on vulnerable families in order to provide the best start to life in a safe environment. Consideration of information systems to link-up multiple providers and social agencies to flag potentially at risk children will, in time, need to be implemented through sharing information. The group will do a scan of the evidence and make recommendations how health providers (but General Practice in particular) can link to existing initiatives such as 'Family Start'. A better information platform is critical to integrating such initiatives to health providers desktop. How we work together intersectorally will be key and 'Before School Checks' are an opportunity here also, with implementing learnings from Auckland District Health Board's (ADHBs) alliancing approach to this initiative. The group will also review the needs assessment information available (Child Health Report) and make recommendations where the greatest gains are likely to be made from a clinical perspective (treatment gap) and also advise on how a whanau ora approach can be taken that compliments the work of the National Hauora Coalition.

One immediate focus will be on reducing infant mortality and morbidity, and improving immunisation rates. The programme will take a vulnerable children and family approach with a focus on reducing inequalities in the health of Maori and Pacific families.

GAIHN will encourage and enable General Practice to take a proactive approach to ensure children have access to the protective health services they need.

#### **Key stages milestones and deliverables for work stream seven**

In 2011/12, focus on reducing avoidable acute events for children (see other work streams for detail)

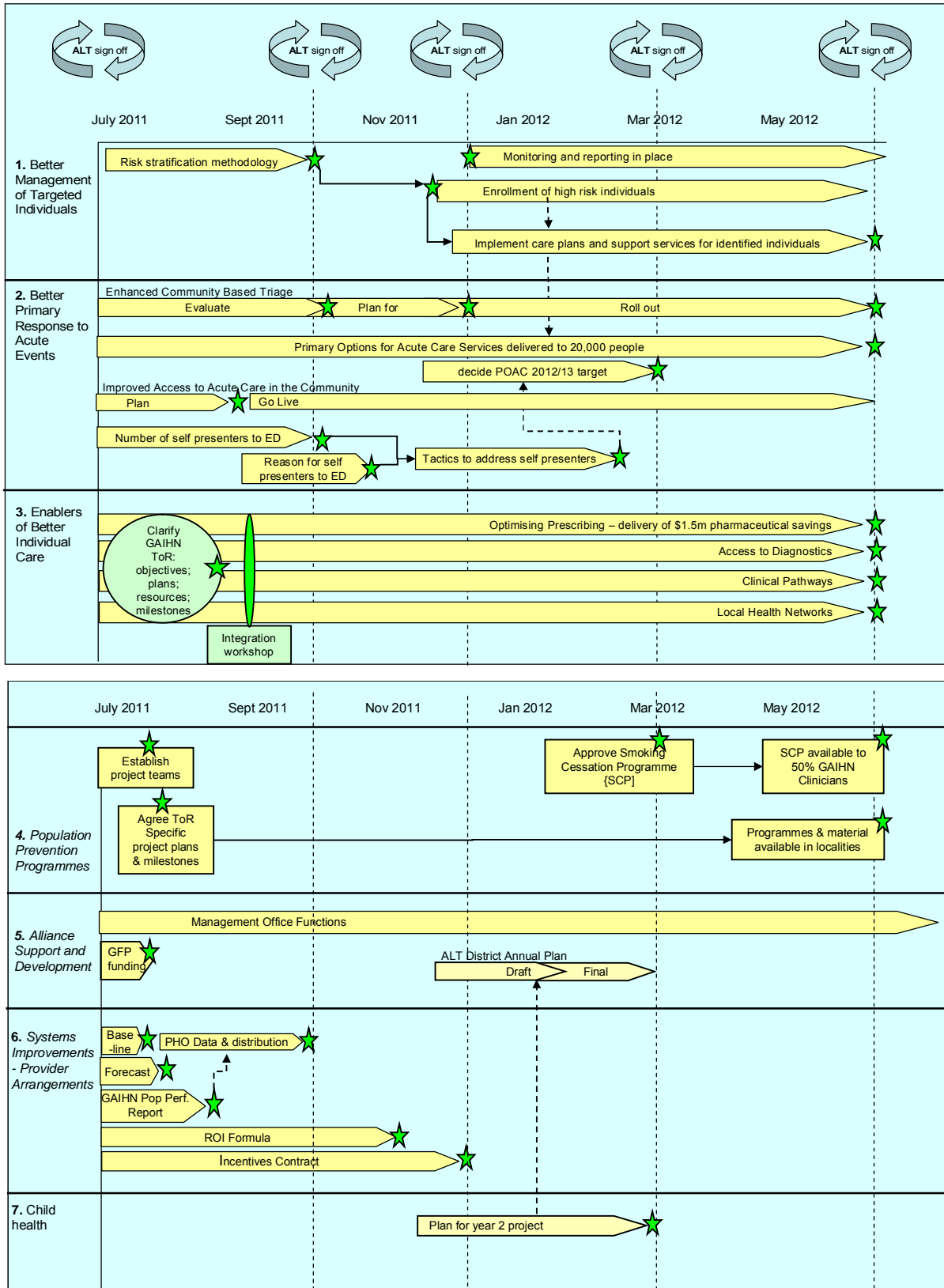
- § Development and planning broader improvements to child health for 2012/13 with draft plan delivered by December 2012
- § Final detailed implementation plan by March 2012.

#### **The phasing of work stream deliverables**

How the seven work streams and associated stages of projects fit together is shown in the overview of the GAIHN programme of work exhibit overleaf.

Further detail of each work stream and project detail is in Appendix B. Activity that will impact on achievement of the GAIHN goal is outlined in Appendix C.

Overview of the GAIHN work programme 2011-2012



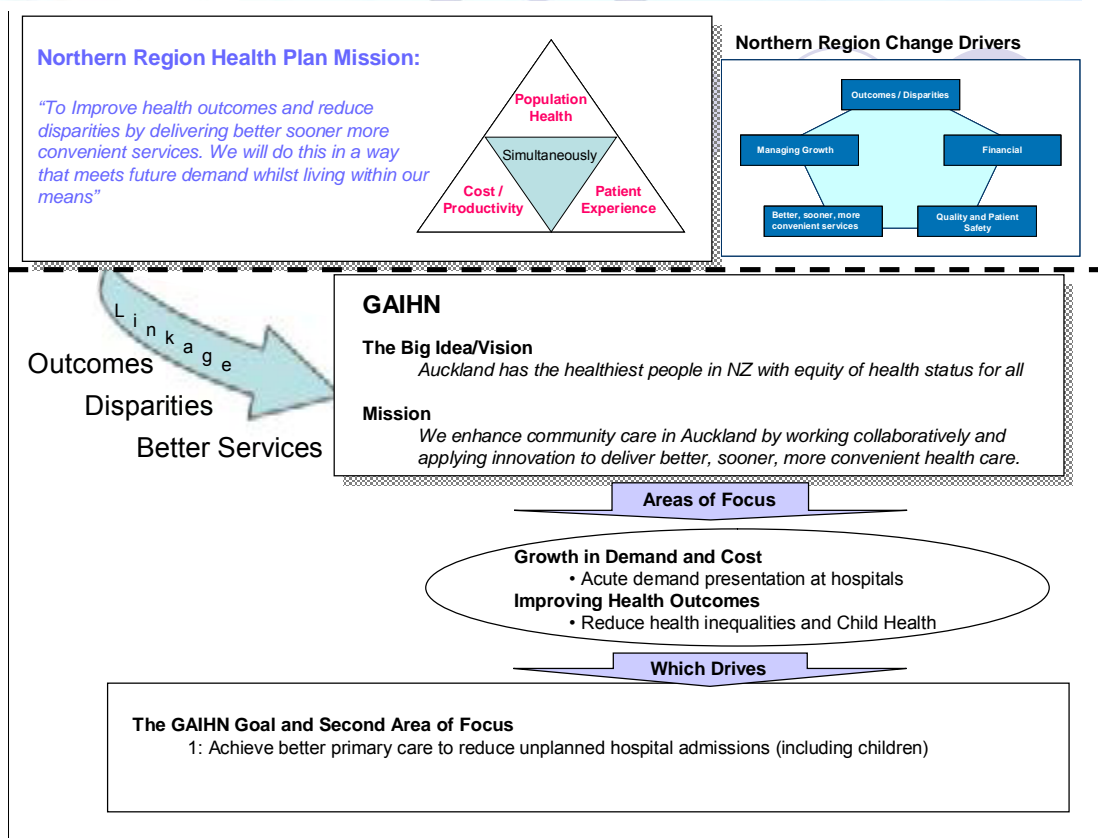
**Linkages with other work**

Our planning approach and our program of work reflects strong inter linkages with other work taking place in our region.

The issue of acute demand growth is a priority for most Auckland and Northern region health entities and agencies due to its scale and potential impact on service delivery. As a result there are strong inter-relationships between:

- § The GAIHN projects
- § Northern Regional Health Plan
- § District Annual Plan projects
- § Activities of Alliance Health+ and
- § Activities of the National Hauora Coalition.

**Links between GAIHN and Northern Regional Health Plan**



There is also a significant relationship between the GAIHN work programme and the locality work being led by the three Auckland DHBs. The objective of the locality work is to provide effective, accessible and convenient services via integrated and streamlined public services. GAIHN’s role is to support these locality-based services. There are three strands to this work:

- § Adoption of a regional planning approach
- § Development of a data action unit across community and hospital based care and delivering both clinical and financial outputs

§ Development of local health networks (LHN).

One area of emphasis for the locality work is to align health services development with local government boundaries of which there are four in Auckland. This locality planning will help provide some infrastructure in primary care to support the GAIHN work programme.

GAIHN will support action within all agencies where such action is complementary to the GAIHN areas of activity and of benefit to our population. In particular, GAIHN will be working in close association with related DHB projects (below) to ensure a mutually beneficial outcome:

§ After Hours Planning

- The ALT may need to consider future GAIHN involvement in after hour service provision and possible expansion of alternative options

§ Workforce development and training

§ Regional Community Nursing/Allied Health

§ Health IT including:

- E-Referrals
- National Shared Care Programme.

A collaborative approach will be required to ensure that satisfactory outcomes are achieved for all stakeholders.

One further consideration for the phasing of the GAIHN programme of work is the need to align GAIHN planning with that of partner agencies and organisations, for example the DHB DAP planning process. This requirement has influenced timelines for the proposed completion of the GAIHN year 2012-13 work programme.

