Patients First

Emerging Trends and Response “Providing Value”

National Primary Care Quality and Information Leadership Group

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1 Document Control

1.1 Distribution List

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1.1	08/6/10	Andrew Terris	Reflecting feedback from Graeme Osborne, Tony Cooke meeting (funder/NHITB representation)

1.3 Document Purpose

The purpose of this document is to provide stakeholders with a checkpoint on the National Primary Care Quality and Information Leadership Group project.

This interim report provides a distillation of four months of research (building on 2 ½ years of prior qi4gp learning and activity)

It outlines the current state of play in the sector, a framework for the Leadership Group, current trends and the response to these, both near and mid-term. This is also both a response to and elaboration on the Primary Care section of the Draft National Health IT Plan.

2 Executive Summary

This interim report outlines emerging trends and responses that will shape the development of a national framework and strategy for quality and information in New Zealand Primary Care. This work underpins the creation of a sustainable, clinically led, leadership group ("Patients First") that will develop and maintain a primary care strategy and roadmap for quality and information management investment.

In the Kurt Lewin's defined stages of change[1], New Zealand is in a un-freeze paradigm in health care at present. New models of care are being planned and, along with them, recognition that these new service delivery models require different organisational structures and a new look at workforce and roles regarding best-person and best place to deliver cost-effective and quality care. The "build more wards" and 'build more hospitals" discussions have evolved into questions such as "how do we make better use the resources we have?"

Many of these discussions have been focussed by the "Better, Sooner, More Convenient" (BSMC) business case process in primary care - a response to the challenge of how to better integrate and utilise the collective resources in a community for better outcomes. Many of these initiatives have traversed secondary and primary care from a planning, service delivery and, increasingly, partnership contracting perspective.

"We now have a primary health care infrastructure in place that's achieved some of the aims of the Primary Health Care Strategy

- an enrolled population
- with improved access to services
- more focus on chronic disease
- and on health inequalities,
- as well as community engagement

………but they seem constrained in their ability to bring about significant change to the model of service delivery in primary care"[2]

Hospital costs are increasing and some of the DHBs still run deficits. As the VOTE Health budget grapples to keep pace with inflation, planners and funders are looking to ways of delivering more with less. Primary Care's response to this can be summarised as "borderless health care".

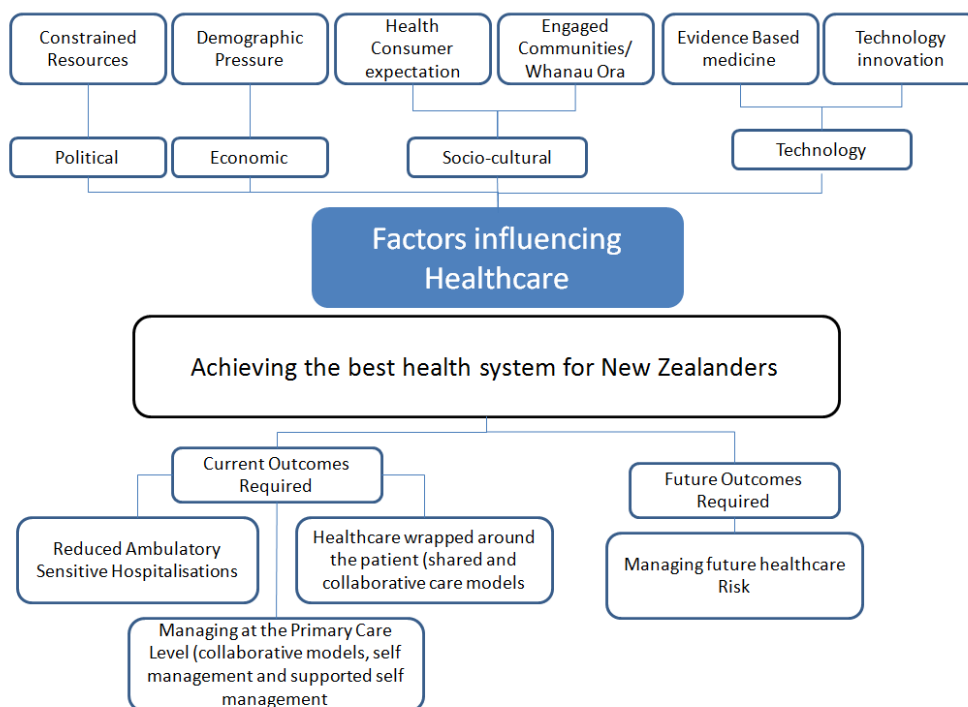

Figure 1: Factors influencing Healthcare in New Zealand

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[1] Kurt Lewin's model defines three stages of change: un-freeze, change, re-freeze

[2] Dr Jim Primrose Chief Advisor, Primary Health Care MOH, "Primary Health Care Next Steps" March 2010

Primary Care networks and PHOs are at different levels of maturity regarding integration with their relevant DHBs and each other. Although this is the case, there are some common trends that are emerging.

1. There is considerable focus on IFHC (integrated family health centres) and IFHN (integrated family health networks) commissioning.
2. There is consistent focus on using interim steps toward a shared care record.
3. There are pockets of capability and success in areas e.g– reporting and information mining, virtualisation, Care Pathway planning, telehealth and videoconferencing, Privacy Impact Assessment in a shared care model among others.
4. Networks are willing to share knowledge where they have it and asking for input where they do not. There is an opportunity to join some dots.
5. There are about to be many examples of similar activity happening in silos and drawing from the same pool of expertise.
6. Many are talking about shared care and managed networks – though time has not allowed for too much sharing or cross-fertilisation of ideas.

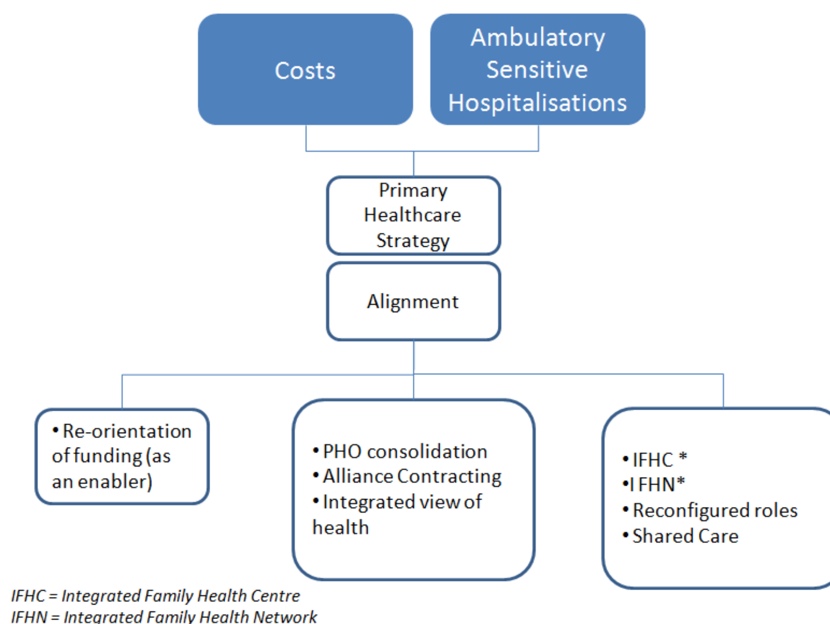

Figure 2: The Primary Care response to sector drivers

Several different strands of activity in General Practice around measurements need to be inter-woven to create an effective quality framework in practice. This includes – a view of the service delivery models, outcomes, clinical quality and information (including data quality and effective tools for the analysis of information). The ultimate goal is ensuring that quality is embedded into day-to-day work practice – and continuous improvement is assisted by reviewing information derived as a by-product of delivering care.

In responding to this and supporting Primary Care, Patients First will

1. Provide leadership to support quality and information in Primary Care
2. Create linkages with relevant groups – become a trusted facilitator and broker.
3. Become part of a coordinated prioritisation setting for Primary Care Quality and Information initiatives
4. Become the owners of the Practice Management System (PMS) requirements for the New Zealand primary care sector (this includes prioritisation of compliance requirements on a panel with funding agencies i.e. ACC, MOH, DHBNZ.
5. Create and maintain an active inventory of sector technology and quality initiatives
6. Provide a co-ordinated sector voice regarding PMS and quality
7. Design, leverage and extend a single dataset within Primary Care that fits into and complements the broader healthcare eco-system
8. Apply the science of quality to general practice and beyond.

The framework within which this will be undertaken by Patients First is outlined in the figure below:

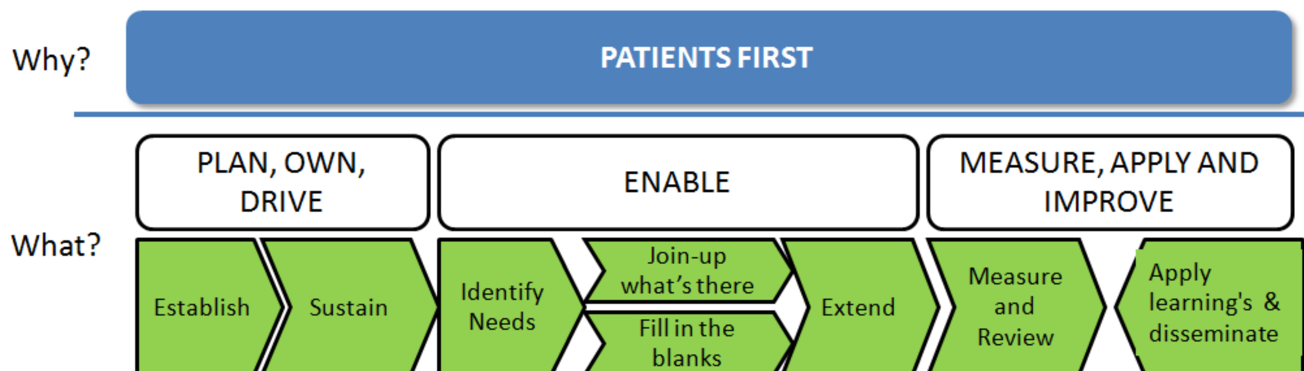

Figure 3: Patients First Framework for delivery

This framework recognises the need for Patients First to manage and drive the coordination and strategy for primary care, a set of operational objectives to enable the sector and applying the quality framework to continuously apply, review and improve.

