

Primary Health Organisation Group (GPHO)

Wednesday 8 April, 2009
12 noon to 4pm
Building 2, Manukau Boardroom

Minutes

1. Welcome & Apologies

Present:

Allan Moffitt (chair), Sam Cliffe (SC), Loretta Hansen (LH), Pam Montford, minute-taker (PM), Mike Lamont (ML), Neil Woodhams (NW), Kate Moodabe (KM), Mark Vela (MV); Lael Meredith (LM); Tina McCafferty (TMC), Denise Kivell (DK); ; Ross Smith (RS); Bernard Te Paa (BT); Manu Sione (MS); Ian Johnson (IJ), John Cosgriff (JC); Siobhan Matich (SM),

Wayne McLean and Esther Blomfield joined the meeting at 2.15 with apologies for lateness.

Apologies:; Jennie Auton (JA); Dolly Rewha (DR); Karyn Sangster (KS);

1a) Previous Minutes

Minutes dated 11 March accepted as true and correct record

Moved: Neil Woodhams

Seconded: John Cosgriff

1b) Matters Arising from Action List

29. Quality Strategy

has been distributed by Allan Moffitt who advised that it will come back to GPHO for formal agenda item and sign off for May meeting

63. Health Promotion Stocktake

An action coming out of the line-by-line review of the DHB identifies that further work needs to be done around this which will include a review of all Health Promotion contracts at a later date.

75 DHB/PHO Board Orientation

As PHOs stated option was not to have a joint session with the board chair this will be actioned though invites for individual PHOs to present to CPHAC throughout the year.

AM to circulate suggested dates

SC

AM

<p>80. B4 Schools</p> <p>Clarification required around future funding from MoH – at this point Sam advised that the Ministry are not prepared to confirm funding in the 2009-10 year, as yet. She went on to say that a regional meeting with funding FMs hopefully will discuss the issue and provide more clarity but in the mean time CMDHB would not be contracting out the service until such time as there as certainty around future funding stream. Some people thought that the emphasis may shift to 0-.3 year olds.</p> <p>82. DCAG Review</p> <p>paper tabled from Shirley Miller for comment and feedback please.</p> <p>83 FAMA</p> <p>Business Case close. Tom Bracken & Linda Bryant had been doing a lot of work with Harry Rea and Shirley Miller and there were still unresolved issues around funding.</p> <p>84. Smokefree</p> <p>Ingrid Minette to update on agenda.</p> <p>87. CCM High Needs</p> <p>\$50K available. Waiting on GMPHO feedback – some advice has been sought from Deloitte - in progress.</p>	
<p>88. Takiwa Ora – Kim Arcus</p> <p>Kim’s paper needs reconfiguring in line with budget review changes.</p> <p>Workshop dates will be distributed when confirmed – Kim still trying to find suitable dates.</p> <p>DAP (Line by Line Review) – Sam Cliffe</p> <p>CMDHB Board has been presented with total package which has been signed off. This has implications across the board.</p> <p>Internal restructure to be finalized in line with this and total package will be available from week beginning 20 April.</p> <p>89. Infant Mental Health</p> <p>feedback still awaited from some on “Moving forward with Training”</p> <p>90. Under 6’s</p> <p>Issues based audit to be undertaken. PHOs to have responsibility for this.</p> <p>PHO analysis 0-6s and how this reflects total population – letter has been sent</p> <p>Action – AM to send out analysis to PHOs for distribution.</p> <p>Breastfeeding Action Plan</p> <p>Pam to check with Paula Sole whether she sent out info to the PHO’s re Baby Friendly community initiatives.</p> <p>91. After Hours</p> <p>RFPs have been received from interested parties and these are currently being reviewed by a panel set up for this purpose.</p> <p>Issue with conflict of one panel member – formal process to be followed and a letter to be</p>	<p>AM</p> <p>PM</p>

sent by PHOs to Sam Cliffe.