## The GAIHN Governance Model

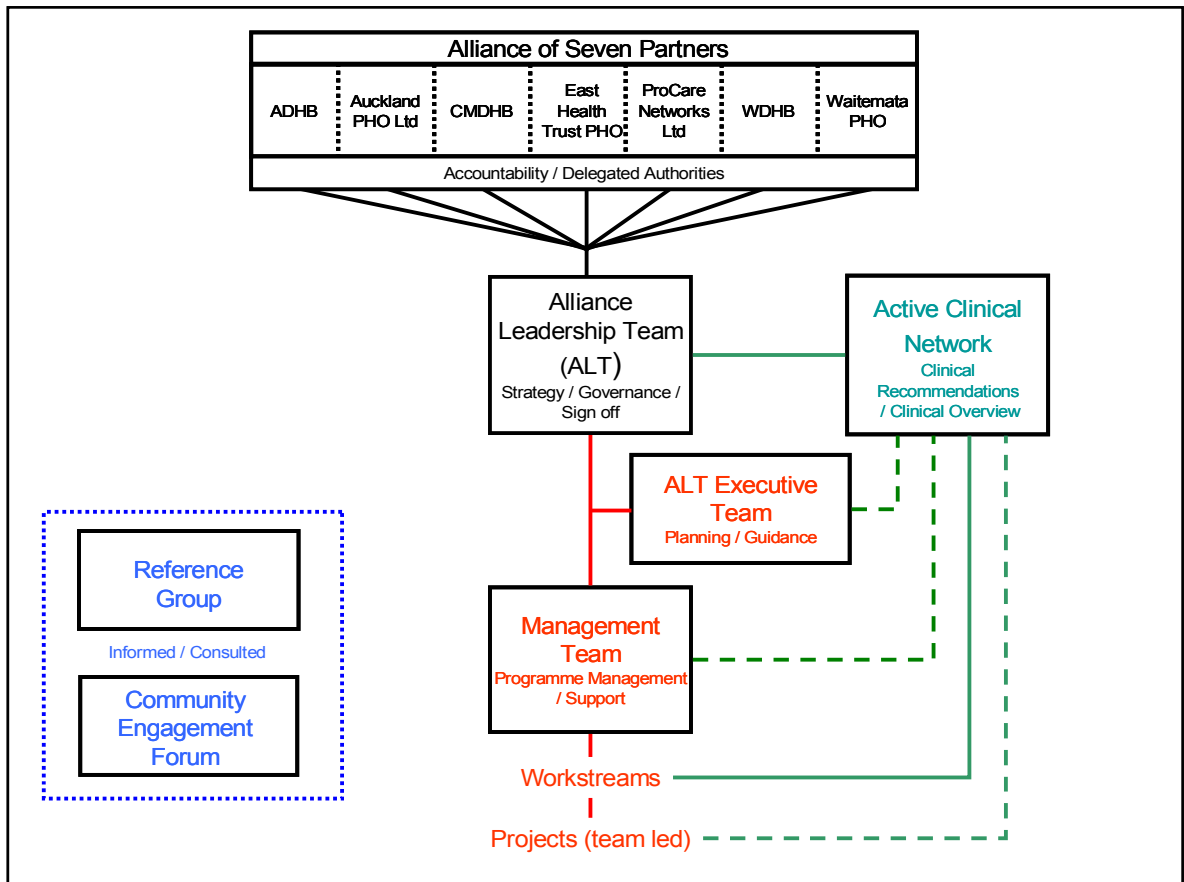
GAIHN is an alliance of seven partners. Due to the independence of the partner organisations, effort has been put into developing a clear understanding of how GAIHN will work effectively to achieve change and implement system improvement. Working arrangements place particular emphasis on:

- § Collaborative working across organisational boundaries to enhance each other's activities
- § Initiatives that focus on prevention as well as response arrangements
- § Targeting of high needs people
- § Initiatives that have the potential to free-up resources that can be used to meet needs that require new investment.

To support this process the GAIHN partners have developed a Charter setting out various 'principles for working together' (see Appendix E)

The alliance partners have also implemented a governance model to ensure that the work programme can be supported and monitored from inception to successful implementation. GAIHN will take responsibility, and be accountable to its partners, for specific projects. The next diagram indicates the key responsibility and accountability arrangements whereby GAIHN ensures that the outlined work programme will be kept 'on track':

**GAIHN governance arrangements: Key lines of accountability**



**Resourcing Model - Top-Down Commitment**

The philosophy of the GAIHN resourcing approach is that alliance partners commit to providing a level of up-front annual resourcing to a pool. This ‘top-down’ resourcing process provides an indicative quantum of the GAIHN alliance resourcing commitment available to fund work streams and projects once those projects pass the ALT approval process.

Each of the GAIHN seven alliance partners have committed in principle to contributing money to the GAIHN Resourcing Pool (GRP):

### Principles Regarding Contributions to the GAIHN Resourcing Pool

Contributions to the GFP will be based on the following principles:

1. Ensuring equity between DHB and PHO partner's contributions
2. Contributions based on an enrolled/domiciled population formula
3. ALT will agree an indicative partner contribution (in \$ terms) to be allocated to the GRP at the beginning of each financial year
4. ALT will manage the expenditure of the GRP
5. ALT will approve funds for projects at key milestones subject to sign off of approved plans
6. Individual project expenditure will be accounted for in a transparent manner
7. Any interest accrued by the GRP will be credited to the GRP
8. Partner organisations will have the option of paying their contribution as
  - a. the full agreed maximum contribution in funds and subsequently billing GAIHN for time spent by staff on GAIHN projects or
  - b. paying a net amount to the GFP consisting of the agreed contribution minus an agree amount for in kind support (staff time).

The indicative total resourcing commitment to the pool for the two years 2011-2013 will equate to approximately \$3 per enrolled patient. The DHBs have pledged to match the contribution of PHO partners which means a GAIHN resourcing pool with a potential maximum value of approximately \$6.8m:

**GAIHN Funding Pool value at \$3 per enrolled population over two years and 2011-12 contribution @ 1.4 / enrolled population**

	Enrolled Population (June 2011)	Equivalent PHO funding commitment at \$3 per enrolled population over 2 years	2011-12 contribution @ 1.4 / enrolled population
Auckland PHO Ltd	52,408	\$157,224	\$73,371
East Health Trust PHO	84,580	\$253,740	\$118,412
ProCare Networks Ltd	803,410	\$2,410,230	\$1,124,774
Waitemata PHO	207,834	\$623,502	\$290,967
<b>Total Enrolled</b>	<b>1,148,232</b>	<b>\$3,444,696</b>	
Auckland DHB (28%)	321,504	\$964,512	\$450,105
Waitemata DHB (43%)	493,739	\$1,481,217	\$691,234
Counties Manukau DHB (29%)	332,987	\$998,961	\$466,181
<b>DHB Contribution</b>		<b>\$3,444,696</b>	
<b>Total Funding Pool</b>		<b>\$6,889,386</b>	<b>* \$3,215,044</b>

\* plus funds carried forward from 2010/11 page 30

## Resourcing arrangements for transferred projects (prior DAP initiatives)

From 1 July 2011, the GAIHN alliance will become directly accountable for four of the regional primary care district annual plan deliverables [Regional DAP initiatives]. These regional DAP initiatives are currently predominantly funded by means of DHB contracts with an activity based resourcing mechanism.

The future GRP resourcing of these GAIHN projects will only include the 'change' aspects of the current DAP initiatives budgets (ie the project management or initiative development) and not the 'service delivery' aspects of the projects. This is sometimes difficult to differentiate for new programmes. For instance:

- § Primary Options of Acute Care funding is excluded from GRP budget but the further development of this initiative is likely to require GRP funding
- § Similarly parts of the Access to Diagnostics work will need to be funded from the GRP.

The current regional DAP initiatives that will be managed as part of the GAIHN work programme in future will include:

- § Access to Diagnostics (Radiology)
  - Aim is to increase the range of diagnostic radiology procedures that
- § Regional Clinical Pathways
  - Aim is to develop and promote clinical pathways to improve care delivery
- § Primary Options of Acute Care (POAC)
  - Aim is to increase the safe management in the community of people's acute care needs thus decreasing the number of avoidable ED presentations and subsequent hospital admissions
- § Optimising prescribing
  - Aim is to improve medicines safety for patients and to improve prescribing quality for providers.

## Ministry of Health Funding Streams

In November 2010, the Ministry of Health (MoH) approved \$419,000 implementation funding support for four specific areas of work as set out in GAIHN's 2010/11 Implementation plan.

### Ministry of Health funding approved 2010

<b>Implementation Funding Support Application</b>	
Item	Funding Approved \$
Acute demand	170,000
Facilitation support	69,000
Inequalities	80,000
Clinical pathways	100,000
<b>TOTAL</b>	<b>419,000</b>

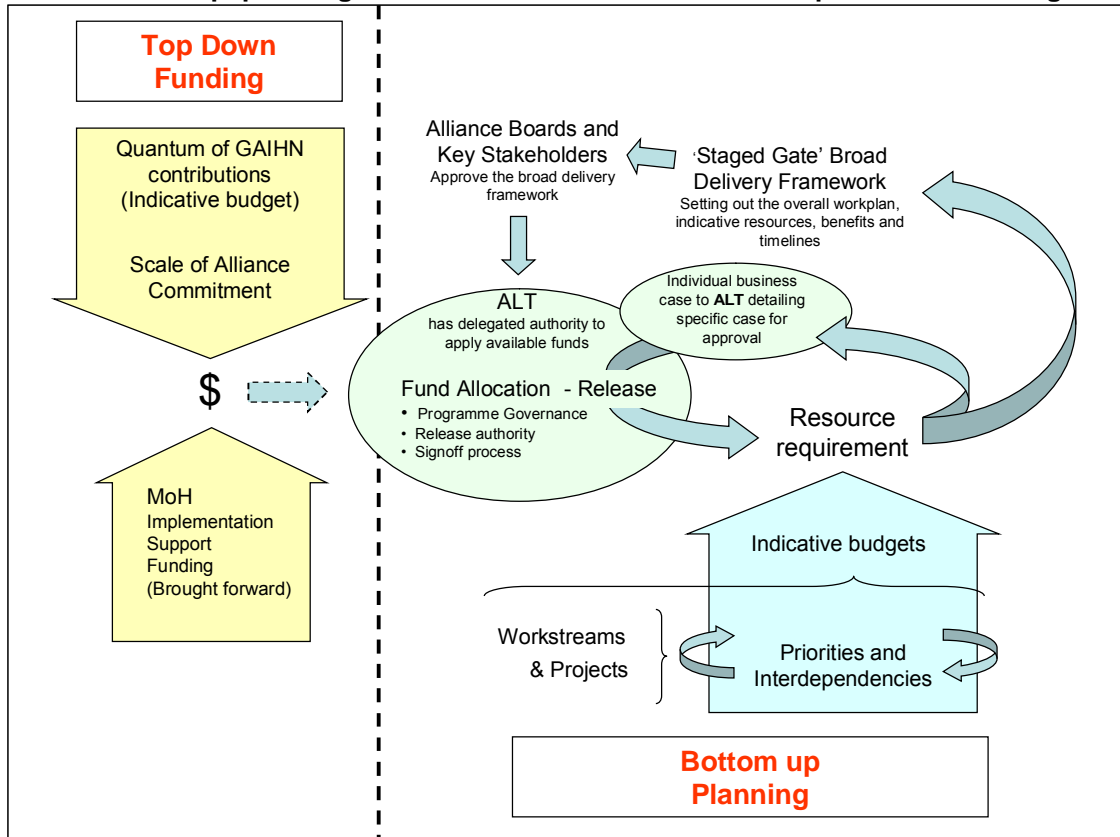
Source: Letter from MoH to GAIHN ALT Team Chair; 19 November 2010

Part of this approved funding is still available (but tagged to the specific outputs). This unspent GAIHN funding is available for future work in relation to the described items. The above table amount will be carried forward and is expected to be approximately \$370,000.

## Resourcing Model – Bottom-Up Planning

Having commitments (in principle) to the indicative 'top-down' resourcing envelope has enabled the 'bottom-up' work programme to be tailored to fit within expected levels of resourcing. The commitment to fund the GRP to the level signalled will give ALT the certainty to proceed with the full work programme.