In addition to the current projects underway within Patients First, the set of initiatives identified in response to assisting the Primary Care sector include:

- Definition of a Primary Care Dataset (leveraging existing datasets and filling in any blanks)
- Implementation of e-continuum of care (e-discharge/e-referral)
- Implementation of a Predictive Risk Assessment tool
- Definition of a Primary and community child health record
- Information to Support Quality Outcomes (including implementation of: Integrated Indicator Library, Clinical Coding Quality and Evaluation of Toolsets for reporting)
- Implementation of a Significant Events Summary system
- Implementation of e-Pharmacy
- Pathway implementation
- Manage My Health implementation
- Definition of a Whanau Ora framework
- Innovation Awards

3 Introduction

This interim report outlines emerging trends and responses that will shape the development of a national framework and strategy for quality and information in New Zealand Primary Care.

This work will underpin the creation of a sustainable, clinically led, leadership group that will develop and maintain a strategy and roadmap for quality and information management investment in primary care.

The scope and sequence of steps outlined in the Project Definition and Approach document is illustrated in the figure below.

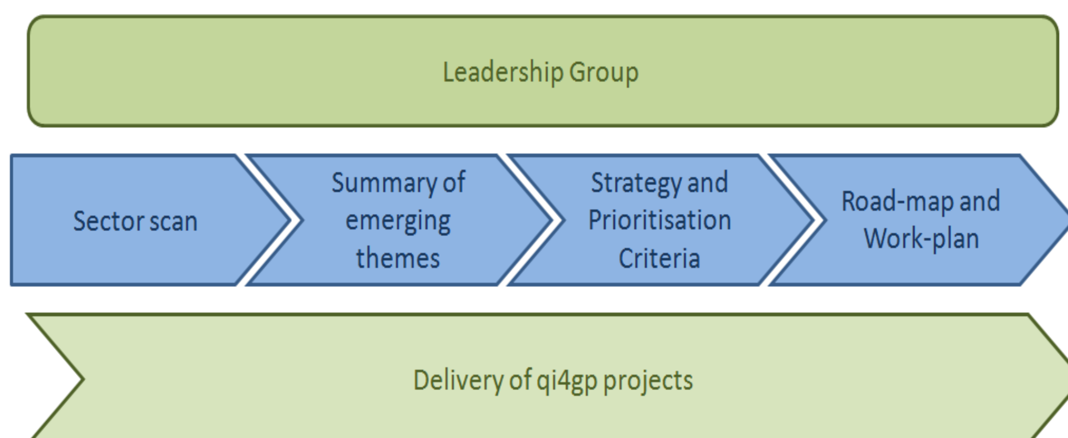

Figure 4: Scope of the Leadership Project

The leadership group will leverage existing initiatives in the sector where possible rather than creating new ones. Its role is to coordinate and prioritise as well as act as a channel for sharing outputs across the sector.

According to the Health and Independence Report 2007, 17.3 million visits were made to general practitioners and primary care nurses in Primary Health Organisation's (PHOs) in the period 2006-2007. The same report tells us that 46.4 million prescriptions were dispensed during the same period. Consequently the initial focus of this groups work is on general practice and pharmacy –capitalising on the work already completed by qi4gp Future phases will encompass broader primary care. To reflect this broader focus, qi4gp has been re-branded as "Patients first". The 'patient' is the single unifying principle in the provision of care among all health providers operating in primary care.

3.1 Objectives

The objectives of the National Primary Care Quality and Information Leadership Group Project (as outlined in the application for Primary Health IT grants funding dated 27 November 2009) are to:

1. Create a sustainable National Primary Health Care Quality and Information Leadership Group accountable for setting direction, strategy and prioritization for primary Health quality and information and an oversight role for delivery against the strategy.
2. Create a national primary care quality and information strategy which sets the direction, priorities and identifies projects and initiatives over a five year period and supports the National Health IT Strategy.
3. Create a delivery vehicle (actual or virtual via the sector) with Programme and Project Management capability and access to capacity and the programme structure and disciplines to deliver projects on behalf of the primary care system and its stakeholders.

4. Deliver a set of currently contracted projects that are targeted at delivering better quality information.
5. Act as a point of co-ordination. Create opportunities to ensure sector initiatives are linked appropriately, issues are managed and duplication of effort is removed.
6. Identify and engage on future (funded and endorsed) projects that complement the strategy.

This interim report outlines progress against the objectives and introduces a framework that will evolve following consultation. It meets the deliverables outlined below:

(a) Develop and communicate an initial clinical framework for the scoping, evaluation and risk management of primary care quality improvement initiatives involving information technology;

(b) Develop and maintain a list of patient centric quality improvement initiatives across the primary health care sector for the 2010/11 year and ensure clinical leadership associated with each initiative;

(c) Apply the clinical leadership framework developed in this initiative to the two projects (PMS Requirements and Clinical Pathway Tool Feasibility Study) provided with Primary Health Care IT grants in the November 2009 round.

3.2 Approach and Acknowledgements

> *"Alone we can do so little; together we can do so much. " – Helen Keller*

This document is the result of four months of research and consultation across General Practice, Pharmacy, National Health IT Board and Ministry of Health. It reflects a series of workshops, forums, meetings and one-on-one interviews with a variety of stakeholders at Executive, funding, clinical and information levels in a number of organisations. It also includes discussions with vendor representatives.

At a broad level – the research included a sweep of the following

- Strategic workshops in the sector including EOI – IS Forum, Strategic Partnership Summit, Quality Conference, Workshop – "What into How" – from the EOI participants.
- Interviews with CEO's, Clinical Leaders and information managers of some of the BSMC business cases.
- Meetings with key stakeholders from the National Health IT Board.
- Workshops with Clinical Leaders of Information Management and Information Leaders from the GPNZ network.
- A series of workshops and meetings with the Patients First sponsors.
- Attendance at the sector Enterprise Architecture forum.
- Desk research of the EOI's (BSMC business cases).
- Desk study of the HMSC business case

Our thanks to those who have contributed their time and insights to this work so far.

4 Emerging Trends

4.1 What is happening in New Zealand Health Care?

Even a casual review of the health sector demonstrates that continuing scientific and technological innovation, together with increased consumer expectations could lead to a virtually unlimited spend on health. Combine this with recessionary conditions, the ageing population and workforce challenges and it is clear why New Zealand needs to consider how best to invest in the health of its citizens.