Also concern expressed by the PHOs with timeframe for submission

AGENDA

1. Lab Update – Tim Wood

- Consultation report from last year will be available this week and will be distributed to all PHOs in region.
- Recruitment under way – interest from DML staff across the board
- Collection Centres - now have Heads of Agreement on leases for 24 sites across Auckland – at present with Council for processing
- PHOs meeting individually with Labtests regarding their own issues.

2. Pharmaceutical Budget Risk Sharing – Allan Moffitt

AM to visit larger PHOs to share knowledge prior to writing up paper with a view to enter into risk sharing arrangement where the DHB will resource some capacity around pharmaceutical facilitator support (clinical pharmacists)

- DHB will expect to save some money but the emphasis is on improved prescribing quality and reduction in variation not on the financial gains.
- target is DHB total spend on pharmaceuticals – how do we incentivise in a way that is equitable across PHOs.
- Ian Johnson raised the issue of wastage and adherence

Feedback

Wayne

- happy to move forward but has some learnings over the last 3-4 years based around KPIs and whether these are DHB or nationally based.
- How do we add value to management of conditions
- Supportive of this but more supportive if target is on high need chronic illness area
- Is it useful to have another structure mechanism that is specific to the DHB to align the National targets

3. Ambulatory Sensitive Hospitalisation Rates

Allan presented a brief overview including some graphs of trends of ASH rates in key age groups, 0-4 year old; 45-64 year olds and 0 -74 year olds.

CMDHB is doing well on the children but is struggling to hit all other indicators especially in the Pacific population. The widest gap from the national average is in Maaori aged 45-64 years.

- ASH rates defined as conditions that can be prevented by early intervention in primary care
- need to plan

<ul style="list-style-type: none"> - quality improvement approach - Biggest determinant of an ASH admission is a prior ASH admissions so targeting 'Frequent Fliers' is important. There will be a clearer picture about the VHIU/FAMA business case will assist with this prior to July when available funding is finalised - Allan will circulate ASH rates compared to national average - Significant issue with hitting targets Pacific and Other - PMP targets needs to be considered for the future with alignment between national indicators and this programme - The biggest initiative we are planning to address ASH rates is the FAMA/VHIU business case and Allan will circulate the business case for this when available – more thinking is required. - Work is ongoing. CGF is operating as the steering focusing on very high intensive users However there is a need for cross-sector representation and CMDHB is keen to see a small representative Steering Group set up including key secondary stakeholders as well as the Integrated Care Team (Harry Rea et al). - PHOs to follow up on their FAMA lists 	<p>AM</p> <p>AM</p> <p>ALL</p>
<p>Mike</p> <ul style="list-style-type: none"> - Analysis on lower social economic effect of this e.g. alpha keri and emollient used for kids with eczema. Mike highlighted the silo'd thinking around PHARMAC when some decision impact adversely on acute demand which is a much greater cost than the pharmaceuticals involved. 	
<p>Bernard</p> <p>More thinking required about what initiatives we are putting up and the overall impact each one makes</p>	
<p>Sam</p> <ul style="list-style-type: none"> - Steering Group will involve senior management of DHB together with clinicians and PHO reps. - Establish joint KPIs by locality - Need to revisit a Steering Group focused solely on acute demand 	<p>ALL</p>
<p>Action</p> <p>Feedback required on the following:</p> <ol style="list-style-type: none"> 1. Awareness of where we are going 2. Target very high users and consider other areas of avoidable admissions 3. Resources – need to recruit resources to be spread between primary and secondary care to address acute demand 4. Who wants to be involved with it? 	
<p>4. Smokefree Update– Ingrid Minette</p> <p>Ingrid presented an update n where the Smoke-free initiatives are at. Unfortunately funding constraints mean that it will not be possible to implement all the good ideas that the PHOs</p>	