### The 'bottom-up' planning has been tailored to fit indicative 'top-down' resourcing



### “Stage-Gate” release of Funding

The agreed governance arrangements will enable ALT to manage the allocation and periodic release of funds from the GRP to different stages of each project. The GAIHN work programme demonstrates that the various work streams and projects will be divided into a number of component stages of work (also see Appendix G for a generic seven stage framework for dividing a GAIHN project into stages of work).

The ‘stage-gate’ concept is that ALT will receive a request for approval of each main stage of project work and the release of funding to meet the staged work resource requirement. ALT will sign-off the funding for specific work streams or project stages on receipt of an appropriate case for funding.

The GAIHN Alliance Leadership Team’s considerations will involve assessment of the project at each request for release of funding. The assessment will be made against the following criteria:

- § Quality of execution: Has the previous stage of work been executed in a quality fashion according to plan?
- § Business rationale: Does the project continue to look like an attractive idea from a value perspective (ie is the overall project still likely to deliver effective, economic and efficient outcomes)?
- § Action plan: Are the proposed action plan(s) and the requested resources for the next stage of work available, reasonable and sound?

Based on these criteria the project will be judged by ALT in order to make a decision with one of three results:

- § Go : Approve funding as requested
- § No Go : Stop the project and disband the team
- § Hold: temporarily stop the work (for example pending greater clarity upon the next stage of work).

To support this assessment ALT will be presented with a funding request by the GAIHN Programme Director and GAIHN Project Manager. The funding request will consist of two main elements: '*Deliverables,*' and '*Next Stage Funding Approval Request*'.

§ **Deliverables:** What the project manager and team have delivered so far (ie to this current decision point). This will report the status of project progress against the deliverables decided at the commencement of the completed stage of work, highlighting any variations from the original plan or issues faced.

§ **Next Stage Funding Approval Request:** A project action plan detailing

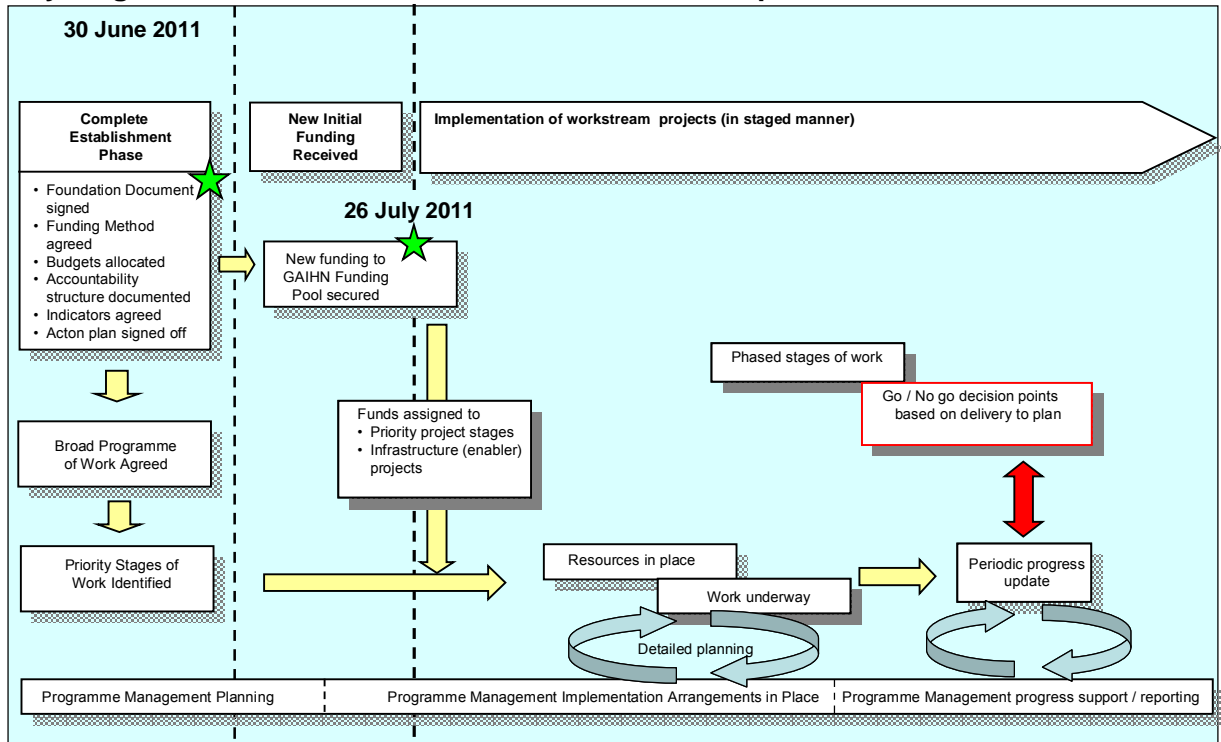
- The plan for next stage of work, including
  - § a list of next stage deliverables
  - § resource requirements for the next stage
  - § date proposed for the next funding request
- Status against overall project objectives including
  - § Risk analysis and any changes to the last overall risk report status for this project.

## Transition from Establishment Phase to Implementation Phase

GAIHN is now in transition from the 'Establishment Phase', (with a focus on governance, infrastructure and programme management arrangements for a potential programme of new work) to the 'Implementation Phase', (with a focus on assigning additional resources to specific new tasks and driving achievement of identified objectives and outcomes). During this period GAIHN has received some resourcing for certain project work already underway and the regional DAP initiatives have also been progressing with secure funding streams.

The securing of new funds to the GRP is a critical step between the two phases of work. Resources for the existing and new projects (and the related project-team-led planning work), can only be progressed once the resourcing is available within the GRP.

## Key stages in the Transition from Establishment to Implementation Phase



## Resource requirement

Ongoing commitment from the GAIHN alliance partners to the expected 'top-down' resourcing contributions to the GRP is important to provide the confidence to deliver the full programme of work outlined in this paper.

Of equal importance is the phasing of the resourcing requirement. This phasing has been identified as part of the 'bottom-up' planning of work. The table below presents the seven work stream budget requirement. It is based on the indicative phasing of the work to provide an indication for the total resourcing requirement in each quarter of 2011/12.

This phased resourcing shows when the funding will be required to enable the plans outlined in this document to proceed according to schedule.

The total phased work stream budget (shown here at \$3.9m) represents 56% of the total indicative top-down resourcing of \$6.8m.

**GAIHN Estimated Budget Spread 2011/12 (23/6/11)**

2011/12 FY Work stream	Q1	Q2	Q3	Q4	Annual Funding Requirement
WS 1	45,000	66,000	66,000	43,000	220,000
WS 2	60,000	90,000	80,000	50,000	280,000
WS 3	261,900	559,100	559,100	489,000	1,869,100
WS 4	0	22,500	45,000	82,500	150,000
WS 5	197,625	197,625	197,625	197,625	790,500
WS 6	100,000	182,000	169,500	98,500	550,000
WS 7	0	10,000	10,000	15,000	35,000
<b>Total</b>	<b>664,525</b>	<b>1,127,225</b>	<b>1,127,225</b>	<b>975,625</b>	<b>3,894,600</b>

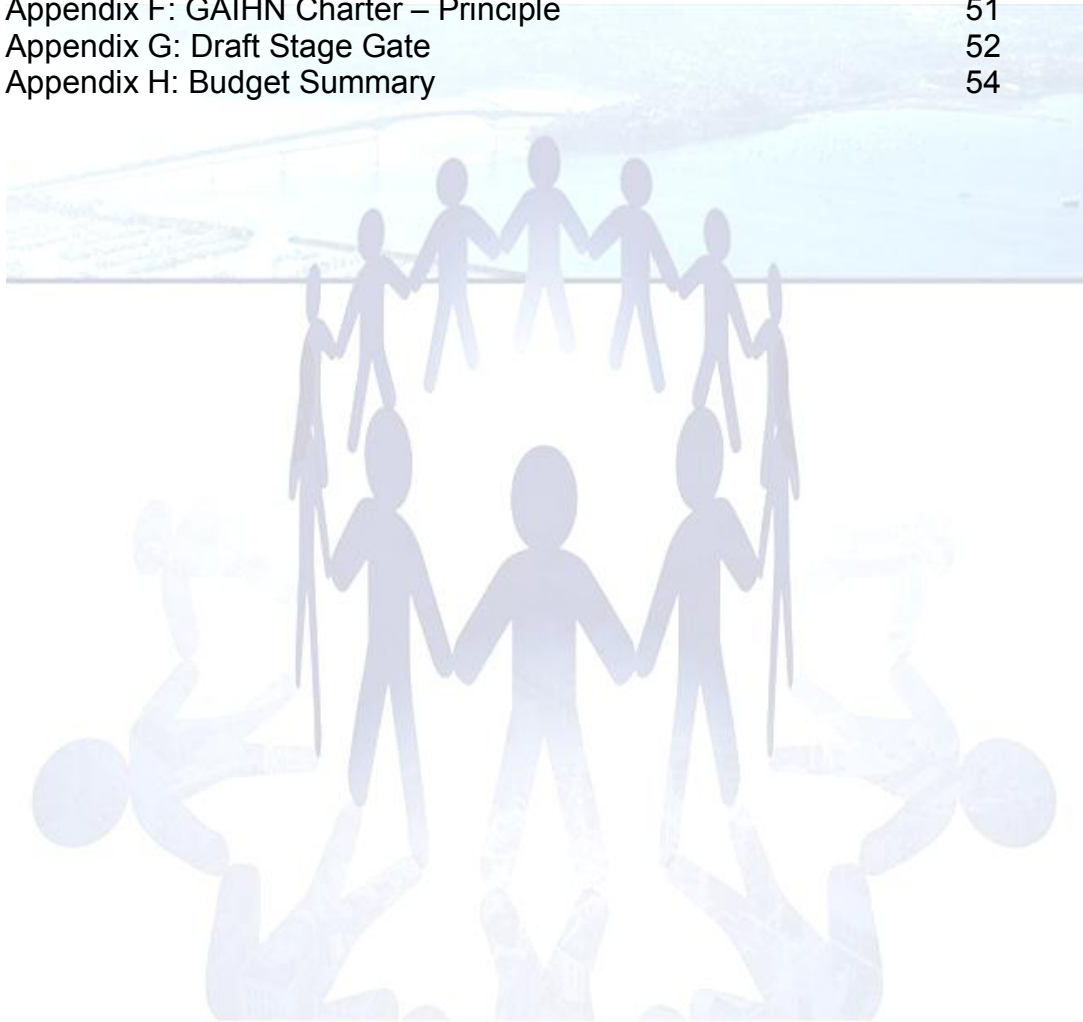
The immediate resourcing requirement is to ensure that each project is populated by the right people to ensure its success. Sufficient funds will be in hand at 1 July to enable the GAIHN Programme to continue for the first three months. For Q2 – Q4 GAIHN partners will be asked to contribute resources ALT approved projects, within the overall funding ceiling.

**GAIHN is seeking**

- § Alliance Partner commitment to the overall programme of work and phased resourcing as outlined in the table above.
- § Approval of project management resourcing to enable the first three months of GAIHN work to be put in place
- § Approval to continue with existing projects commenced in 2010/11 year.