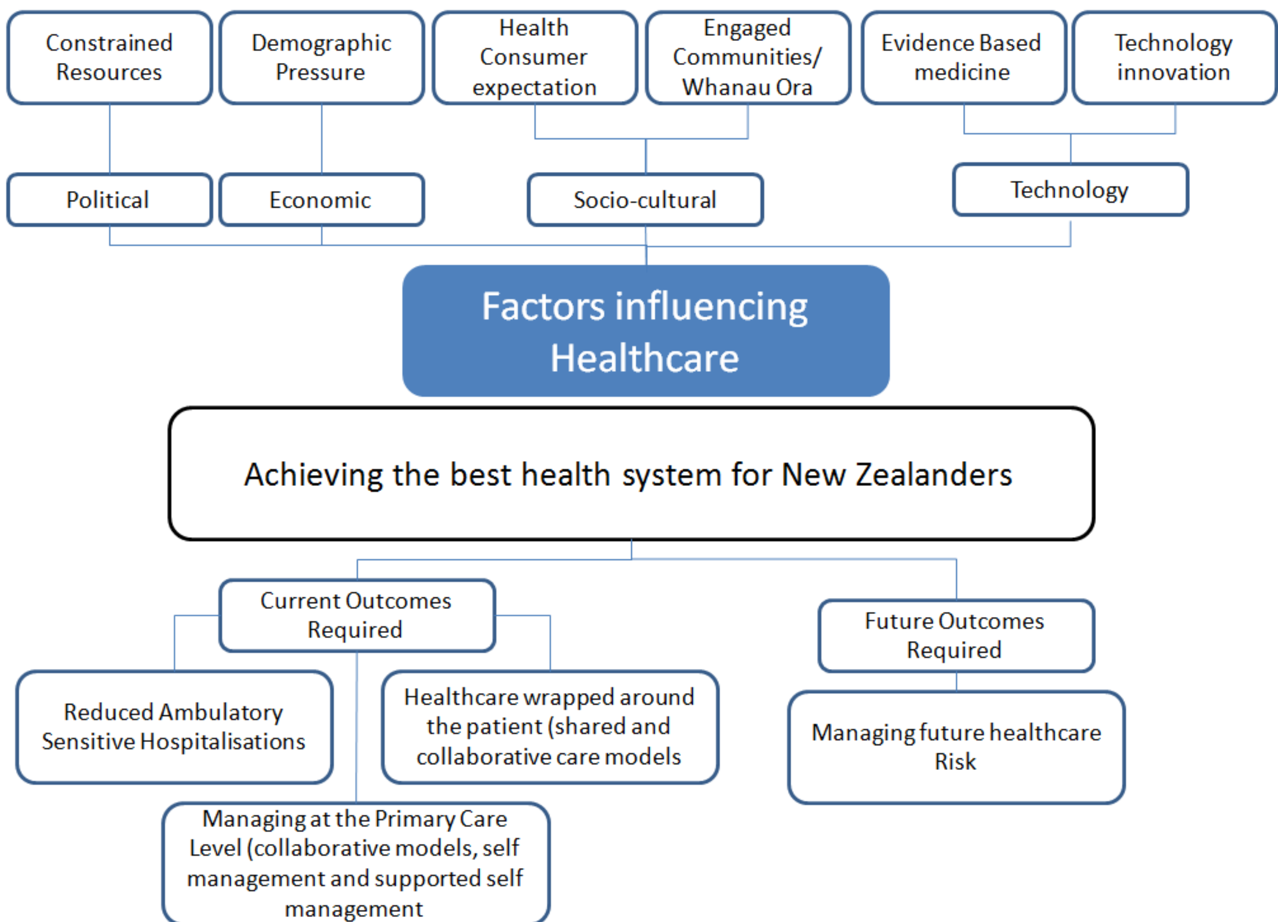

Figure 5: Factors influencing Healthcare in New Zealand

The outline that follows is necessarily high level.

4.1.1 National Response

At a national level these drivers are leading to:

- **Greater recognition of the need to use the health dollar wisely.** Average lengths of stay, waiting lists and managing acute demand in hospitals, are all factors that contribute to the tension. Meanwhile, the burden of chronic disease and co-morbidity also create pressure on the effective management of patients in the community. Several approaches are emerging to address this. These are:

- **Reducing Ambulatory Sensitive Hospital admissions.** Keeping consumers out of hospital is important. Preventable hospital admissions or Ambulatory Sensitive Hospital (ASH) admissions are clearly a focus at national, regional and local levels to help reduce the burden, cost and public health impact of hospitalisation. The more people who can be treated in the community the less expenditure is required on comparatively expensive interventions.
- **Devolving some secondary care services to primary care.** Some secondary care services are suitable for devolving to more convenient (timely and cost effective) primary care settings. This recognises the fact that some services being delivered in a hospital setting is merely a function of tradition. This places an increased expectation and pressure on primary care that they have the resource, training, management and technical expertise to deliver these services.
- **Ensuring workforce, IT and capital are appropriately aligned.** Reconfiguring services creates opportunities for doing things differently. The National Health Board has recognised the inter-dependencies and linkage between three types of assets in health care delivery - *people, technology and facilities*. They have taken an integrated view of how investments in one of these areas have a corresponding impact on the others. This recognition and treatment has driven similar discussions at regional and local levels and is “unlocking” hitherto unexplored territory in funding and service delivery models and discussions.

4.1.2 Regional Response

These national responses are cascading into regional and local initiatives. Many of these blend the need to spend the health dollar wisely with variations of the approaches outlined above. These include:

- **PHO consolidation and mergers:** At the regional level we are seeing some consolidation of Primary Health Organisation’s (PHOs). At the time of writing this document, the Ministry of Health recognise there being 81 PHOs in New Zealand. There is a balance to be struck between local accessibility, autonomy and service against duplication in overhead costs and the number of patients as being optimal for a PHO to be viable. The Ministry proposes to drive aggregation of PHOs to improve management capability and capacity by reducing the management subsidy to PHOs with less than 40,000 enrolled patients – with that happening by amalgamation, confederation or some other shared managerial support approach. This, along with other drivers, has caused a move toward consolidation and mergers. The biggest example of this to-date is the consolidation to a single PHO that occurred in Dunedin in January 2010. The Dunedin example is further punctuated by the DHB merger between Otago and Southland DHBs this year. Consolidation brings opportunities to review service delivery models and contracting arrangements with DHB Funding and Planning arms and broader network affiliations. As this evolves and consolidation takes place (causing organisations to serve larger populations), the need for more sophisticated resource (workforce management and planning) becomes more acute. New and different service delivery models will develop to optimise resource around the patient and improve the patent journey while also reaping some of the rewards of better co-ordinated care. These models are evolving from both Secondary to Primary care relationships and primary to primary care (including NGO) relationships.
- **Developing alliance contracting models:** Funding and corresponding contract agreements have traditionally been a master-servant relationship between DHB Funding and Planning and PHOs for specific delivery of service to the population. The contract landscape is evolving into multi-party relationships that reflect a principle-based and outcome-based intent rather than the traditional legal and risk-management based contracts. This results in a “light/high principle, low legal” framework that a number of partners is willing to sign up to with a corresponding pain/gain share. Gain is seen as re-investment of any savings into other collaborative work for the patient population in areas mutually identified as needing focus to improve health outcomes. As these models evolve, there is a need for greater transparency and common definition of measurements to evaluate the effectiveness of the outcome and to provide a useful framework for the early identification of issues and corresponding modification of service delivery models. This implies – everyone using the same framework, everyone reporting on tangible measurements that directly relate to the quality of the targeted outcome and up-to-date information on which to evaluate progress. There are broader Intellectual property issues to work through; though New Zealand has a high degree of willingness to share.
- **Re-configuring service models:** In catering for population need, providers are increasingly looking to new and different service delivery models to optimise resource around the patient and improve the

patient journey. These models are evolving from both Secondary to Primary Care relationships and Primary to Primary Care (including NGO) relationships.

- **Integrated Family Health Centres (IFHC):** IFHC have been identified by the Government as one solution to secondary devolution of care. An IFHC is a single facility that provides multiple co-ordinated services – including front-line clinical and care services supported by diagnostic, pharmacy and other support services under one roof. Of the successful "Better, Sooner, More Convenient" (BSMC) business cases, there are at least 20 IFHCs that have been identified for commissioning as part of the business cases. It should be noted that, as the business cases are fine-tuned, this number may change and some may opt for the networked model outlined below.
- **Virtual Integration Share Care (IFHN):** A variation on the IFHC theme is the network of integrated care which coalesce around the patient and their needs – with a hub-and-spoke support and coordination arrangement or a network arrangement without the care being delivered in a single facility. Some have termed this "community health hubs". Mid-Central have defined three different types of integration: (i) Co-located, (ii) Visiting and (iii) Co-ordinated. Each of these have a role to play depending on the circumstances, population and workforce in an area. A number of the BSMC business case respondents have opted for a virtual model of care either in addition to or instead of an IFHC.
- **Shared care models/collaborative care:** Shared Care provides a patient-centred and prospective and coordinated plan that links clinicians and care givers across a range of services and locations. In some cases, these are pre-defined "pathways' reflected well-established clinical protocols – in other cases, it is a plan agreed, monitored and acted upon by a multi-disciplinary care team. In some cases (and increasingly evident through research), the patient themselves becomes an integral member of their care team.
- **A unified system**: An integrated view of available resources across the region, regardless of the setting of care. This "systemic" view provides a more effective view of resources to help better allocation for right-siting and right-resource to perform the relevant intervention for patients.
- **Re-configuring roles for service delivery:** As new models of care are being evaluated, this is providing an opportunity to review the "right-siting" and right resource (i.e. work someone at the top of their pay grade and skill set). This is resulting in an increasing focus on nurse-led clinics, nurse specialists and, in one case, First Specialist Assessment being undertaken by General Practice in a community setting. This trend creates new paradigm for case management (in some cases, Specialist or Hospital-centred co-ordination, GP as case-manger, or a "Health Navigator" being a clinician though not necessarily a medical professional). We will watch with interest to see what this does to a once--medical model centred approach. It creates a broader network or resource for patient care – closer to the point of their home. At the same time, it creates more resources to co-ordinate and the need to consider how best to blend or optimise medical records to reflect the combination of medical, nursing and wider allied-health into a single record around the patient. As the locus of patient co-ordination shifts outward from hospital specialist and GP to nurse and other health care provider, this also increases the need for better certification and identity management processes to be in place to ensure people with the relevant qualifications and current practicing certification are enrolled in the patient's care.

- **Re-orientation of funding streams:** As new models of care delivery are developed, the current funding streams and silos that separate secondary and primary services through referral mechanisms will need to be examined. Some districts have already started to evolve the thinking into a more "borderless" approach e.g. The Canterbury Initiative that has used the Care Pathways designed by local clinicians (representing secondary and primary care) to map patient journeys, relevant measurements and funding flows to.

4.1.3 Community (Local) Response

The healthcare domain is beginning to blend into the wellness domain. This is to be encouraged, as greater self management potentially reduces ambulatory sensitive hospital admissions and encourages treatment in primary care.

Health consumers have much clearer expectations and are asking to be better informed and have more choices in their own care. As chronic disease becomes more prevalent and there is a greater focus on indicators of risk that are markers of on-set chronic disease, there is a greater move toward patient and family education and enabling the patient to become a key partner in their own care. This calls for the right educational material to be made available for patients (i.e. a trusted source) and the right feedback loops to be built into the process to enable the clinical community to react at the right time and with the appropriate intervention when a patient is outside the normal range. At the same time, experience with other consumer services such as banking are driving demand for services that are wrapped around the patients and that are better linked up and coordinated. Patients need to be aware of the relevant pathway(s) for their condition, the local resources available to them and be plugged into a “prepared, pro-active practice team” for case management and supported self-management.