<p>and her have been working on.</p> <p>Pharmac will approve NRT on script from 1 July which will negate the need for Quit Cards.</p> <p>CMDHB is also lobbying to have NRT listed on MPSO so that GPs and nurses can give out starter packs as well as quit cards.</p> <p>Action:</p> <p><i>Ingrid to provide advice to the Sam as to where the “biggest bang for bucks” falls within the current budget.</i></p>	<p>Ingrid</p>
<p>Health Promotion – Maria Rehue, Andrew Lynch and team from Health Promotion.</p> <p>Recommendations from paper</p> <ol style="list-style-type: none"> 1. that GPHO accepts and approved guidelines submitted 2. that GPHO PHO managers endorse the use of the Guidelines in their own PHOs 	
<p>There was a presentation and then discussion concerning the guidelines. It was clear that further work was needed to get these to a stage that GPHO would be comfortable signing them off.</p> <p>Comments</p> <p>Wayne – does not support because</p> <ol style="list-style-type: none"> a) is not satisfied with the process (have they engaged Maaori and smaller PHOS?) b) Health Promotion needs to be seen in context with everything else that is undertaken with the DHB c) North Waikato would like to have further discussion particularly in regard to Treaty based input. <p>Action:</p> <ul style="list-style-type: none"> - <i>HP Team to do more work on document and bring the Guidelines back to the June meeting</i> - <i>Sam to do stocktake on what other health promotion money is available</i> - <i>Agenda with revised plan for June</i> 	<p>ALL SC PM</p>
<p>3. Devolution – Summary of Minister’s Expectations re “devolving secondary services to primary care” – Pauline Hanna spoke to document already circulated.</p> <p>Within the Minister’s Letter of Expectation for 2009/10 there is a focus on hospital services being the target area of the sector charged with delivering on this objective and for leading overall quality improvement within the sector as a whole. The purpose of this document is to provide a plan for how CMDHB will meet the requirements for the 09/10 year and outline key areas of activity in preparation for the 2010/11 DAP that will focus on the appropriate devolution of services to primary and community care services.</p> <p>Comments as follows:</p> <p>Mark – gatekeeping. need to consider devolvment of responsibility for this e.g. Access to diagnostics</p> <p>Ross – unbundling of services – greatest barriers to success would be provider only seeking to unbundle certain parts of it and then marginally pricing services.</p> <p>Discussion followed on the process of devolving from hospital to primary care and how you do this.</p> <p>Sam – what are the principles and process</p> <p>Neil – mismatch between MoH letter to DHB re their expectations and the paper that was</p>	

<p>sent which in his view, was clear that Devolution would occur through PHOS.</p> <p>Neil noted that the last paragraph of the first page of CMDHB's Plan refers to "not only the primary care providers but also to community providers...." PHOs are not mentioned which seems to be clearly in conflict with expectations from the Minister.</p> <p>Pauline added that this was not intentional and will revise paper to reflect.</p> <p>Allan added that where it makes sense the approach CMDHB will take will be a locality one.</p> <p>Wayne</p> <ul style="list-style-type: none"> - Draft a good start. Clear understanding required on what devolution is. - Wants to go back to the starting point of the letter and suggest that we have to develop a framework that has principles that might be around good faith, openness, frankness and recognition of tribal interests. <p>Mike</p> <ul style="list-style-type: none"> • Many of the services that are called devolution services are enhanced services – definition about the word "devolve." • There are a number of services that could be devolved and talked about for the last year e.g. primary care nurses, infection control, smoking cessation. • Need to have some joint planning between us that are the things that make sense and the process of getting there. <p>Denise – co-location may precede full devolution or change in employment – need to build up a transition process e.g. district nurses and the opportunity to do some initiatives. Need to be aware of the IR and union issues.</p> <p>Allan – there needs to be a process around agreeing the approach we will take and what would CMDHB should include in next DAP (2010/11).</p>	<p>PH</p>
<p>Action:</p> <p>Workshop prior to 8 May be set up to discuss responsibilities etc. Include Nettie Knetsch and Jenni Coles. Workshop to be half a day. Pauline/Pam to set up and invite to be sent out</p>	<p>PH/PM</p>

