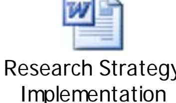
Clinical Advisory Group (CAG)

Minutes

Of the meeting held on Wednesday, 18th February 2009, Meeting Rooms 1&2, 19 Lambie Drive at 1800 - 1930 hrs

Agenda Item		ACTION
Present	Peter Gow (Chair), John Roke, Michael Clark, Pam Williams, Karyn Sangster, Tanu Toso, Denise Kivell, John Savory, Soli Henare, Tom Braken, Nua Tupai, Val McCullough, Gillian Davies	
Apologies	Don Mackie, Paula Nes Gary Jackson, Stella Ward, Allan Moffitt, Richard Hulme	
Minutes of November 2008 meeting	Passed as true record	
Review of Consumer Panel – Solitaire Henare CP Review doc	CMDHB Community Panel was established in August 2005. Under the Community Panel's Terms of Reference a review of the Panel was to occur after 12 months • A review is prudent to evaluate the effectiveness of the Panel, identify what works well and determine what areas could be improved. • The review will clarify how the Panel has added value to CMDHB. CMDHB also wants feedback on how they can add value to the Panel. • **Areas for review** - Terms of Reference - Function and purpose - Structure - Membership (Numbers; Recruitment; Selection; Performance) - Operational matters (Frequency of meetings; Quorum; Remuneration; Agenda setting/content; catering • **Key Stakeholders will be interviewed** • The Review will be conducted by a person independent of CMDHB and • the Community Panel. • Review should be completed within a two month period. A small team will lead the Review. This team will comprise: - Chair of the Community Panel and - One member of the Community Panel and - Community Liaison Manager and - Member of the Clinical Advisory Group (CAG) Paula Nes nominated and accepted. • Sponsor for the review is Sam Cliffe, Director Integration Services who will take final review findings to CMDHB Strategic Forum (replacing EMT).	

Integrated Care: The discharge Care Co-ordinator Role -Gillian Davies Discharge Coordinator Role	**Aims** • To identify patients at risk of readmission and prevent this by early recognition, support and referral • To identify high risk patients requiring intensive Primary Care support and patients who might qualify for enrolment in the Care Plus and/or Chronic Care Management (CCM) programmes • To contact self referring patients and reconnect them to Primary Care • To prevent hospital admission by ensuring patients understand their discharge care management plan and are convalescing well **Process** • 0.5 RN role Mon – Fri • Profiles patients recently discharged from hospital be reviewing: - Discharge summaries - Referral letter from GP (if any) - Classifications (problem list) - Patient alerts (enrolment in Care Plus and/or CCM programmes) • Contacts patient • Performs needs assessment • Gives advice and co-ordinates care as appropriate • Completes template in MEDtech32 **Lean Thinking and Discharge Care Planning** **Reducing demand by preventing re-work** • Need to reflect on how well clinicians are assessing patients' self management attitudes, knowledge and skills in order to reduce avoidable and late presentations to primary and secondary care • There is a significant acute care self-management knowledge and skills gap **Why Discharge Co-ordination** • 3015 patient discharges reviewed Oct – Dec 2008 - 70% Maori and Pacific peoples - 1584 Pacific, 527 Maori, 416 Indian, 268 European - 73% self refer to emergency Care - 2199 self referred, 810 GP referred - 75% with a LOS >5d are self referrals and may not be connecting with Primary Care. Need to improve the connection in hope of preventing future avoidable presentations and so reduce waste and costs - 202 LOS >5d, 151 self referred, 51 GP referred - ~1 in 5 patients discharge is a FAMA patient. - 591 ≥ admissions in previous 12 months (FAMA) - 92% of discharged patients do not have two or more chronic conditions and not eligible for intensive management through Care Plus and/or CCM - Medication reconciliation between hospital, GPand Pharmacy continues to be a significant risk for discharge patients - ~70% of patients discharged relate to medical assessments and admissions - ~1in 6 patient discharges is a potential readmission - 1% actual readmission - ~80% Maori and Pacific - Actual readmissions by diagnosis - ? some preventable Bronchiolitis LOS 0-6 days Abdominal pain nos LOS 1 -2 days Hyperemesis gravidarum LOS 2-5- days Unstable Angina LOS 4 – 10 days	