In addition to changing health consumer expectations, at a Community level, three other trends need to be noted:

- **Whanau Ora:** Community based and culturally appropriate models of support that recognise whanau and community input to wellness and health are being developed in conjunction with relevant specialists and professionals when required. This is an empowering model that provides tools, education and encouragement within communities to take control of their own health and wellbeing as a community. While the health profession grapple with how best to manage the medical versus the nursing centred model of care, this replaces both with the element of whanau as integral to the provision of care and wellness.
- **NGO’s within Primary Care:** There is a change occurring in the sector that is seeing an increasing move to organisations partnering (particularly in primary care) rather than a master-servant contract relationship between funder and provider. This reflects the alliance contracting model and reconfiguration of services. This move legitimises the NGO’s role as active participants in a shared care environment. Some of the implications of this move include:
    - The need to address NGO relationships and contracting models with the health sector.
    - The need to de-silo data appropriately.
    - The need to address privacy issues in relation to shared care records.
- **Looking after the Children will look after the future:** The need to actively managing future health demand is very clear and will be further enabled by technological innovations that are currently in development. Child health is a key domain for improved quality and information. Currently, a range of NGO’s and other agencies are wrapped around the unborn child and their early life thanks to maternity and children’s wellness services. If shared care is not achieved in this area then valuable opportunities to manage future health demand is forfeited. The health records related to maternity and early childhood are currently owned by a variety of different organisations. In our view opportunities to insure the future health of citizens is being missed through this fragmentation.

4.2 What is happening internationally?

Most of the New Zealand trends are echoed internationally. In a recent survey by PriceWaterhouseCoopers of 580 executives across 27 countries[3], the following trends were reported:

- The most effective means of demand management are wellness, immunisation and disease management.
- More than 80% of respondents identified lack of care integration as a major problem facing the health delivery system.
- There is wide support for a health system with shared financial risks and responsibility among private and public payers versus the historic cost-shifting model.
- Preventative care and disease management programs have untapped potential to enhance health status and reduce costs.
- IT is an important enabler in resolving healthcare issues when there is system-wide and organisational commitment and investment.

[3] Healthcast 2020 – Creating a sustainable future – PWC (www.pwc.com/nz/healthcast)

- Convergence is occurring as best practices are shared and the lines become blurred among Pharmaceuticals, life sciences, providers, clinicians and payers in the provision of care, access and safety.

Comparison of international trends and NZ drivers/responses	
International trends	**New Zealand mirror**
Managing wellness	• Demographic pressure • Informed and activated patient • Self managements and assisted self management • Looking after the children with look after the future
Integrating care	• Shared care • Contract management • Reach out (General Practice out to NGO and community – see Section 4.4) • Reach-in (primary care visibility of hospital clinical workstation – See Section 4.4) • Reconfiguring service models • Shared care models/Collaborative care • Unified system
Public Private partnerships	• Contract management • NGOs within Primary Care • PHO consolidation and mergers • Developing Alliance contracting • Re-orientation of funding streams • Aligning workforce, IT and Capital
Preventive care and Disease Management	• Teleconferencing and telehealth • Whanau Ora • Reduced ambulatory hospitalisation • Constrained resources
Management IT as an enabler	• Document management • Web presence • Teleconferencing and telehealth • Regional data warehousing & reporting • PMS system data consolidation • Regional identification services • Regional Authentication services • Virtualisation and consolidation of managed • Aligning workforce, IT and Capital
Best practice and intra-professional team working	• Contract management • Teleconferencing and telehealth • Reach out • Reach in • IHFC • IHFN • Developing Alliance contracting • Shared care models/Collaborative care • Secondary care devolution • Reconfiguring roles for service delivery

The report goes on to identify the common characteristics of a sustainable healthcare system (many of which are familiar from a New Zealand context):

1. A quest for common ground – a vision and strategy is needed to balance public and private interests.
2. A digital background – Better use of technology and electronic networks accelerate integration, standardisation and knowledge transfer.

3. Incentive realignment – Incentive systems need to manage access to care while supporting accountability and responsibility for healthcare decisions.
4. Quality and Safety Standardisation –defined and enforced clinical standards establish mechanisms for accountability and enhanced transparency, thereby building consumer trust.
5. Strategic resource deployment - Resource allocation satisfies competing demands on systems to control costs while providing sufficient access to care.
6. Climate of innovation - Innovation, technology and process changes are a means to continuously improve treatment, efficiency and outcomes.
7. Adequate delivery, roles and structures – flexible care settings and expanded clinical roles provide avenues for care that are centred on the needs of the patient.

One further interesting observation in the report is:

Portfolio management – Governments are calling for rational approaches to regional service planning. Providers are organising and allocating services to meeting consumer's needs for access manage quality of care and reduce duplication and inefficiency. In the UK, there has been some experimentation with Polyclinics, facilities that house and provide integrated services, in some areas. The polyclinic's first prominent appearance was in 'Healthcare for London' (NHS London, 2007) the strategic review of London's Healthcare conducted by Lord Darzi. These have not proved as successful as expected.

4.2.1 Predictive Risk Modelling

Predictive Risk Models (PRMs) are case-finding tools that enable health care systems to identify patients at risk of expensive and potentially avoidable events such as emergency hospitalization. Examples include the PARR (Patients-at-Risk-of-Rehospitalisation) tool and Combined Predictive Model used by the National Health Service in England. When such models are coupled with an appropriate preventive intervention designed to avert the adverse events, they represent a useful strategy for improving the targeting and cost-effectiveness of preventive health care. [4]

Putting this in a New Zealand context, PRM provides the opportunity to identify high-risk patients so that they can be offered a preventive intervention and is aimed at simultaneously improving care and reducing net expenditure. The predictive tool is used to target "upstream" interventions at those patients who are most likely to benefit in terms of a reduction in the "downstream" costs of emergency hospitalization and managing these patients in the community setting.

4.3 The New Zealand Health IT Plan

The Draft National Health IT Plan (April 2010) maps the three main facets of "Enabling an integrated healthcare model" as being Secondary, Primary (and corresponding linkages) as a Phase 1 focus with the longer-term focus of a Shared Care model – all underpinned by a clinical data repository.

Patients First is the vehicle that the National Health IT Board is holding accountable to deliver the Primary Care component of the Plan, working closely with the sector and points of integration between secondary and primary care with a view toward Shared Care.

[4] Adapted from Predictive Risk Modelling in Health: Options for Australia and New Zealand - Laura Panattoni, Rhema Vaithianathan , Toni Ashton, and Geraint Lewis

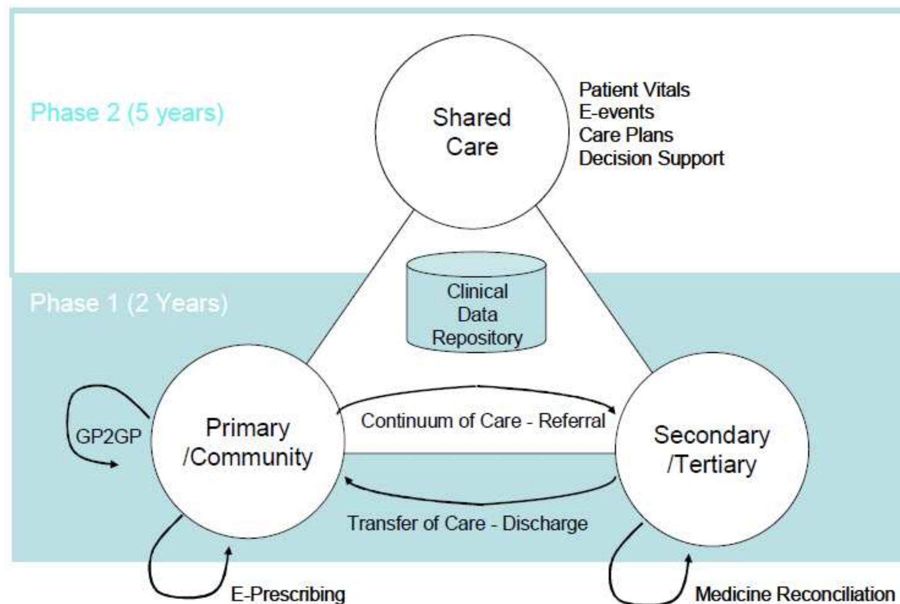

Figure 6: The (Draft) National Health IT Plan- enabling an integrated healthcare model[5]

The Purpose of the Health IT Plan is to

"define and progress the development of a sustainable, effective nationwide information and technology environment that:

- *Fosters safety and quality care*
- *Is person-centred*
- *Is provider-friendly*
- *Increases productivity of the system as a whole"*

We believe these will be the success criteria against which both the national health IT delivery is measured including the Primary Care information and quality programme as a major contributor to it.

The approach outlined in the plan reflects that incremental change leads to transformational change. This step-wise approach is one that the Patients First Programme is adopting in

- Recognising existing local and regional initiatives in the sector that are useful in a broader context and can be amplified and disseminated to others.
- Building on foundational work then leveraging it (e.g. delivery of GP2GP then leveraging it for e-continuum of care and evolving it as a primary care dataset)

The Draft National Health IT Plan identifies several existing or signalled projects in Primary Care. With the benefit of the market scan and identification of emerging trends in Primary Care identified in this report, we can now further contribute to and elaborate on the Primary Care and elements of the Shared Care areas of the National Health IT Plan.