<p>4. DCAG Review</p> <p>Paper was circulated. Feedback required around recommendations and if all agreed</p>	<p>ALL</p>
<p>5. CCM Report – Sarah Tibby</p> <p>Updated volume and targets for March – 144 net growth for month – big increase in Diabetes and COPD noted. Depression still progressing well with 198 new patients.</p> <p>Allan stated no new volumes for CCM in 09/10 year, except for depression which is funded from separate MoH money. This is a cost containment measure proposed for one year only and will allow some consolidation of the programme, The year-end forecast likely to be nearly 16,000 volumes – so this will be target for next year. So in order to 'enroll', practices will need to 'disenrol' – FAMA category is the exception which also attracts full pricing so not dependent on Care Plus.</p> <p>Likely to have conversation around reducing prices for Get Checked – this will reduce volumes. Targets cannot be changed as this is a national indicator and we will have to hit this.</p> <p>CMDHB would also be seeking to renegotiate the price of Diabetes Get Checked and</p>	

<p>Allan was seeking initial feedback about the impact of these changes. Some people felt that if the price dropped then the DHB might as well can the entire DGC programme.</p> <p>Action:</p> <p>Cover in discussion on devolution as to whether to continue with Diabetes Get Checked. Review first principles of evidenced based outcomes.</p> <p>Known Diabetes Survey presented to meeting. – Siniva Sinclair on behalf of the LBD management team.</p> <p>Purpose of survey to take sample of diabetes and then by ethnicity, Maaori, Pacific, Asian and Other. Range of questions including both primary and secondary care services.</p> <p>GPHO approved the survey”</p> <p>Issue</p> <ol style="list-style-type: none"> 1. Ethics committee giving permission to access database as initial way to contact people but without the permission of anyone else. 2. the problem of getting permission in the first place to contact 22,000 people. 3. Siniva to initiate letter to state why patients are being contacted and what is in it for them. 	<p>Siniva</p>
<p>Protocol for a Diabetes Nephropathy Data Collaborative – S Tibby</p> <p>Recommendation</p> <p>That GPHO endorses the use of the previous renal work by Mark Marshall for the purpose of informally sharing with the collaborative participants.</p> <p>Request to set up Diabetes Nephropathy Data Collective – aim to progress study.</p> <p>Ministry would like to have a look at the Mark Marshall analysis and share information around data</p> <p>If PHOs wanted to get involved in collective to let Sarah know so that wider representation can be made on the collaborative.</p> <p>Action:</p> <p>S Tibby to send out information around time involved and what personnel – clarity required around this. Sarah also to send out analysis.</p>	<p>Sarah Tibby</p>
<p>Clinical Networks – S Tibby</p> <p>Recommendation</p> <p>That GPHO receives the paper on Clinical Networks and the linkage to the recommendation in CCM External Evaluation Phase II that the DHB, PHOs and practices develop a framework for integrating a process of CQI in to the CCM</p>	

<p>programme.</p> <p>The team has identified the two localities in Mangere and Papakura to discuss the project further. Once practices are agreed, some further work will occur around creating the Locality Characteristics Profile with a combination of primary and secondary data at both a clinical level and organizational level such as attendance and secondary utilisation. To be facilitated by the University of Auckland working independently with GPs and nurses.</p>	
<p>6. Hospice/Palliative Care – Allan Moffitt</p> <p>Graham Kidd GP of Howick, who also works for South Auckland Hospice has been the key link to the DHB's Palliative Care strategy and Steering Group. He is keen to look at setting up networks to improve palliative care in the community e.g. bed ridden patients not getting any service. His sense from his hospice work is that many people fall through the cracks and needlessly suffer a very poor experience. It is important to ensure that the hospital and community work together.</p> <p>There is a meeting being set up to have discussion around this and how we can collectively engage to do something about it.</p> <p>Action:</p> <p><i>Pam to invite to the meeting Ian Johnson's business partner Lynette O'Brien plus nursing representative and copy PHOs with invite.</i></p>	<p>PM</p>
<p>7. Next Meeting May 13th</p>	