## Appendices

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**Appendix A: Context – demand growth and other challenges  
(Extracts from the Northern Regional Health Plan)**

**A  
growing and  
aging population**

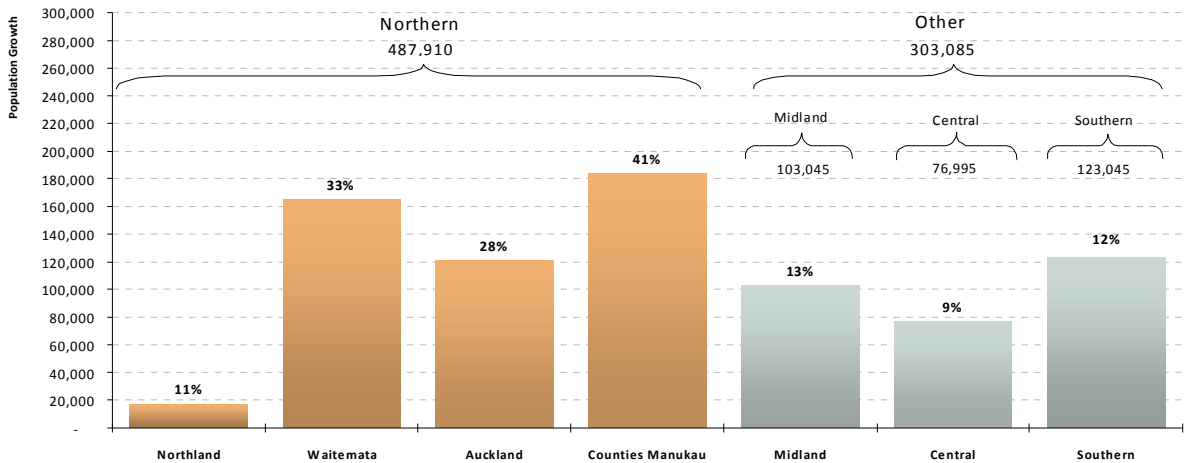
**Managing Growth**

Demand for health care services, and particularly acute care, is predicted to exceed population growth and therefore the level of health care resources. Our population is younger than other regions, but we still have the fastest rate of growth in the 65+ age group. Growth is not uniform across the region, some population groupings, such as the 65+ age group, are likely to generate disproportionate demand for health services. Revised and new models of care must be developed and implemented to sustain the health system.

We serve a population of 1.6m but our population is growing at a rate much higher than elsewhere in NZ:

- Over the next 20 years the Northern Region population growth will account for two out of every three additional people in New Zealand
- The scale of regional population growth expected over this period is greater than the current population of any other DHB.

**Population Change 2006 - 2026**



**Demographic changes will generate significant demand for health services**

The expected demographic changes will generate additional demand for health services in the Northern Region due to:

- Significant health needs of the growing Maori, Pacific and new immigrant populations
- High birth rates: The region accounts for 40% of all births in New Zealand, and the Total Fertility Rate for Northland and Counties Manukau DHBs is significantly higher than the national average
- High growth in the 65+ age groups: This is significant because this age group is strongly associated with high admission rates and longer lengths of stay.
- Ongoing and increasing demand associated with the leading causes of morbidity and mortality in our region : cancer, cardiovascular disease and diabetes

**Other trends also affect demand for certain services**

In addition to the demographic driven growth in demand it is apparent that demand for certain services is growing at a rate significantly higher than the population growth. The services which are experiencing the greatest pressure are those which are focused on providing care for people with chronic diseases particularly Diabetes and CVD and those services which cater specifically for the elderly. The services with high demand include Emergency Departments, acute medicine and surgical services, radiology, cancer and cardiology.

Demand growth for home based support services and aged residential care services has been tracking around 6-7% annually which is nearly double demographic growth. Of the Northern Region's older population, 11.6% access Home Based Support Services and 6% live in aged residential care facilities.

Demand is also impacted by repatriation of specific services between DHBs. This is particularly so for Waitemata DHB.

**Better Sooner More Convenient Services**

Delivery of care is fragmented between primary and secondary services and is based around an episodic model of care which does not work well for people with long term and complex conditions. Access to service is variable with disparities in intervention rates for elective procedures across the region. New innovative, patient centered and integrated models of care are required which in some instances will require regional service models to be deployed and in other instance will require greater emphasis on local delivery which will involve repatriation and devolution of services.

**Quality and Patient Safety**

There are substantial human and financial costs to our community associated with failures in health and disability services. It is estimated that nearly 13% of hospital admissions involve some form of harm caused by medical treatment and that more than a third of these are preventable.

There is compelling evidence that fully integrated health systems significantly improve the delivery of care for patients and will improve access, quality of life and health outcomes at the same time as reducing costs.

Improving the patient journey through the system and addressing issues relating to patient safety across all health services will be key drivers of future models of care.

**Improving our patients' experience is a key strategic driver going forward**

## Appendix B: Work stream and project detail

### GAIHN-Accountable Projects and Timetable 2011/12

#### Year one goal:

***Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions***

#### 2011/12 work streams aimed at delivering the goal above:

##### 1. Better Management of Targeted Individuals

- a. Identify individuals (enrolled and non enrolled) at high risk of acute events
- b. Encourage and facilitate individuals to enrol with a primary care provider (medical home) if they currently do not have one
- c. Ensure the primary care provider is aware of their enrolled high-risk patients
- d. Support the primary care provider in providing an individual care programme for their enrolled high-risk patients.

##### 2. Better Primary Response to Acute Events

- a. Building the capability of the primary/community sector to manage acute episodes through planning and implementing improvements to a range of options including:
  - i. Triage
  - ii. Primary Options for Acute Care (POAC)
  - iii. Same day and urgent access to medical home
  - iv. After hours availability
  - v. Better management of self referrals
  - vi. Others as necessary.

##### 3. Enablers of Better Individual Care

- a. **e-Practice:** Integrating the multiple initiatives relating to electronically enabled best practice including:
  - i. Access to Diagnostics
  - ii. Clinical Pathways
  - iii. Optimising Prescribing
  - iv. E-Referrals
  - v. E-Shared Care Planning
  - vi. Advance Care Planning.
- b. **Locality infrastructure** including the accessibility of specialist services and infrastructure to support ensuring effective linkages with Local Health Networks (LHN) e.g. Community Health Hubs (CCH)
- c. **Specialist support:** Ensuring that the specialist support services needed to support enhanced primary care are developed including:

- i. **Specialist services required in clinical pathways**
- ii. **Access to Diagnostics**
- iii. **Nursing Development Project**
- iv. **Community Specialist Clinics**
- v. **Advanced Care Planning**
- vi. **Optimising Prescribing Project (clinical pharmacist support).**

- d. **New models of care:** Where appropriate, develop new organisational guidelines for models of care for people with long term conditions (LTC) in support of work streams 1 & 2 above.

#### **4. Population Prevention Programmes**

Programmes to enhance community awareness and better self/whanau care to prevent or response to acute events including:

- a. Smoking cessation in primary care
- b. Cellulitis, prevention/early intervention
- c. Stroke
- d. Falls prevention
- e. Others

#### **5. Alliance Support & Development**

- a. All normal Management Office functions including: alliancing contracting, communications and engagement, funding partner capability building.

#### **6. Systems Improvement (Provider Arrangements)**

- a. Information project developing a better understanding of the drivers of acute demand.
- b. Redesigned incentives and contracting.
- c. Workforce development (currently not under consideration but needs to be)

#### **7. Child Health Improvement Project**

- a. Incorporation of child health equity issues into 2011/12 focus on better management of acute events
- b. Development and planning for 2012/13 roll out

#### **Work Stream/Project Outlines**

The project outlines below will be subject to refinement by the ALT and Project Teams.

### Work Stream 1: Better Management of Targeted Individuals

Project Outline	<p><b>Identify individuals with a high risk of acute presentations to ED's (enrolled and non enrolled)</b></p> <p><b>Encourage and facilitate individuals to enrol with a primary care provider (medical home) if they currently do not have one.</b></p> <p><b>Ensure the primary care provider is aware of their enrolled high-risk patients.</b></p> <p><b>Support the primary care provider in providing an individual care programme for their enrolled high-risk patients.</b></p>												
Contribution to GAIHN goal	<p>Identification of individuals at high risk of acute events which could potentially lead to hospital admission.</p> <p>Assignment of these individuals to a primary care coordinator to plan and arrange care programme to reduce the likelihood of acute events.</p>												
Milestones/deliverables (provisional)	<p><i>Key Milestones (aligned to ALT agenda deadlines)</i></p> <ul style="list-style-type: none"> <li>§ Agree risk stratification methodology (and tool development) by September 2011</li> <li>§ Identify targeted individuals at high risk of an acute event and assign to practices by November 2011</li> <li>§ Assign primary care coordinators by November 2011 who will plan and arrange the care programme to reduce the likelihood of acute events;</li> <li>§ Support the primary care provider in providing an individual care programme for their enrolled high-risk patients;</li> </ul> <p><i>Targets</i></p> <ul style="list-style-type: none"> <li>§ Enrol 2500 patients by March 2012</li> <li>§ Care plans and support services in place for &gt;5,000 targeted individuals by June 2012</li> <li>§ &gt;10% Reduction in number of admissions; and bed days usage of targeted individuals.</li> </ul>												
Project leadership	<p><b>Project lead:</b> Kylie Ormrod</p> <p><b>Clinical lead:</b> Harley Aish</p> <p><b>Team membership:</b> Small design/implementation team of 4-5 people. Members approved by ACN. (include PHO managers responsible for implementing this work)</p>												
Estimated costs (11/12)	<table> <tr> <td>Project management:</td> <td>\$90,000</td> </tr> <tr> <td>Clinical release time:</td> <td>\$40,000</td> </tr> <tr> <td>Specialist advice:</td> <td>\$50,000</td> </tr> <tr> <td>IT costs</td> <td>to be determined</td> </tr> <tr> <td>Team member reimbursement:</td> <td>\$40,000</td> </tr> <tr> <td>Total:</td> <td>\$220,000</td> </tr> </table> <p><i>Note: There is likely to be a service delivery cost associated with the assignment of individual care coordinators. Estimate \$1.4m with an assumption that it will be sourced from existing funding such as Care Plus funding.</i></p>	Project management:	\$90,000	Clinical release time:	\$40,000	Specialist advice:	\$50,000	IT costs	to be determined	Team member reimbursement:	\$40,000	Total:	\$220,000
Project management:	\$90,000												
Clinical release time:	\$40,000												
Specialist advice:	\$50,000												
IT costs	to be determined												
Team member reimbursement:	\$40,000												
Total:	\$220,000												
Revenue sources	GFP												

Interdependencies	Locality planning within DHB's. Regional Nursing & Allied Health Project IT costs may be associated with this project.
Risks	<i>Defining/agreeing risk stratification tool in a short timeframe</i> Mitigation: early discussion between DHB officers, PHO representatives & Active Clinical Network (ACN). <i>Lack of work force capacity</i> Mitigation: Early discussion with PHO's, Nursing and Allied Health Work stream to anticipate requirements. <i>Lack of incentive to provide enhanced primary care to target group.</i> Mitigation: Enhance support from specialist support services. Redesign incentives (see work stream 3, 6.3).