[5] National Health IT Plan (Draft for discussion) April 2010- IT Health Board

4.3.1 Key themes relating to Primary Care

The Plan outlines the health sector priorities and creates "focus areas" between these priorities and corresponding information initiatives. While Primary care is just one component of the Health strategy and Health IT Plan, the breadth of primary care creates many direct and indirect touch-points on many areas of the plan. These may be viewed in two main areas:

- Foundation Projects/Enablers – which define data consistently and enable the various players in the eco-system to join-up information for more cohesive and effective service delivery to patients and the measurement thereof.
- Enabling new models of care – the transformative initiatives that create a sustainable and cohesive approach to better enabling access to and analysis of information to drive quality of care and outcomes and to join-up providers across the eco-system of care centred on the patient.

The table below outlines the six focus areas of the National Health IT Plan and reflects the Patients First contribution to the plan. In some cases, the contribution is direct, in others, there are indirect relationships that will contribute to the goals.

National Health IT Plan – Focus Areas	**Primary Care contributors:**
Quality Information for Primary Healthcare	This is our fundamental linkage with the plan – it recognises a bottom-up/sector driven set of information systems and processes to support day-to-day service delivery and business – though balanced with a coordinated view of shared information and corresponding quality measures. Patients First provides the bridge between the autonomous activity within the care networks with a facilitation and coordination role around information sharing and quality. Specific current projects that support this area currently include: • PMS Requirements • Clinical Pathway evaluation study • Clinical Quality indications • GP2GP • SMM Our research has highlighted some other areas that complement and leverage the strategy. The main driver is to get quality and consistency of information for sharing, measuring and consequent evolving of practice models that create a learning and quality model. Primary Care needs to achieve quality and reach in order to succeed - we will be measured on effective change in practice and supporting systems to achieve it.
Continuum of Care	Continuity of care relies on timely, accurate and relevant information being shared throughout the health eco-system in a structured way. GP2GP creates a platform for transfer of structured patient data between practice management systems. The plan is to leverage this platform to enable the exchange of information both within the primary environment and between primary and secondary environments i.e. evolving GP2GP as a primary care

National Health IT Plan – Focus Areas	Primary Care contributors:
	dataset (and extending it over time to a broader primary care set of information that accommodates other disciplines beyond General Practice). This will initially take the form of e-referral and e-discharge though from a primary/secondary interface though also paves the way for shared care.
Safe Medications Management	Patients First is working with the SMM Programme as the interface with Primary Care. A range of initiatives are underway within this work stream which include – a measurements framework, defining a primary care view of medication information required for referral and discharge, medicines reconciliation (between hospitals and GPs and GPs and Rest Homes) and community e-prescribing.
Clinical Support	While the main focus of this in the Health IT Plan is secondary and tertiary services, the diagnostics area of focus has links to enabling the networked model of care articulated in many of the BSMC business cases. Primary Care needs to have effective and active access to diagnostic information at point of care and link-up with secondary services to avoid duplication of or silos of results (i.e. take a patient-centric view of diagnostic results).
Safe Sharing of Information	One of the areas of focus is the shared care plan. There is considerable work in primary care around shared care driven by secondary care devolution and a desire for more efficient care delivery and patient focus. This is a consistent theme in the BSMC Business Cases. The Patients First work around The Clinical Pathway Tool evaluation has a strong emphasis on safe sharing of information as does the Clinical Quality Indicators work to date. Identity Management (formerly RPI - the replacement to NHI and HPI) is a key enabler of shared care records and there needs to be primary care input to the design considerations around identification and authentication elements of this project.
Patient Administration	This area is focussed more toward secondary care Patient Management systems and seeks consolidation of them. There are linkages that Patients First needs to have into this regarding e-continuum of care – particularly in the sharing of information in a structured form regarding referral, transfer and discharge between secondary and primary care systems.

4.3.2 Where does Patients First fit with relation to the plan?

The National Health IT Board is holding Patients First accountable as the 'Primary Healthcare IT Programme Group". As such, the programme needs to use its existing linkages with General Practice, Community Pharmacy and Nursing to create a baseline of effective information and quality then leverage this by developing effective working relationships into the broader Primary Care sector.

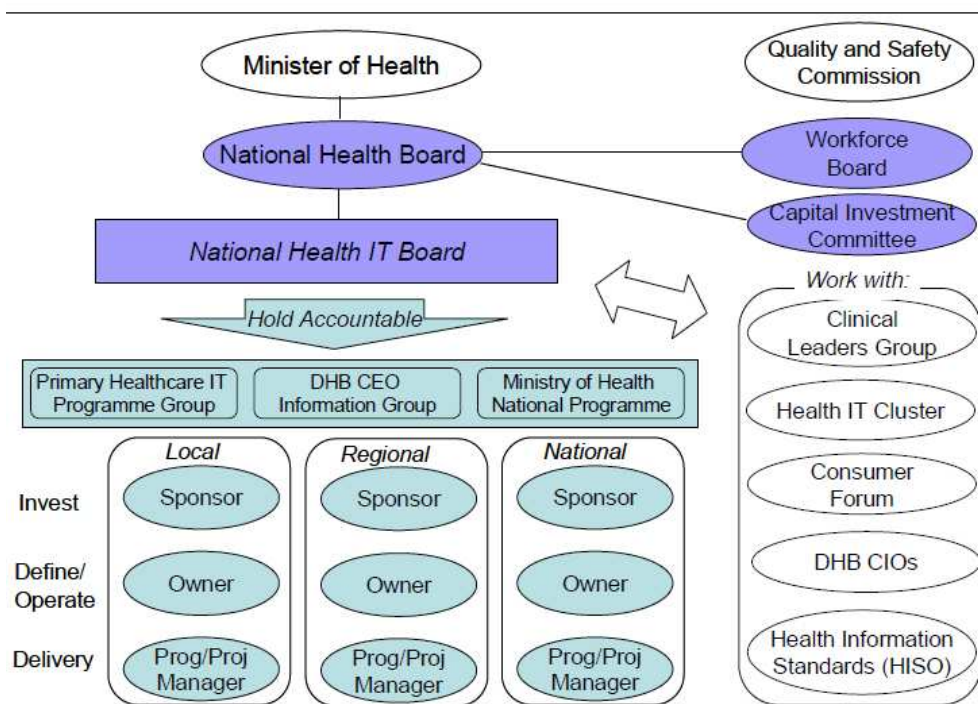

Figure 7: Governance of the National Health IT Plan[6]

4.3.3 Shared Care

While the National Health IT Plan draws clear distinctions and linkages between Secondary, Primary and Shared Care with a Phase 2 focus on Shared Care – these new models of delivery are being considered and designed now – in regional and local clusters. This can be seen clearly in the BSMC initiatives where most have short term action planned that will depend on an increased level of communication, interaction and shared care between hospital and primary clinicians. Each of these have information, quality and performance requirements that are not readily achieved within the current information environment.

To date most of the focus has been on information exchange across organisational and practice boundaries – e-referrals, e-discharges, The next step requires forming an information environment that shifts these into a capability to support integrated, cross boundary care processes. The work Patients First is currently undertaking around the feasibility of a National Clinical Pathways tool is one area of work that contributes to this development.

There are also strong drivers for further integration of cross boundary care processes into coordinated shared programmes of care that are emerging within the BSMC initiatives, Whanau Ora, and efforts by DHBs to address acute demand. A common feature is that shared care has to be capable of addressing the complexity of patients situation and multiple care needs, it must be people centric not service or particular

[6] p9 - National Health IT Plan (Draft for discussion) April 2010- IT Health Board

condition based. Both international research and local experience demonstrate that that this is effectively realised through a generalist, multi-disciplinary approach that focuses on what matters to patients and integrates multiple care processes around these needs. This requires primary/community based leadership of shared care; secondary driven or specialist led shared care approaches are unlikely to be successful or transferable across service domains.

The logical alignment of Shared Care co-ordination lies with Primary Care as that closest to the community and patients. Delivery of "up-stream" management and intervention in primary care settings has better health outcomes and lower cost profile than preventable "down-stream" hospitalisation or re-admission. As part of the sector scan and consultation, we have been asked by the clinical networks to assist in coordinating a sector response or comparisons of models and tools for Shared Care.

This document outlines a number of other initiatives that contribute to effective Shared Care management including the importance of this to child-health.

4.4 Information and Technology trends in Primary Care in New Zealand

The focus to-date for this report has been on General Practice and its integration with Secondary care and community Pharmacy. Further consideration will be given to the broader primary care sector in future phases – using a ripple effect emanating out from general practice.

Technology trends outlined below are a result of two different factors:

<u>Existing maturity and capability</u>

A function of the focus and corresponding maturity of specific streams of effort in some areas of the sector. This can be considered as a "composite success" model i.e. where no single organisation has all of the answers though collectively, there are pockets of success that could (and should) be encouraged, developed and applied more broadly in the sector (amplified, and distributed)

<u>Response to clinical and business drivers in this time of change</u>

These are areas of yet-to-be-developed current and future-focus required to address some of the current drivers and issues being faced by the health care sector in New Zealand.

Trend	Narrative
Shared Care	Providing a care pathways framework for effective shared-care between providers. This combines pathway protocols and either integrated or related referral tools. Some providers are using clinical decision support tools to map specific illness and corresponding intervention – whilst others are considering Map of medicine or other alternatives (e.g. The Canterbury Initiative's in-house developed "Health Pathways").
Document management	As PHOs merge and new service delivery models consider multi-disciplinary teams or re-configured roles, practices and managed service agencies are recognising the need to more effectively disseminate information including standards, training and reporting. Different Clinical Networks are looking at different solutions for this – each of those who are looking are asking what others have done and whether there is a shared knowledge and or purchasing opportunity.