	Take Home Reflections • How do we assess patient self-management knowledge and skills prior to hospital discharge? • If 75% of patients with LOS >5 days are self referrers, 1 in 5 patients a FAMA, and 1 in 6 patients at risk of potential readmission, how do we prevent re work and ensure better connection to Primary Care prior to hospital discharge? • How can we make the self referred and FAMA status of the patient explicit for clinicians on admission and discharge? Ensuing discussion: • There is a lack of knowledge of various programmes. How do we rectify this? • This is happening informally in every practice. • Would like to see a discharge co-ordinator in the hospital to connect patients to Primary Care • Informal relationships are being built between secondary and primary care where handovers are occurring • Paper sent to GPHO re how patients can be connected together. Discussions are occurring about using Navigator where patients can be referred to someone who doesn't carry any other work load. Many patients don't know conditions, what to do when things go wrong. Problems more evident in Mangere and Manurewa. Should have some progress to report back in a couple of months (Tom Bracken). • Lowest level of RMOs in hospital history. No time to do discharge summaries. • Term 'discharge' needs to be replaced by 'transition of care' • Many teams doing similar things. How can CAG get a view of what is happening? • Dr None still an issue.	
The Role of Research at CMDHB – Peter Gow The Role of Research at CMDHB  Research Strategy Implementation	**WHY DO WE NEED A RESEARCH STRATEGY?** **Clinical Governance** **Innovation** - Observational Research - Randomised Controlled Trials **Standard Care** - Guidelines (evidence-based) - Clinical Audit - Morbidity & Mortality **Strengths** • "Good for patients" who participate • Provides access to drugs not routinely available • Keeps clinicians up to date with new developments • Helps DHB budgets **Weaknesses** • Doesn't provide outcomes we seek • Limited by lack of workforce development • Regulatory approval process difficult & time-consuming • Community consultation & participation limited **Outcomes we seek** *Reduce the incidence and impact of priority conditions* such as heart disease, diabetes, lung disease and cancer and improve access to mental health care *Reduce Health Inequalities* Support workforce and provider development that increases the capacity of the health sector to deliver services to populations with high health needs. We will maintain our inclusive board and committee structures and fully implement our Maori and Pacific Health plans **What is Proposed?** • Previous version of strategy presented to POU on 20th February 2008 • Separate Maaori goal with specific aims • Pacific mentioned alongside Maaori • Strategy writers were asked to strengthen the Pacific voice and separate it from the Maaori voice • MRRC has reviewed the revised strategy	

	Goals of revised Strategy
	• CMDHB as a centre of health research excellence focusing on building infrastructure, facilities & staff
	• Deliver improved standards of care by increasing the number of patients enrolled in clinical studies
	• Undertake research in partnership with Maaori with an emphasis on equity of access and outcomes
	• Perform Health Research in Partnership with Pacific peoples and promote Research which addresses health equalities within the Pacific Communities
	Aims - Goal 1 (Infrastructure)
	• Invest in improved facilities
	• Develop streamlined processes
	• Workforce development
	  - research professionals to conduct clinical research
	  - training programs
	• Develop strong research relationships with the University of Auckland
	Aims - Goal 2 (Participation)
	• Partnership with industry
	• Innovation Fund
	• Research programs to address health priorities and health inequalities
	• Disseminate research results and research plans so that there is widespread knowledge of the current research activity occurring in the CMDHB
	Aims - Goal 3 (Treaty of Waitangi)
	• Research responsive to the needs of Maaori, and Maaori engaged and consulted in the research process.
	• Research priority areas for Maaori health
	• Engage with Maaori communities resulting in:
	  - Maaori driven research projects which address specific Maaori priorities
	  - Maaori participation in generic research
	• Support the development of Kaupapa Maaori research (research that is centered in Te Ao Maaori, projects from, focused and is lead by Maaori).
	Aims - Goal 4 (Pacific aspirations)
	• Undertake Pacific relevance research which improves Pacific health outcomes and adds to the general body of Pacific health research knowledge
	• Engage with Pacific communities and perform health research activities in partnership with Pacific peoples
	• Develop Pacific research capability and Pacific governance research
	Where to next?
	Maaori Engagement
	POU is asked to
	• Approve the revised CMDHB Research strategy
	• Comment on the components of goal 3, which will help the MRRC in partnership with CCRep to develop an implementation plan to progress the strategy into successful outcomes for Maaori
	
	Ensuing Discussion
	• Need to embrace/enhance links to university and professorships within departments and credentialling. The more these are strengthened the better you are able to attract high calibre senior medical officers, consultants and junior staff, this is an absolute key to staff retention. Need academic and research base with highly complex cases.
	• Academic presence of 10-20 years ago has lapsed. Have lost Professor of Medicine and Surgery. Research seen as vital in workforce retention
	• Looking at Nursing Professor role. Nurses leading research projects that is changing practice and driven strongly in the universities. Looking at philanthropic funding that is ethical and we can accept to fund the professorships. Looking at different models of care. Need to be thinking about the future and workforce.	

	• HRC in a consultation document looking at what grants should be given and prioritisation. • Magnificent opportunity for CMDHB to assist with some primary care research especially with the investment in primary care and chronic care management • CCRep wanting to encourage people with provision of innovation awards, running research courses, and have made available a biostatistician. • Research Office Centre will assist with co-ordinating and optimising funding opportunities. Need to look at funding available in the community for research also.	
Standing Agenda Items **Community Panel**	• **First meeting centred on Terms of Reference. Second meeting cancelled** • **Chronic Care Management project to run for approximately another year** • **Peter highlighted the role of the community participant in the credentialling process is not as prominent now. Credentialling policy out of date.** **Action Point: Val to follow up policy review with Wilbur Farmilo.** • **Don Mackie will be talking with the Community Panel next month about credentialling.**	
Other Business Primary Care Network Science Fest Criteria	Primary Care Network – Invitation for all allied health professionals to participate in a primary care network to support development of primary and community based services. Please see attachment for more details of first meeting. It was asked how broad Allied Health is. Does it include podiatrists, acupuncturists, chiropractors, pharmacists etc? Action Point Val to ask Stella to provide a definition. Science Fest New categories being proposed. Feedback being sought as to whether these are appropriate as soon as possible. Need to make sure community participants receive the guide outlining clear instructions. Difficult to meet all needs. Pure researchers and innovators feel they can't compete against each other. Meeting this need is difficult.	
Next Meeting:	**March 18th 2009 ♦ 1800 - 1930 hours** **♦In Meeting Rooms 1& 2 ♦ Counties Manukau DHB, 19 Lambie Drive**	