### Work Stream 2: Better Primary Response to Acute Events

Project	<b>Improving the breadth &amp; range of options available for managing acute responses in primary care.</b> <b>Includes:</b> <ul style="list-style-type: none"> <li>• <b>Community based triage</b></li> <li>• <b>Broadening the scope of primary options</b></li> <li>• <b>Same Day and urgent access to Primary Care/Medical Home</b></li> <li>• <b>After hours service availability (Currently being lead by CCA)</b></li> <li>• <b>Others as necessary</b></li> </ul>
Contribution to GAIHN goal	All patients will have appropriate access to triage in the community reducing the number of people who present to ED without prior triage.  More patients will have access to a broader range of options to deal with acute events in the community (reducing the number who need acute hospitalisation)
Milestones/deliverables	<i>Key Milestones (aligned to ALT agenda deadlines)</i> <ul style="list-style-type: none"> <li>§ Complete data analysis and volumes to establish baseline for 'self presenters' to ED July 2011</li> <li>§ Review outcome of MMH study "What brought you to ED today?" to identify the reasons and possible solutions to ED self presentation – August 2011; Appropriate range of triage services agreed and available by September 2011</li> <li>§ Ability to measure and report percentage of patients presenting to ED who have had prior triage by November 2011</li> <li>§ Telephone triage service(s) holds after-hours plans for each GAIHN practice by November 2011</li> <li>§ Public education/media campaign and resources available to promote use of triage services as alternative to ED – November 2011</li> <li>§ Broadening of POAC - description of the range of alternative community options for acute care available and in place by December 2011 for piloting before year end.</li> </ul>

	<p>§ Draft 2012-13 DAP content finalised including POAC volumes by January 2012</p> <p>§ Final 2012-13 plan for the development of community options for acute care signed off by ALT February 2012</p> <p>§ Increasing POAC volumes by 20% from 15,000 to 20,000 by June 2012.</p>
Project leadership	<p><b>Project lead:</b> Alison McPhee (tbc),  <b>Clinical lead:</b> Campbell Brebner  <b>Steering group:</b> Barbara Stevens, Loretta Hansen, John Ross, Ron Hooton, Stuart Jenkins</p> <p><b>Sub work stream: Broadening Primary Options:</b>  <b>Clinical Lead:</b> Campbell Brebner  <b>Project Lead:</b> Deana Williams?</p>
Estimated costs (11/12)	<p>Project Management: \$120,000  Clinical release time: \$ 20,000  Specialist advice: \$ 40,000  Reimbursement for team members: \$100,000  Total: \$280,000</p> <p><i>Note: Project costs will be subject to agreed business case approval by ALT and stage gate funding release process.</i></p>
Revenue sources	GFP
Interdependencies	DAP planning timeframes.

### Work Stream 3: Enablers of Better Individual Care

There are three sub work streams within this area:

- a) e-Practice
- b) Locality infrastructure
- c) Specialist support
- d) New models of care

Sub work stream 3a	<p><b>e-Practice: Integrating the multiple initiatives relating to electronically enabled best practice including:</b></p> <ol style="list-style-type: none"> <li>i. Access to Diagnostics</li> <li>ii. Clinical Pathways</li> <li>iii. Optimising Prescribing</li> <li>iv. E-Referrals</li> <li>v. E-Shared Care Planning</li> <li>vi. Advance Care Planning.</li> </ol>
Contribution to GAIHN goal	These processes will enable better care of the targeted individuals identified in work stream 1 and patients who have acute events (work stream 2) so that fewer events occur or lead to avoidable hospitalisations.
Milestones/deliverables	<p><i>Key Milestones (aligned to ALT agenda deadlines)</i></p> <p>§ Development of an integrated overview of all of the activities relevant to e-enabled primary care practice by September 2012 Advocacy Plan (if relevant) including options for development of integrated e-practice by November 2011.</p>
Project leadership	<p><b>Project lead:</b> David Tucker (interim)  <b>Clinical lead:</b> Jeff Garrett  <b>Team membership:</b> John Vendrig, Stuart Jenkins,</p>

	Graeme Osborne										
Estimated costs (11/12)	<table> <tr> <td>Project Management:</td> <td>\$100,000</td> </tr> <tr> <td>Clinical release time:</td> <td>\$ 50,000</td> </tr> <tr> <td>Specialist advice:</td> <td>\$100,000</td> </tr> <tr> <td>Reimbursement for team members:</td> <td>\$ 20,000</td> </tr> <tr> <td>Total:</td> <td>\$270,000</td> </tr> </table> <p><i>Note: Capital costs will be dependent on the scope and nature of respective initiatives.</i></p>	Project Management:	\$100,000	Clinical release time:	\$ 50,000	Specialist advice:	\$100,000	Reimbursement for team members:	\$ 20,000	Total:	\$270,000
Project Management:	\$100,000										
Clinical release time:	\$ 50,000										
Specialist advice:	\$100,000										
Reimbursement for team members:	\$ 20,000										
Total:	\$270,000										
Revenue sources	GFP										
Interdependencies	DAP planning timeframes Clinical Pathways Project Access to Diagnostics Project Optimising Prescribing Project Regional Nursing and Allied Health Advance care planning e-Referrals.										

**Sub Work Stream 3b: Locality infrastructure including the accessibility of specialist services and infrastructure to support ensuring effective linkages with Local Health Networks (LHN) e.g. Community Health Hubs (CCH).**

This will require on going collaboration of PHO's and DHB's and effective linkages between LHN and GAIHN's patient centred care approach to ensure that collaborative relationships between local expert providers are better integrated.

**Watching Brief:** David Tucker

**Sub Work Stream 3c: Specialist support** - Ensuring that the specialist support services needed to support enhanced primary care are developed including:

- i. Specialist services required in clinical pathways
- ii. Access to Diagnostics
- iii. Nursing Development Project
- iv. Community Specialist Clinics
- v. Advanced Care Planning
- vi. Optimising Prescribing Project (clinical pharmacist support).

Project	Regional Clinical Pathways
Contribution to GAIHN goal	Development and implementation of regionally agreed clinical pathways that directly contribute to the GAIHN goal will ensure that care is delivered in the right place by the right clinicians across the primary-specialist continuum.
Milestones/deliverables	<p><i>Key Milestones (aligned to ALT Agenda deadlines)</i></p> <ul style="list-style-type: none"> <li>§ Project re scoped to ensure a direct focus on supporting the delivery the goal and evaluation of the work to date and plan for full implementation by August 2011</li> <li>§ 6 pathways (could be subject to variation by ALT) fully implemented including the four pathways developed in 2010/11 by June 2012</li> <li>§ As part of work stream 3a, investigate electronic solutions and complete a business case for preferred options by March 2012</li> </ul>

Project leadership	<b>Project lead:</b> Kris Vette <b>Clinical lead:</b> Jeff Garrett <b>Steering group:</b> Existing Team
Estimated costs (11/12)	\$732,100 in bid, needs clarification during re-scoping
Revenue sources	GFP
Interdependencies	e-Practice project Access to Diagnostics Project
Risks	<i>Lack of capital funding for IT requirements</i> Mitigation: Ensure appropriate bids in the system on time. Effective advocacy to the appropriate people.

Project	<b>Access To Diagnostics – Radiology</b>
Contribution to GAIHN goal	More timely and direct access to diagnostic radiology for GP's. This will result in quicker diagnosis for patients and a reduction in referrals that do not meet the clinical triage criteria to the hospital system.
Milestones/deliverables	The rate of referrals that do not meet the clinical triage criteria from GPs to radiology are less than or equal to 20% by the June 2012 (currently up to 35%).  The volume of DHB-funded GP-requested diagnostic radiology procedures performed in the community will increase by 10%, on 2010/11 volumes by June 2012  Through engagement with primary and secondary clinicians, agree an appropriate target for waiting times for routine imaging and report performance against the target for Metro Auckland DHBs from January 2012.
Project leadership	<b>Project lead:</b> Lara Sedcole <b>Clinical lead:</b> Donald Mackie (will change) <b>Steering group:</b> Existing Team
Estimated costs (11/12)	\$ 802,000 (will require further separation of costs of further development and monitoring (GAIHN) from implementation and service delivery (arrangements by individual DHB approximately \$500,000)
Revenue Sources	GFP
Interdependencies	e-Referrals project Clinical Pathways Optimising prescribing.

Project	<b>Pharmaceuticals, Optimising Prescribing</b>
Contribution to GAIHN goal	More effective and efficient prescribing by clinicians  Improvements in patient safety, reductions in acute episodes of care related to suboptimal use of medications  Focus on poly-pharmacy in patients at high risk of acute or unplanned admission to hospital  Improve health literacy, especially for high needs patients around the use of medicines to improve health outcomes from medicines prescribed for LTC.  Possible savings available for redirection resulting from

	<p>increased efficiencies</p> <p>Improvements in the quality of prescribing by clinicians leading to improvements in patient safety, reductions in acute episodes</p> <p>Possible savings available for redirection resulting from increased efficiencies</p>
Milestones/deliverables	<p>On going, to June 2012</p> <ul style="list-style-type: none"> <li>§ Improved medicines safety through reduced poly-pharmacy</li> <li>§ Simpler medication regimens especially for patients with multiple LTC</li> <li>§ Less risk of harm through unnecessary medications left in homes through addressing prescription wastage</li> </ul>
Project leadership	<p><b>Project lead:</b> Keith Crump</p> <p><b>Specialist advisor:</b> Paul Roseman</p> <p><b>Team membership:</b> Existing team</p>
Estimated costs (11/12)	<p>\$600,000 *</p> <p>Incentive (savings) components of this initiative still being negotiated in addition to direct costs.</p> <p><i>* not included in budget estimate</i></p>
Revenue sources	Savings generated by project
Interdependencies	All acute demand management work
Risks	<p>Unusual or unplanned activity undertaken by Pharmac to reduce efficiencies</p> <p>Epidemic, natural disaster or other change in the overall requirement for medicines not related to the programme.</p>

**Sub Work Stream 3d - New models of care** - Where appropriate, develop new organisational guidelines for models of care for people with long term conditions (LTC) in support of work streams 1 & 2 above.

Project	<b>Develop new organisational guidelines for models of care for people with long term conditions (LTC) in support of work streams 1 &amp; 2 above.</b>
Contribution to GAIHN goal (11/12)	<p>Measureable reduction in avoidable acute admissions to EDs for people with LTC in selected localities.</p> <p>A shared understanding across metro Auckland of guidelines for care of people with LTC.</p> <p>A greater proportion of people with LTC are effectively managed in community settings by appropriately qualified practitioners.</p>
Milestones/deliverables	<p><i>Key Milestones</i></p> <ul style="list-style-type: none"> <li>§ New models of care including self management models are trialled in selected localities by June 2012</li> <li>§ New organisational models of care guidelines adopted as the standard for implementation across Metro Auckland by June 2012.</li> </ul>
Project leadership	<p><b>Project lead:</b> tbd</p> <p><b>Clinical lead:</b> tbd</p> <p><b>Team membership:</b> tbd</p> <p><i>Note: Leadership not an urgent priority for 1 July</i></p>
Estimated costs (11/12)	<p>Project management: \$45,000</p> <p>Clinical release time: \$10,000</p>

	Independent expert advice: \$10,000 Total: \$65,000
Revenue sources	GFP
Interdependencies	Local Health Networks Nursing and Allied Health.
Risks	<i>Possible lack of work force capability needed to deliver</i> Mitigation: Early identification of workforce requirements.