Trend	Narrative
Web presence	As the BSMC business cases evolve and highlight the need for closer integration and commonality of reporting, shared care and clinical records, providers are seeking to extend their web capabilities to include on-line learning and member forums including reporting capability.
Contract Management	The advent of new collaboration models and Alliance Contracts creates a more complex multi-lateral contracting environment. This is made more acute as PHO mergers occur – where smaller PHOs with "in flight" contracts need to be assumed into larger PHOs. Different PHOs are looking at different solutions for this – each of those who are looking are asking what others have done and whether there is a shared knowledge and or purchasing opportunity.
Video-conferencing and telehealth	PHO consolidation, new service delivery models and shared care place an increasing geographic spread of people within the same or related networks of care. With the advent of increased network speed, technology maturity and reduced cost-profile of videoconferencing and IP based meeting and web-cam technology; some clinicians and teams are increasingly turning to virtual meetings for management and clinical peer-group discussion and education. In at least one known case, this has also extended to private consultations using SKYPE with web-cam technology. While this technology is becoming increasingly of interest, complexity of setup and occasional "technical glitches" have limited the up-take – though demand is increasing.
Reach-out (rest homes and emergency services)	Clinical Networks and providers realise they work in an eco-system. With the goal of better coordination of care and, in many cases, virtual networks of care around a patient, practices are recognising the need to integrate with broader care providers in primary care. This includes rest homes (particularly around the need for medications reconciliation and prescribing) and emergency (e.g. Ambulance) services for diagnosis and rudimentary care provision.
Reach-in (ED visibility)	Some providers have "given up" on e-discharge being an effective way of gaining useful or timely visibility of their patients who have had an acute hospital admission. Instead, they are turning to access of the local DHB's clinical workstation and some way of flagging the attendance so they have visibility as a trigger to know to view the record. In one case, a network funds a partial FTE in the ED department to enter the details of the ED event in a networked version of their Practice Management System. Discharges are mostly electronic postage systems at present- providing a single object of the discharge information (as interpreted as useful information by the discharging physician) – and ending up in the GPs in-box- then requiring re-keying of relevant detail. The health event summary record – if held at a regional level – may go some way to addressing this. There is a gap between information specialists believe may be useful in a Discharge summary and what primary care clinicians find useful. This is exacerbated by different formats used by different hospitals.

Trend	Narrative
Regional data warehouse and reporting	Information is the window to good practice and quality. With the advent of PHO consolidation, closer integration, shared care and alliance contracts, there is greater reliance on consistent recording and reporting of information. Some networks have or are in the process of developing sophisticated suites of analysis software that overlay their PMS systems and mine them for quality, clinical indicator and compliance information. These tools also need to be used to assess the efficacy of service delivery and allow information to be used in a way to modify pathways and service delivery models to optimise them. Most of the existing tools (and those being considered) are overlays on existing PMS's or highly customised reporting frameworks custom developed for the local requirements. There are few cases where the native PMS reporting capability is quoted as being suitable for these reporting needs.
PMS system data consolidation and conversion	Some Clinical Networks are running multiple PMS vendor systems – and/or versions. This creates issues when trying to take a consolidated view of information and corresponding interpretation. It also means an added training and administration burden. Many providers within the network are looking at upgrading existing systems or using the upgrade need to review functionality, support and fit for purpose of their current PMS. PHO consolidation is also driving the need for conversion management (for population registers and PMS consolidation). Data conversion for PHO mergers mid-reporting cycle (for PPP or other compliance reporting) will be an issue that larger PHOs and network providers will need to consider. Among other considerations, real time enrolment aspects of the Identity Management project (formerly RPI – the NHI/HPI replacement) need to be carefully considered in the light of PHO and clinical network reporting processes.
Regional identification service	As the system gets or needs to become more joined-up, there is a greater need for identity management services (a trusted directory of clinicians who need access to defined levels of information across various settings of care and who might work for different organisations). In some cases, the complexity of this is compounded by clinicians who practice across multiple organisations simultaneously.
Regional Authentication Service	Linked to a regional identity service is the need for a regional authentication service which provides authenticated and secure access across a defined eco-system. This includes secondary, primary (and sometimes community and NGO) care providers and settings.
Virtualisation and consolidation of managed PMS environments	PMS systems in New Zealand operate on a client/server architecture – with the lowest common denominator being a "PC on or under a GPs desk". While this is manageable for a practice in a single location – it does provide challenges for multi-location practices who need to share information or localised practices who require some form of robust backup and disaster recovery plan. There is a tension between the increasing demand for an "always-on" environment and the benefits of a hosted model in doing this versus network latency or reliability for remote areas. Some of the networks are looking at the virtualisation and hosting of PMS for all of their sites to provide better service, maintenance, reporting and business

Trend	Narrative
	continuity. Cloud computing and SaaS are also being looked into as ideal platforms to move from capital cost to operating cost – and managed/shared environments available beyond the 4 walls of a practice.
IFHC commissioning	Creating a centre of excellence for management and coordination of Integrated Family Health Centres (and/or networks) will require a suite of systems and processes to manage clinical delivery and front line support services. Shifting the focus from co-located to integrated will require consolidation and standardisation of processes, tools, information, definitions and policy/standards. This is unlikely to be as easy as copying and re-purposing what's already there. With approximately 20 IFHCs identified in the original BSMC business cases, the sector runs the risk of some duplication and (vendor) resource contention.
Privacy policy and framework	As new service delivery models are planned, shared care models explored and alliance relationships are formed, there is a need to address some core and common principles around privacy. A number of organisations seeking to develop and use a consistent health summary record across providers have or are due to undertake Privacy Impact Assessments (PIA). While there is a need for a PIA for each different implementation – there is use in providing the sector with a core and common set of principles and easily applied template and checklist for undertaking a PIA.
Shared e-health record	Many providers are "Waiting and watching" the shared care space to see what evolves. There is no clear vendor leader in this space at present – and the closest the sector has to good integration in a region (though at a level of referral rather than prospective case management and shared care) is the Canterbury Initiative.
ManageMyHealth	As a placeholder and short-term solution to integrated care, most of the BSMC business cases have identified MedTech's ManageMyHealth as a proxy for a shared care record. Although all admit that this is limited to a web-based/accessible summary record (originally intended as a patient held and managed record) – and not a prospective planning record, it does provide a readily available and sharable summary record of the patient. The business and commercial model (including information governance) for this technology is not proven as yet and various providers are at differing levels of planning and discussion with MedTech regarding applying the technology. The most advanced in the process is Compass Health. The simultaneous demand has the risk of creating resource contention (from the vendor) for delivery. Several networks have highlighted the usefulness of clubbing together on this initiative or sharing knowledge with a beacon site/project.
Broadband for rural and remote areas	As primary care becomes more integrated between providers and networks, there is an increasing demand (if not expectation) that there will be sufficient network bandwidth and quality to accommodate high-availability and fast response times. Some providers who do not have fibre or other high-speed options are currently looking at network provider options – while others have created their own WANS or clubbed with local DHBs to provide a secure and robust network.

Trend	Narrative
Measurements framework – Clinical, contract, outcomes	The combination of factors that is leading to a need for joined-up and consistent information that is patient-centred is also driving the need for effective measurement – of clinical process (to inform peer review, internal benchmarking and pathway improvement), contract management and delivery (especially under multi-lateral alliance agreements) and outcomes (e.g. PPP). There is a recognition of the need to move information up the value chain – from Data to Information to Knowledge and then to Wisdom. A number of Clinical Networks use a model that acknowledges this or a similar construct.
Data quality and better clinical coding	Measuring and quality is only as good as the data in the system. Recent evaluation by the Wellington School of Medicine as part of the Clinical Quality Indicators project highlighted a number of issues in clinical coding that would potentially compromise the indicator results. This issue has also been echoed by the Cornerstone programme and sponsors of CQI within RNZCGP.

4.5 Key Learnings from Emerging Trends

There are many similarities in the Primary sectors response to the current drivers in health care. These are evidenced through a review of the BSMC business cases. This provides benefits in terms of a coherent response to a more focussed and integrated model of service delivery – and recognises that different regions and organisations face different challenges unique to their local circumstances.

There is also a risk, however, that through disaggregation comes potential duplication of effort and calling on common resources and vendors to do similar or the same things many times over.

Some of the key lessons that have emerged from the themes include:

1. There is considerable focus on IFHC and IFHN (network) commissioning
2. There is consistent focus on using interim steps toward a shared care record
3. There are pockets of capability and success in areas e.g.– reporting and information mining, virtualisation, Care Pathway planning, telehealth and videoconferencing, Privacy Impact Assessment in a shared care model among other things.
4. Networks are willing to share knowledge where they have it and asking for input where they do not. There are opportunities to join some dots.
5. There are about to be many examples of similar activity happening in silos and drawing from the same pool of vendor expertise.
6. Many are talking about shared care and managed networks – though time has not allowed for too much sharing or cross-fertilisation of ideas.

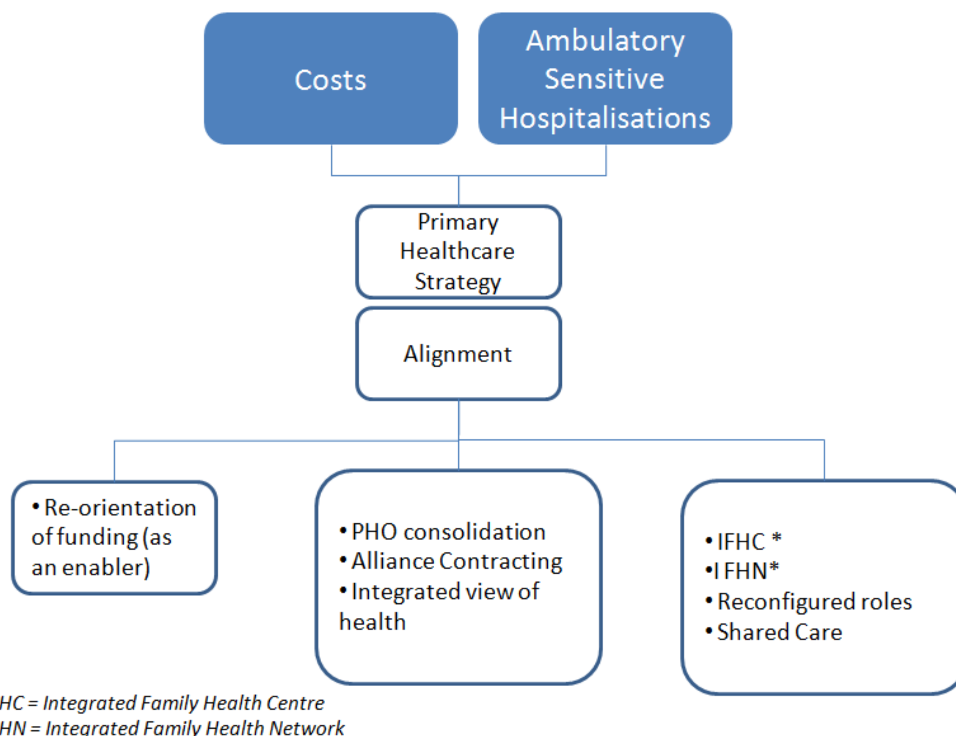

Figure 8: The Primary Care response to sector drivers

5 Response to Emerging Trends

In this section, we consider a framework for sustainable and cohesive action and a series of projects/initiatives to progress Patients First.

> *Anything done in health care that does not help a patient or family is, by definition, waste, whether or not the professions and their associations traditionally hallow it. (Berwick 1997)*

5.1 Framework

In responding to the current trends and creating the Leadership group and evolving its focus, we have developed a framework that considers strategy, leadership and delivery. This is best reflected from the three different perspectives of:

“Why” is a constant – a unifying focus – The Patient.

“What” lets our mandate be tested and evolved. This should be clear and agreed by the stakeholders including the shareholders, funder and the sector by the time consultation under the programme is completed. This gets turned into a mandate.

“How” will evolve and develop over time – at a tactical level, it is a set of identified initiatives and prioritisation criteria that describes the action plan for Patients First.

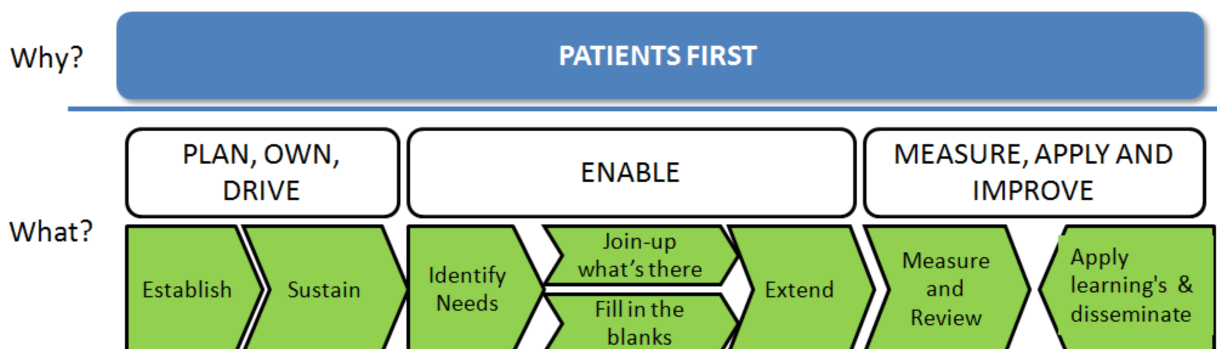

Figure 9: Patients First Framework for delivery

5.1.1 Why – Patients First

In evolving from qi4gp, we wanted to reflect a name for the programme that encompassed the essence of our primary reason for being. Patients First is a name that transcends different settings of care, healthcare disciplines or practice focus and puts the focus where it belongs.

Using “Patients First” as being synonymous with Primary care is also a message about where people spend most of their time – at home, at work and in the community. 80% of all New Zealander’s have seen their regular GP in the last 12 months, there are 17m patient visits to general practice each year in comparison with 650,000 hospital discharges.

Lining up behind the patient means different things to different stakeholders in healthcare. These are summarised as:

What does it mean for me?

Patients

- Clearer/simpler journey through system
- Care leadership role (a health navigator)
- Safe and effective care
- Right information available at right time
- Equity of care – regardless of location
- Information available and more accessible for me

Clinicians

- Assurance of excellence (how am I doing in comparison with peers?)
- Access to and part of a joined-up network of care
- Access to a robust and consistent evidence base regardless of location
- Joined-up information between providers that presents a holistic view of the patient

Funders

- Value for money/efficiency
- Improved population outcomes
- Reduced disparity
- Joined-up care
- Accurate, timely and relevant information for heath planning and research

Figure 10: Patients First – what does it mean to different stakeholders?

5.1.2 What – Organisation (Plan, Own, Drive)

The programme needs to turn into an operational entity with an operating framework and established rhythm of operation. To date there have been a number of discussions between RNZCGP and GPNZ regarding relevant transfer charges between the two shareholders in the programme – these have not been useful and have the risk of detracting from the external facing delivery for Patients First.

The joint sponsor organisations of Patients First are reviewing the creation/structuring of the Programme as an entity in its own right – e.g. in the form of a Charitable Trust with two equal shareholding organisations (RNZCGP and GPNZ). This vehicle would be used to channel all future quality and information initiatives and operate a governance group that reflects business operation and links with the primary care sector.

Resourcing will be via a small programme office that oversees the activity and acts as a co-ordination point for strategy, operation and reporting. Resources will be supplemented for specific projects on a project-by-project basis and co-opting the network where this is feasible. Over time, a core Project Management capacity may be built up within Patients First. Enough runway for 12 months rolling contracts is required before this can be achieved.

Patients First will

1. Provide leadership to support quality and information in Primary Care
2. Create linkages with relevant groups – become a trusted facilitator and broker.
3. Become part of a coordinated prioritisation setting for Primary Care Quality and Information initiatives
4. Become the owners of the PMS requirements for the New Zealand primary care sector (this includes prioritisation of compliance requirements on a panel with funding agencies i.e. ACC, MOH, DHBNZ.
5. Create and maintain an active inventory of sector technology and quality initiatives
6. Provide a co-ordinated sector voice regarding PMS and quality
7. Design, leverage and extend a single dataset within Primary Care that fits into and complements the broader healthcare eco-system
8. Apply the science of quality to general practice and beyond.

5.1.3 What – The Enablers

This area of the plan looks at how we can provide the necessary pieces to primary care for effective information and quality management. This is reflected in four areas:

5.1.3.1 Identify Needs

This involves active consultation and interaction with the care networks – building the networks out from General Practice to a broader primary care view. Specific work includes:

1. Identification of the systems that the networks currently have in place – and reflection of where these fit in the overall New Zealand health eco-system (i.e. an inventory of systems across primary care)
2. Identification of current and planned initiatives around information (new systems, integration or sharing of information) and quality reporting and processes (new or additional indicators and mechanisms for review of quality and how learnings from these can be applied in practice).

This report reflects a large amount of work around a market scan. This needs to be maintained by continually getting out and talking to various forums and progressing the dialogue and understanding - informed by and informing the delivery of the programme.

5.1.3.2 Join Up what is there

This area focuses on joining the dots where activity is currently happening in silos and there is benefit in sharing the knowledge, resource or output with the broader sector. Examples of this include many of the referral and discharge projects currently happening between secondary and primary care and some of the work being done around child records (midwifery and maternity, Plunket, and better integration between child health and General Practice).

This focus does not necessarily call for new projects or activity – rather it creates a facilitated discussion and structures between initiatives that have the same or overlapping goals though may be duplicating effort or not aligned in the outcome. The main goal is to create accessible and common sets of information that can be joined-up among and between providers of care and fit within a defined and accessible eco-system.

5.1.3.3 Fill in the Blanks

This focus area seeks to gradually enhance the information base that is there and leverages it to add-on additional pieces (in terms of quality indicators, information systems and data). As gaps are identified in information (either a lack of a structure or poor data recording and data quality around existing information) these areas will be factored into the work plan.

This seeks to work with the frameworks we have and enhance them so we can contribute to better application and sharing of information.

At the heart of this is the consolidation and evolution of a Primary Care dataset (leveraging off GP2GP and other initiatives e.g. RSD (the Referral, Status, Discharge standard), then developing this out to a broader primary care perspective.

5.1.3.4 Extend

Reach is the main goal of this focus area. It looks to how we can leverage beyond general practice into broader primary care networks including the need to reflect NGO and community as key players in the provision of healthcare. As consultation and discussion with the sector around a patient centric approach evolves so too will the need to make information available between parties to achieve better outcomes. This is both in the area of information technology and quality (where some of the frameworks and measurements already developed can be used across a broader spectrum of care settings and disciplines).