**Work Stream 4: Population Prevention Programmes  
(Commencing Post 1 July subject to ALT approval)**

Project	<b>Programmes to enhance community awareness and better self/whanau care to prevent or response to acute events including:</b> <b>Smoking cessation in primary care</b> <b>Cellulitis, prevention/early intervention</b> <b>Stroke</b> <b>Falls prevention</b> <b>Others.</b>
Contribution to GAIHN goal	Fewer patients smoking thereby reducing the risk of acute episodes Increased awareness amongst high risk individuals and others of the preventative strategies necessary to prevent acute events occurring.
Milestones/deliverables	<i>Key milestones (aligned to ALT agenda deadlines)</i> § Stock take of Smoking Cessation services completed by August 2011. Plan for extended services by 31 October. § Resources for patients available at practices 18 November 2011 § Service directory for smoking cessation made available to practices October 2011 § Review evidence re Cellulitis prevention campaign (note that past Glen Innes Pilot was successful) by September 2011 § Design publicity and resources for targeted suburbs/localities with high incidence of Cellulitis admissions November 2011. § Work with Heart Foundation to promote CVD risk screening and “know your numbers” by January 2012 § Aim for 80% CVD Risk assessment coverage of high risk groups by June 2012.
Project leadership	<b>Work stream lead:</b> tbd, post 1 July <b>Project leads:</b> <b>Smoking Cessation:</b> tbd <b>Stroke:</b> Rex Paddy <b>Cellulitis:</b> tbd <b>Falls Prevention:</b> tbd <i>Note: leads do not need to be determined before 1 July 2011.</i>
Estimated costs (11/12)	\$150,000
Revenue sources	GFP
Interdependencies	Clinical pathways Better management of targeted Individuals.

### Work Stream 5: Alliance Support & Development

Project	<b>Programme Management and Support (GAIHN Operations)</b>
Contribution to GAIHN goal	Stakeholders supported in the delivery of the GAIHN Programme through the following: Work streams implemented to time cost and quality. Stakeholders engaged in and informed about GAIHN programmes. Alliance governance & project structure supported.
Milestones/deliverables	2011/12 GAIHN Programme approved by ALT funding commitment secured from partners, appropriate alliancing documentation signed by July 2011.  Key deliverables will include hitting milestones for this plan and also completion of 2012-13 planning documents in time to inform Alliance Partners Draft Plans for 2012-13 (ie draft plans by January 2012 (initial indicative recommendations by December 2011 or specific detail for inclusion in plans by March 2012)).
Project leadership	<b>Independent Chair ALT:</b> Ray Naden: <b>Programme Director:</b> David Tucker <b>Project Support &amp; Communications:</b> Kirsty Hunter
Estimated costs (11/12)	\$790,500
Revenue sources	GFP
Interdependencies	All GAIHN related activity
Risks	Heavy reliance on secondments and influence to achieve outputs rather than traditional line management. Partner organisations can recall seconded staff away from GAIHN activity. Limited capability for 2 support people to deliver comprehensive support across a wide ranging set of initiatives. Mitigation: Ensure that appropriate agreements are in place to secure staff, funding and commitment from partners.

### Work Stream 6: Systems Improvement (Provider Arrangements)

Projects (all interrelated)	<ol style="list-style-type: none"> <li>1. <b>Information gathering: Better understanding the drivers of acute demand</b></li> <li>2. <b>Programme indicators agreed</b></li> <li>3. <b>Redesigned Incentives, Contracting &amp; (Re)Investment Process</b></li> </ol>
Contribution to GAIHN goal	The above cluster of interrelated projects will contribute to the goal in the following ways:  Better informed intervention logic and shared understanding for all GAIHN initiatives especially the proposed changes to the contracting environment.  Stakeholders will achieve a shared & robust understanding of the drivers behind ED presentations in Metro Auckland.

	<p>GAIHN Programme will be monitored and adjusted accordingly in furtherance of achieving the goal.</p> <p>Will enable changes to pathways to yield greatest results in reducing ED presentations</p> <p>Improved ways of providing primary care are contracted for and incentivised so that they are adopted and therefore effective in producing better outcomes for patients.</p> <p>Resources saved or freed up from acute hospitalisations are redirected to effective care options.</p> <p>Investment is more clearly divided to services which achieve the greatest benefit for patients, particularly those with high needs</p>
Milestones/deliverables	<p><i>Key Milestones (aligned to ALT agenda deadlines)</i></p> <ul style="list-style-type: none"> <li>§ Performance baseline established for acute demand by July 2011</li> <li>§ Performance forecast counterfactual established and agreed by August 2011</li> <li>§ GAIHN population performance reporting established by September 2011</li> <li>§ PHO datasets and regular distribution established by October</li> <li>§ Practice level reporting in place by November 2011</li> <li>§ Return on Investment formula established and agreed by December 2011</li> <li>§ Incentives contract agreed by March 2011</li> <li>§ Roll-out of education and training plan once the detailed work programme for intervening has been determined.</li> </ul>
Project leadership	<p><b>Project leads:</b></p> <p><b>1 - Information Gathering</b>  <b>Project lead:</b> Kylie Ormrod  <b>Clinical lead:</b> Paul Roseman  <b>Team membership:</b> Former ADM CAT Team (interim)</p> <p><b>2 - Programme Indicators:</b>  <b>Project lead:</b> Kylie Ormrod  <b>Clinical lead:</b> Paul Roseman  <b>Team membership:</b> Existing ADM CAT (interim)</p> <p><b>3 - Redesigned Incentives, Contracting and Reinvestment</b>  <b>Project lead:</b> Possible consultant/contractor to maintain independence possibly a commercial or legal expert  <b>Clinical lead:</b> tbd  <b>Team membership:</b> tbd  <b>Clinical mead:</b> tbd</p> <p><b>Initial Establishment group:</b> Peter Didsbury, Stuart Jenkins, Jonathon Simon, David Tucker to determine capability requirements and report to ALT August 2011.</p>
Estimated costs	<b>Project 1: Information Gathering (commenced)</b>

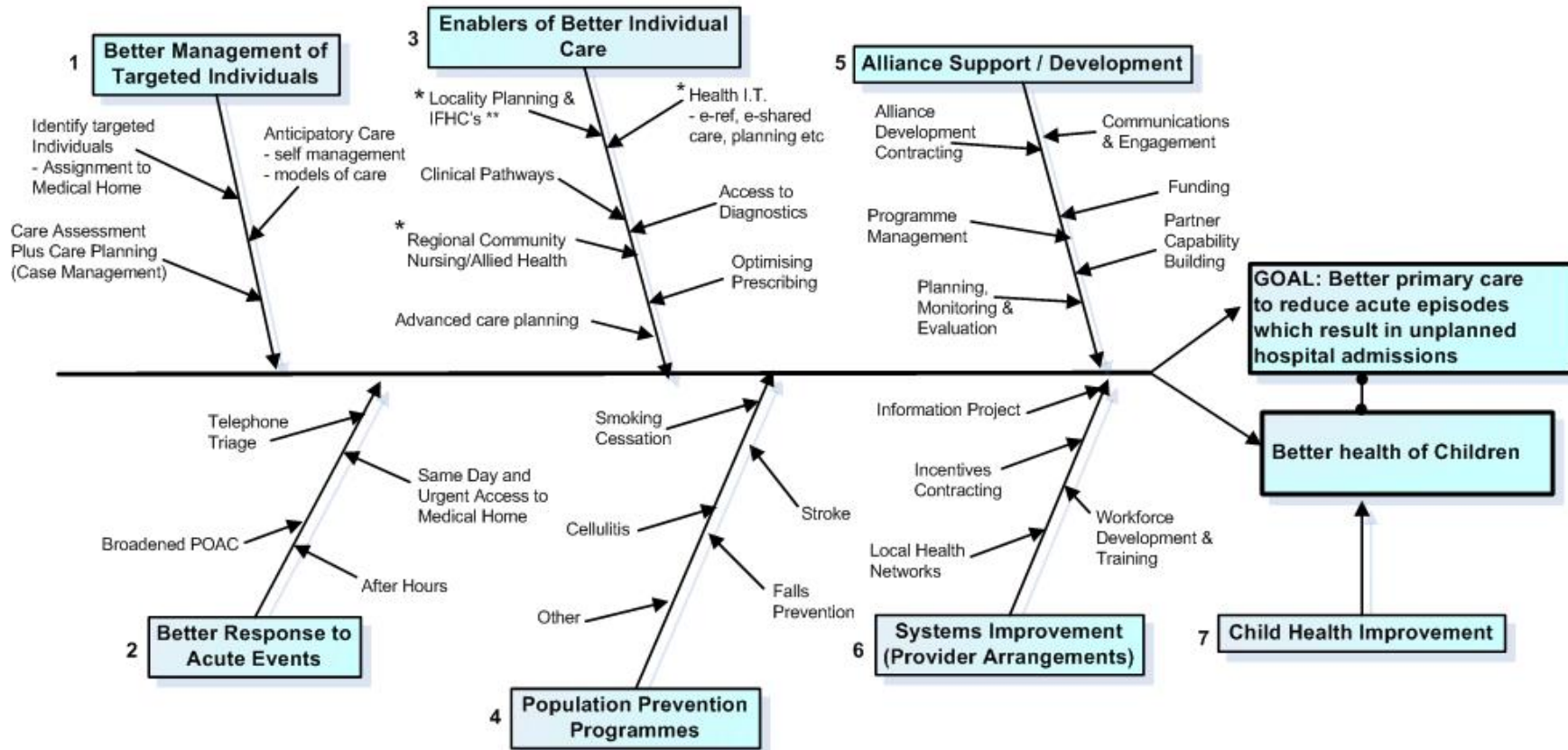
(11/12) & revenue sources	<p><b>2010/11</b>  Projects 1 &amp; 2 are partially funded by the MoH funding of \$170,000 received in 2010/11</p> <table> <tr> <td>Project Management:</td> <td>\$ 30,000</td> </tr> <tr> <td>Professional Advice:</td> <td>\$110,000 (check KO)</td> </tr> <tr> <td>Clinical Release time:</td> <td>\$ 10,000(will increase)</td> </tr> <tr> <td>Total</td> <td>\$150,000</td> </tr> </table> <p><b>Project 2: Programme Indicators (underway 16/6/11)</b></p> <table> <tr> <td>Project Lead:</td> <td>\$30,000</td> </tr> <tr> <td>Professional Advice:</td> <td>\$75,000 Clinical</td> </tr> <tr> <td>Release time:</td> <td>\$10,000</td> </tr> <tr> <td>Total:</td> <td>\$115,000</td> </tr> </table> <p><b>Project 3: Redesigned Incentives Contracting and Reinvestment</b></p> <table> <tr> <td>Professional advice:</td> <td>\$250,000</td> </tr> <tr> <td>Clinical Release time:</td> <td>\$ 35,000</td> </tr> <tr> <td>Total:</td> <td>\$285,000</td> </tr> </table>	Project Management:	\$ 30,000	Professional Advice:	\$110,000 (check KO)	Clinical Release time:	\$ 10,000(will increase)	Total	\$150,000	Project Lead:	\$30,000	Professional Advice:	\$75,000 Clinical	Release time:	\$10,000	Total:	\$115,000	Professional advice:	\$250,000	Clinical Release time:	\$ 35,000	Total:	\$285,000
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Total:	\$115,000																						
Professional advice:	\$250,000																						
Clinical Release time:	\$ 35,000																						
Total:	\$285,000																						
Revenue source	GFP																						
Interdependencies	Projects 1, 2 & 3 are sequentially interdependent.																						

#### Work Stream 7: Child Health Improvement Project

Project	<p><b>Focus on better management of acute events in 2011/12</b>  <b>Development and planning for broader child health improvement initiatives 2012/13.</b></p>						
Contribution to GAIHN goal	Liaison with all work streams to ensure that children are considered in delivery of new models of care.						
Milestones/deliverables	<ul style="list-style-type: none"> <li>§ In 2011/12, focus on reducing avoidable acute events for children (see other work streams for detail)</li> <li>§ Development and planning broader improvements to child health for 2012/13 with draft plan delivered by December 2011</li> <li>§ Final detailed implementation plan by March 2012 (will include the outcomes framework and KPIs).</li> </ul>						
Project leadership	<p><b>Project lead:</b> tbd, post 1 July 2012  <b>Clinical lead:</b> tbd, post 1 July 2012  <b>Team membership suggestions:</b> Tom Robinson, Nicola Young, Tim Jellyman, Louise McCarthy.</p>						
Estimated costs (11/12)	<table> <tr> <td>Project management:</td> <td>\$20,000</td> </tr> <tr> <td>Release time:</td> <td>\$15,000</td> </tr> <tr> <td>Total:</td> <td>\$35,000</td> </tr> </table>	Project management:	\$20,000	Release time:	\$15,000	Total:	\$35,000
Project management:	\$20,000						
Release time:	\$15,000						
Total:	\$35,000						
Revenue sources	GFP						
Interdependencies	Whole of GAIHN Programme						
Risks	<p><i>Loss of momentum due to postponement of implementation from 11/12 to 12/13</i>  Mitigation: Keep this project on the programme and monitor planning.  Effective advocacy by project leadership during 2011/12.</p>						

Appendix C: Activity that will impact on the GAIHN goal

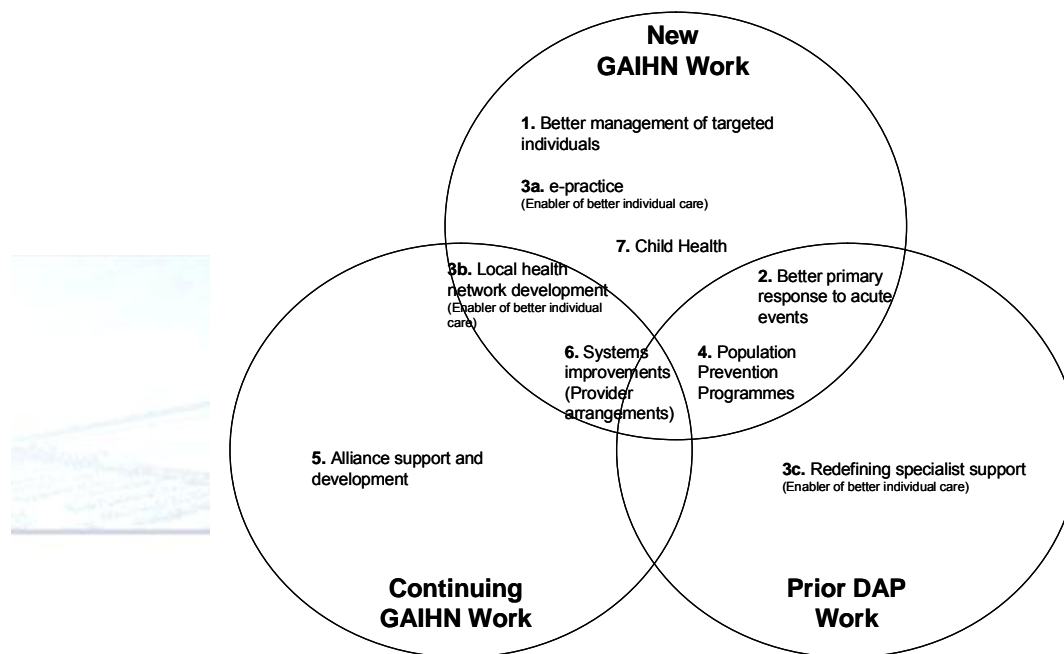
Activity that will impact on the GAIHN goals



\* Non GAIHN projects which contribute to the goal  
 \*\* IFHC's – Integrated Family Health Centres

## Appendix D: Categories of GAIHN work streams

### Categories of GAIHN Work streams



The seven work streams can be broadly categorised between

- **New GAIHN Work:** Where the objectives have been identified for each work stream but there is no (or very limited) existing GAIHN project resource and a full work structure needs to be put in place. This New GAIHN work category includes a few projects that will be building on other work already undertaken by DHBs or by other partners within the alliance.
- **Continuing GAIHN Work:** Where project resources are already in place and reporting mechanisms / structure already exists. Several projects within the supporting/enabling work streams are already underway as part of the original GAIHN business case. The GAIHN projects underway and continuing for 2011/12 include:
  - § the Alliance Support and Development work (providing programme management and infrastructure)
  - § (aspects of the) Systems improvements (provider arrangements)
- **Four Prior DAP Initiatives:** Where project structures are already in place and there have been historical resourcing paths. Whilst these initiatives are new to GAIHN they comprise ongoing 'delivery' work for the next year associated with each of the four GAIHN 'DAP initiatives'. In each case the resourcing distinguishes between:
  - § Contract delivery (with no GRP resourcing required)
  - § Programme management/ co-ordination and initiative development work (with GRP resourcing required).

## Appendix E: GAIHN participants, structure and role

The Government's BSMC approach for primary care resulted in a number of changes that required a new approach to relationship management. GAIHN is one of three business cases<sup>3</sup> that were approved by the Minister of Health for the Auckland region. It provides an ongoing focus for Northern region health services and supports the implementation of an Auckland region whole of system approach with joint primary and secondary health care clinical leadership and decision making.

GAIHN is an alliance of seven independent partners.

- § Auckland District Health Board
- § Auckland PHO Limited
- § Counties Manukau District Health Board
- § East Health Trust PHO
- § ProCare Networks Limited
- § Waitemata District Health Board
- § Waitemata PHO.

Estimated Enrolled Population: 1.15 million people

The alliance has agreed to pursue a collaborative approach to achieve its Mission. The structure of GAIHN has therefore been established to enhance and reinforce the collaborative approach. It provides opportunity for a wide range of stakeholders to participate in the development and sharing of ideas as to how GAIHN's Mission can be achieved; whilst at the same time providing a governance structure that will ensure that a sound and reasoned work programme is put in place, and supported, to implement change.

<sup>3</sup> The three Better Sooner More Convenient (BSMC) Business Cases are: Alliance Health Plus (AH+); Greater Auckland Integrated Health Network (GAIHN); and National Maori PHO Coalition (NMPHC) who are soon to be re-named National Hauora Coalition (NHC)

As an alliance - GAIHN's role is to work as a collaborating partnership to implement change across its spheres of influence to achieve the GAIHN Goals

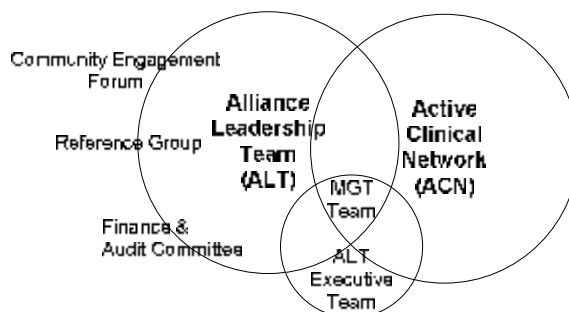
To perform this role GAIHN needs to:

- § Identify strategic goals to benefit its populations
- § Design a staged work programme to implement improvements in relation to the identified goals
- § Secure funding to the GAIHN Resourcing Pool (GRP) to enable resources to be acquired to implement the staged programme of work
- § Allocate the GRP resourcing to the planned stages of work based on well stated funding proposals for each stage (that set out achievable stages of work with documented expectations of benefits, resource requirements and defined progress points that can be monitored)
- § Manage and administer the stages of work and allocated resourcing to ensure that risks are managed and progress kept on track.

**GAIHN's Role:**

- Securing funding for projects
- Establishing a collaborative premium
- Supporting and enabling a better acute response in primary care
- Supporting customised locality responses
- Championing initiatives vigorously in political and other forums
- Developing and making available a tool kit of options for improved primary care
- Research and development
- Monitoring, reporting & evaluation
- Quality oversight
- Identifying and sharing best practice
- Advocacy and change leadership
- Strategy and prioritization of alliance activity.

**GAIHN Structure**



**GAIHN Workstreams**

- Better Management of Targeted Individuals
- Better Response to Acute Events
- Enablers of better Individual Care
- Systems Improvements
- Population Prevention Programmes
- Alliance Support & Development

**GOAL:** Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions (including Children)

**GAIHN Accountability structure from 1 July 2011**

<b>Team</b>	<b>Function and Membership</b>
<b>Alliance Leadership Team (ALT)</b>	Strategy, governance, performance monitoring, final sign off of all relevant activity. (Membership: 7 partner reps + 6 clinical reps + 2 Iwi reps). Chair of ACN to be Deputy Chair of ALT. Sub committees: Finance & Audit, Alliance Contracting & others as needed
<b>ALT Executive</b>	Meets weekly with management to discuss, plan and guide in more detail (Membership: Chair ALT, Chair ACN, 1x PHO Rep, 1x DHB Rep & Management) others on an as needed basis
<b>Active Clinical Network (ACN)</b>	Quality control, clinical overview, recommendations to ALT (Membership: A representative slice of primary & secondary clinical expertise, nursing and allied health reps based on relevant technical skills)
<b>Management Team</b>	Programme strategy & management, communications, admin support to all of the above (currently Programme Manager, & Project Support)
<b>Reference Group</b>	Wider group to provide feedback analysis and comment includes representation from the following but may be varied according to need and the desire of groups to become involved: Consumers, Pacific & ethnic communities, clinical, nursing and allied health professionals, other business cases and others representation as needed.
<b>Community Engagement Forum</b>	Provide a customer perspective to GAIHN activity including broad direction and approach to implementation. Conduit to wider networks
<b>Project Teams</b> (Drawn from partner organisations with advice from external expertise)	Project development, management, implementation oversight and advocacy. (Membership: Skills based. Subject matter expertise, drawn from partner organisations and external consultants as required). Project team Leaders recommend team membership to ACN/ALT for approval.

## Appendix F: GAIHN Charter – Principles

### *GAIHN Charter - Principles for Working Together*

*GAIHN Programmes* - We select soundly based programmes that make a major impact on the health of people, improve the patient experience and delivery of a collaboration premium.

*Promoting Health Equity* - All our programmes will promote health equity and will reduce health inequalities

*Incentivised Change* - Our change initiatives provide an incentive for all relevant parties to change. This includes an incentive for the patient, the health professionals and the organisations.

*Sovereignty of Organisations* - All the GAIHN organisations are autonomous and participate willingly in the Alliance programmes because they can add real value to the alliance's compelling proposition and perceived real value to the aims and goals of their own organisations.

*Resourcing* - GAIHN partners effectively resource all programmes to deliver breakthrough results with dedicated staff to deliver each programme and funding from the Alliance partners because each alliance partner sees compelling value in each investment.

*Our Focus* - We will focus our efforts on areas where the greatest value can be gained in solving the challenges of the health system using the resources and expertise of our alliance

*Alliance Contracts* - All our alliance contracts are based on a mutually agreed direction rather than on detailed specification of services, outputs or outcomes. We recognise that there is a wide range of ways of working outside alliancing.

*Adaptive Learning* - GAIHN will move rapidly from ideas to execution through an adaptive learning model where changes in approach and direction can occur in response to learning's along the way.

*Relationship-based Alliance* - We have an alliance based on the trust, understanding, respect and the equal status of all our partners; we invest in building and maintaining our long-term relationships.

*Target Groups* - We improve health status by delivering integrated high quality services to targeted high need groups and continuously monitor and improve outcomes

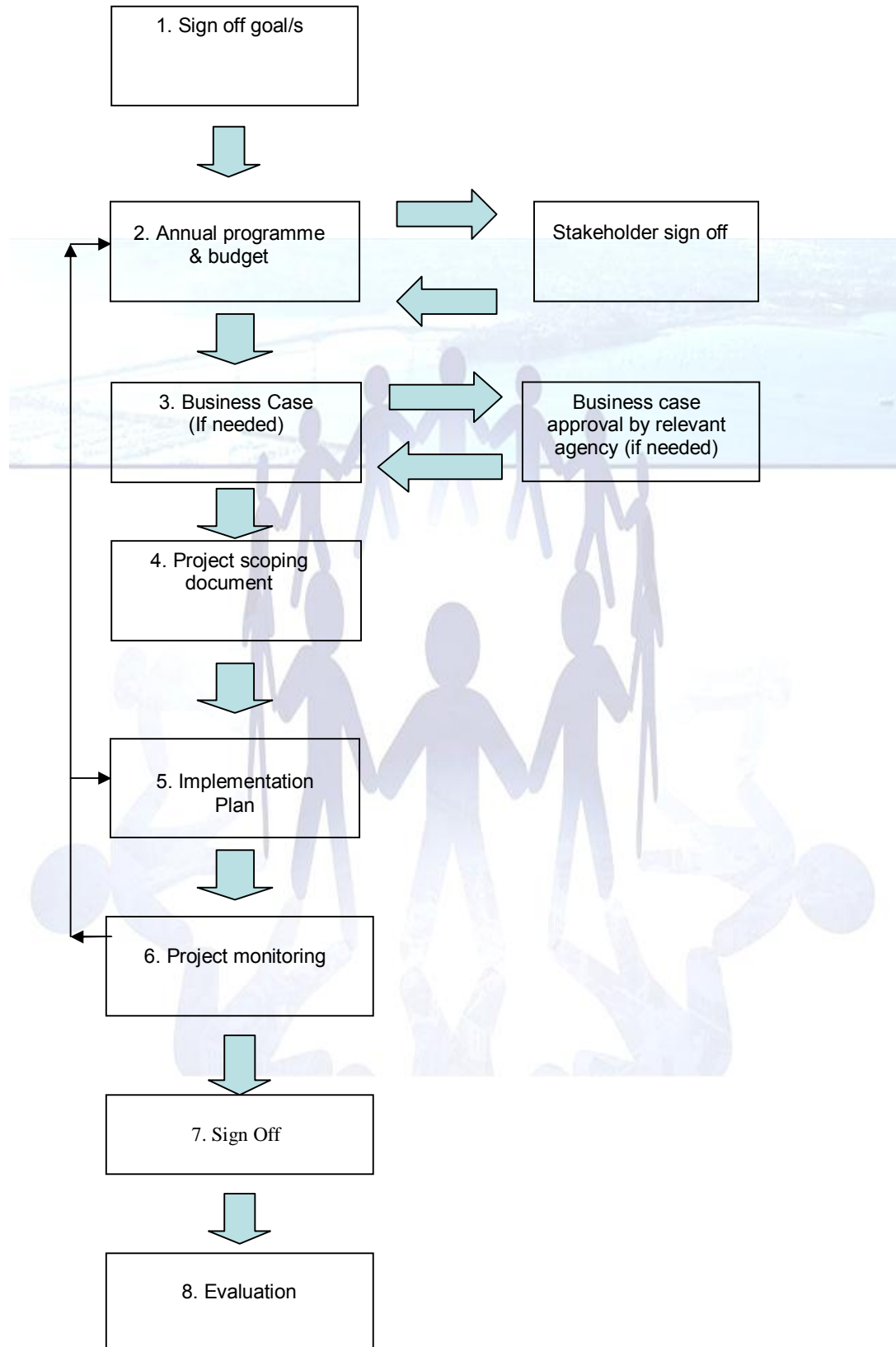
*Consensus Decision Making* - We will make all alliance decisions on a consensus basis – this means identifying the common view and assisting others to move to this view – we will all support our consensus decisions outside the meeting room.

*Reducing Barriers* - We will reduce the barriers to effectiveness

*Building Capability* - GAIHN partners will work together to develop the capacity and capability of member organisations to achieve the aspirations and goals of the alliance.

Appendix G: Draft Stage Gate

ALT Key Milestones (Stage Gates)



### Stage Gate Notes:

	Stage	Content	Approval required by
1	<b>Agree goal/s:</b>	Where GAIHN wants to be by when, relative to a specific issue or problem as prioritised within the regional context	ALT, Stakeholders & Partners
2	<b>Agree Annual Programme &amp; Budget:</b> Includes consideration of which projects should comprise the GAIHN-Accountable programme for the year based on their potential to deliver the goal	How GAIHN will achieve the goal. Project leads will submit high level project scoping documents for consideration by ALT using the following weighted criteria  <i>Weighting Guidelines:</i> May vary according to the project focus and the specific situation (e.g. high political profile) <i>Example:</i> Probable contribution to Goal: 40% - Evidence of immediate & sustainable impact (within 12 months) 30% - Evidence of sustainable medium term impact (within three years) 10% - Contribution to Triple Aim 10% - Evidence of proof of concept from literature and practical experience. 10% - Other factors e.g. political significance, potential savings, and likelihood of success.	ALT & Stakeholders
3	<b>Approve Business Case</b> (if needed)	Probable requirement of external funding agencies such as MOH to secure support for GAIHN projects  Not likely to be a requirement for “internal” GAIHN-initiated projects to be funded from the GFP	Stakeholders Funders
4	<b>Approve Developed Project Scoping Document/s</b> (Refined from the high level scoping documents considered at stage 2)	Will contain robust information on: Project outline/description Contribution to Goal/Return on Investment Key deliverables and milestones Leadership/project structure Estimated costs Risks	ALT/ACN
5	<b>Approve Implementation Plan</b>	Documentation will vary but should contain enough information to assure ALT that the project will be delivered to time cost and quality including risk management (template format)	ALT/ACN
6	<b>Project Monitoring</b>	On going, according to ALT requirements e.g. monthly, quarterly, yearly. Results and feedback may influence implementation and planning for coming years. Reporting templates will vary according to stakeholder requirements	ALT/ACN Steering Group  ALT/Stakeholders
7	<b>Project Sign off</b>	Relates to pieces of work with a discrete start and finish date e.g. develop a new contract by.	
8	<b>Evaluation</b> (where considered necessary by ALT (e.g. for ongoing work streams such as evaluating the effectiveness of the Target Management of Individuals Programme))	Preferably an independent evaluator. May occur during the delivery phase (e.g. after 1 year) in order to assess the effectiveness of the intervention and to affirm/change direction of the project.	ALT/ACN

## Appendix H: Budget Summary

Work Stream/Project	Estimated cost 2011/12	Comments
1. Better management of targeted individuals	\$220,000	
2. Better response in primary care to acute Events	\$280,000	
3. Enablers of better primary care (includes A2D \$802,000, Regional Clinical PW \$732,100)	\$1,869,100	Excludes capex
4. Prevention (smoking cessation)	\$150,000	
5. Alliance development & support GAIHN Office	\$790,500	
6. Systems improvements		
- Information	\$150,000	
- Indicators	\$115,000	
- Contracts/incentives	\$285,000	
7. Child Health	\$35,000	
<b>Total estimated costs 2011/12</b>	<b>\$3,894,600</b>	
Estimated Carry forward from 2010/11 MOH funding (Tagged)	\$370,000	Tagged to specific outputs
Second Tranche payment received from partners (23c/enrolled person)	\$528,182	
<b>Suggested budget spread</b> (subject to ALT approval of projects at appropriate stage gates)***		
Quarter 1 - 1/7/11	\$664,525	
Quarter 2 - 1/10/11	\$1,127,225	
Quarter 3 - 1 1/12	\$1,127,225	
Quarter 4 - 1 4/12	\$975,625	
<b>Total</b>	<b>\$3,894,600</b>	

### \*\*\* Assumptions:

- GAIHN Support function spread evenly over 12 months
- Project costs spread based on estimated staged approval process taking into account a carry forward of approximately \$200k from 10/11 in Q1
- Assumption that each partner will pay the second tranche of 23c/enrolled individual in 10/11 year
- Assume a 2 month lag in GAIHN receiving first payment from partners (ie September 2011)
- Assumes a project/operations spread as per table below (could be subject to change).





# Community and Public Health Advisory Committee Agenda

<b>MEETING DETAILS</b>		
Time and Date	2:00 p.m. – 5:00 p.m. Wednesday 20 July 2011	
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre	
Members	Dr Lee Mathias (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Dr Lester Levy, Robyn Northey, Gwen Tepania-Palmer, Ian Ward, Rob Cooper.	
Apologies		
On Leave	Rob Cooper	
In Attendance	Garry Smith, Dr Denis Jury, Taima Campbell, Hilda Fa'asalele, Naida Glavish, Janice Mueller, Ian Bell.	
	<b>Item</b>	<b>Page No</b>
<b>1</b> 5m to 2:05 pm	<b>Karakia</b>	<b>001</b>
<b>2</b> 5m to 2:10 pm	<b>Attendance and Apologies</b>	<b>005</b>
<b>3</b> 5m to 2:15 pm	<b>Conflicts of Interest</b>	<b>007</b>
<b>4</b> 10m to 2:25 pm	<b>Confirmation of Minutes</b> - Wednesday 15 June 2011	<b>015</b>
<b>5</b> 10m to 2:35 pm	<b>Action Points</b> - Wednesday 15 June 2011	<b>021</b>
<b>6</b> 25m to 3.00 pm	<b>Planning and Funding Performance</b> 6.1 Planning and Funding Summary Report	<b>025</b>

	6.2 Planning and Funding Indicators List and Exception Report	
<b>7</b> 15m to 3:15 pm	<b>Improvement Activities</b> 7.1 DAP Projects Report	<b>043</b>
<b>8</b> 15m to 3:30 pm	<b>Feedback from Maori Health Advisory Committee and Pacific Health Advisory Committee</b>	<b>053</b>
<b>9</b> 30m to 4:00 pm	<b>Papers</b> 9.1 Migrant Health 9.2 GAIHN proposed Work Plan 2011-13 9.3 Community Pharmacy Contract Renewal (to be circulated under separate cover) 9.4 After Hours Proposal for Auckland Metro Region (to be circulated under separate cover)	<b>055</b>
<b>10</b> 10m to 4:10 pm	<b>Confirm</b> 10.1 Actions Points for next CPHAC Meeting 10.2 CPHAC Feedback to Board	<b>077</b>
<b>11</b> 10m to 4:20 pm	<b>General Business</b>	<b>079</b>
<b>12</b> 5:00 pm	<b>Appendices</b> 12.1 GAIHN Programme 2011-2013	<b>081</b>
<b>NEXT MEETING</b>		
<b>Date and Time:</b> 2:00 p.m. – 5:00 p.m. Wednesday 10 August 2011		
<b>Venue:</b> Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre		

*Hei Oranga Tika Mo Te Iti Me Te Rahi*

**Healthy Communities, Quality Healthcare**