In some cases, this approach will be an inside-out from secondary to general practice then out to broader networks of care. In other cases, it will be useful to create an outside-in or "pull" by using care and wellness models that are based more on self-support, supported self-management and community focussed wellness (e.g. shared care and Whanau Ora).

5.1.4 What – The Quality Agenda (Apply, Measure, Improve)

Quality is a cornerstone of the Leadership Group and integrates the information work with embedding continuous improvement and review in practice.

Whilst the National Health IT Board hold this Leadership Group accountable as the "Primary Healthcare IT Programme Group", the broader mandate and focus of the group is that of quality. Our working definition of quality is Safe, Timely, Effective, Efficient, Equitable and Patient-centred (STEEEP) care. The Leadership Group needs to ensure that information is seen in the context of an enabler of effective delivery of care and improving patient outcomes – and the application of quality measurements and frameworks around achieving this goal.

There has been considerable research and design work undertaken by the College in the area of Clinical Quality indicators and service quality under the Cornerstone programme. Patients First creates the vehicle for applying the science and integrating quality and technology for efficacy and reach.

Several different strands of activity in General Practice around measurements need to be inter-woven to create an effective quality framework in practice. This includes – a view of the service delivery models, outcomes, clinical quality and information (including data quality and effective tools for the analysis of information). The ultimate goal is ensuring that quality is embedded into day-to-day work practice – and continuous improvement is assisted by reviewing information derived as a by-product of delivering care.

As the sector better demonstrates its patient-centricity, it makes sense to move to an indicator model that also revolves around the patient and can provide some of the quality disciplines and measures against the broader network of care delivery.

What is required is an integrated view of indicators with a common governance model and common definitions, augmented by effective tools and teams to mine the information then review processes that allow constructive application of the learnings to improve the models of care delivery.

5.2 Managing the Work Programme

We neither lack for ideas nor the energy to implement them. However, if we do not take a focussed and step-wise approach we risk taking on too much and failing to deliver.

We see three ways in which we can achieve the balance of being plugged into and a common reference point for the sector while also delivering to the Primary Care Quality and information plan:

Active Projects and Pipeline	active programme workload delivering on the plan
Active Participation	staying plugged into the networks and forums
Watching brief	watch and publicise local and regional initiatives where there may be interest in others adopting and adapting them.

5.2.1 Active Projects and pipeline

This is the work plan of projects that are currently active or identified for work-up as part of delivering the plan. This will be managed by a funnel process whereby there are candidate projects identified which align to the strategy and direction of travel. This list will grow over time and be reviewed by the Leadership Group.
Of these candidate projects, a number will be identified for work-up to a business case and, pending approval of that, to implementation.

5.2.2 Active Participation

This includes sponsoring forums and events – centred around primary care Leadership and quality and workshops with sector forums and panels. Identified forums include: the HINZ conference, RNZCGP Quality conferences and, more regularly, the use of the Primary Care Information Management Group as a core reference group and point of dissemination.

5.2.3 Watching brief projects

These include projects and initiatives of interest from around the sector where the learning's can be published and explored for applicability to broader contexts than the original project. This may include a small set of innovation awards providing people a platform and reward – and shining a spotlight on grass-root initiatives that others may wish to borrow from.

5.3 Prioritisation

The following is a list of criteria for ranking projects
How does the initiative align to the STEEEP quality principles of:

- Safety
- Timely
- Effective
- Efficient
- Equitable
- Patient Centred

Reach (how many patients will this positively impact)?
Value for Money
Complexity
Risk
Cost

5.4 Current Projects/Initiatives

A set of projects is currently being delivered under the programme. A high-level summary of these is provided below:

	Leadership	PMS Requirements	Clinical Pathways Feasibility	GP2GP	Safe Medication Mgmt – Primary Care	Clinical Quality Indicators
Purpose	Create a sustainable "centre of gravity" for primary care quality and information initiatives. Create the governance model for managing it	Define the requirements for effective PMS functionality and eco-system for vendor product certification	Assess the feasibility of the implementation of a national toolset for clinical pathways and assess products that will fit this	Implement the structured dataset and mechanism for transferring patients between various PMS systems (and PHOs)	Extend the SMM programme into Primary Care (starting with GPs and Rest homes)	Apply the science of RNZCGP/WSoM CQI by operationalising the framework in practice
Progress	✓ Workshops held ✓ Governance group established ✓ Sector scan undertaken ✓ Programme oversight of projects	✓ Draft framework developed ✓ Network input to framework underway ✓ EOI system themes identified for inclusion	✓ Health Sector panel established ✓ First workshop held ✓ Problem definition ✓ 1st set of criteria identified ✓ Market scan underway	✓ Contracts being negotiated with MoH for delivery of service ✓ Vendor quotes being finalised ✓ Scope of build and delivery phases	✓ Contract signed ✓ Resources contracted (via Compass Health) ✓ Scope agreed ✓ Project underway ✓ Evaluation framework	✓ Meetings held with WSoM ,MoH, DHBNZ ✓ Discussions underway with DHBNZ regarding best way of working together
Next Steps	Interim report – emerging trends and priorities o Strategy and prioritisation criteria o Sector/stakeholder consultation o Identify and bid for future projects	o Interim report – draft framework o Sector/stakeholder consultation o Framework evolved	o Shortlist of products o Interim report o 2nd workshop - Review of products against criteria o 3rd workshop – implementation considerations	o MoH contract signed o Contracts signed with vendors o Functional Spec and Test Planning completed. Development underway by .	o Evaluation framework in place o Meds reconciliation project (GP to Rest home) underway o Minimum medications data (primary care view)	o Develop the plan for integrating CQI measurements into requirements for PMS o Work with DHBNZ re concept of an indicator library

5.5 Candidate Projects/Initiatives

Based on our analysis and response to current trends, the following summarises the projects Patients First has identified as being of most use in delivering against the plan:

Project	Description	Rationale
Primary Care dataset	Consolidate existing datasets (including GP2GP, RSD, Forms server) and augment where necessary to create a primary care dataset.	Create a common dataset for exchanging, reporting and using information between secondary and primary care and within primary care.
e-continuum of care – discharge and referral	Provide a common view of content and context of information best suited for Secondary Care to primary care flow of information to follow the patient.	Leverages the GP2GP work and information framework to adopt and adapt GP2GP as a broader primary care dataset. Creates a common language and framework for communicating patient flow between secondary and primary care and between providers within primary care.
Predictive Risk Assessment tool implementation	Provide a proactive risk and planning tool for identification and management of patients at high risk of unplanned readmission – based on the UK PARR (Patients at Risk of Re-admission) tool. This is implemented in Emergency Departments as part of the secondary care discharge process.	This is a proactive tool aimed specifically at addressing Ambulatory Sensitive Hospitalisations. Many of the BSMC business cases and networks have identified proactive management of high-risk patients as a key focus area – this initiative closes the proactive loop between secondary and primary care in attempting to address the issue of ASH.
Primary and community child health record	Create a protocol (set of practices and information) for better integration between maternity, midwifery and Plunket services and general practice.	The role of primary care in setting a solid foundation for child wellness is well understood though poorly integrated between providers of care. This seeks to better integrate information between providers so there is an uninterrupted transition of child health from pre-natal, early childhood and into an ongoing record of health for the over fives.

Project	Description	Rationale
Information to Support Quality Outcomes	A project with a number of work streams which include: • Integrated Indicator Library • Clinical coding data quality • Review of Tools for reporting (A summary of these is provided in the section below)	Creating a common framework and focal point for clinical quality and other indicators and making this available, accessible and meaningfully applied in clinical practice.
Significant Events Summary	Provide a common and centrally accessible tool across general practice for Significant Event Reporting that is hosted and maintained by an independent and trusted quality body (The College) and is used for effective information analysis for improving quality of care.	Learning should be adaptive and applied at local and aggregate levels. A significant Events system that caters for medication prescribing or other clinical events provides opportunities for review and learning. It also provides a structured protocol around escalation and management of events that are consistent and reflect the code of practice. Having a single common system allows standardisation of the protocol, information analysis and reduces the duplication of effort in networks designing and maintaining their own disparate systems.
e-pharmacy (SMM)	As part of the contracted SMM Primary Care work – implement and e-pharmacy project to electronically prescribe in community pharmacy and electronically record and reconcile dispensing.	Closes the loop electronically on medication management processes in the community.
Pathway pilot and rollout template (SHARED CARE)	As a logical phase 2 to the Clinical Pathway Feasibility Study – subject to the outcome of the feasibility project, this project seeks to implement a Pathway system that addresses the criteria outlined by the feasibility study and provide a core and common template for doing so to the broader sector.	Addresses the duplication of effort and some of the processes, governance and maintenance questions raised about pathway tools. Provides a consistent approach and understanding about how national level drivers can be driven and managed at a regional and local level within an agreed framework.
Whanau Ora quality and information framework (SHARED CARE)	In partnership with the National Maori PHO Coalition – create a framework for a shared care model and corresponding exchange and sharing of information and quality measures for socially centred wellness models (rather than medical or clinician centred healthcare delivery).	Whanau Ora will become an important delivery mechanism that embeds primary care within a broader people centric social and community continuum. The Coalition is seeking to develop the core information and quality constructs that will support Whanau Ora as a process of collaborative shared care.

Project	Description	Rationale
		Patients First aims to compliment this through linking those requirements to the wider primary health information and quality initiatives. This collaboration would provide a platform for a developing a complimentary shared care model. Creates an outside-in driver for patient-wellness.
ManageMyHealth template implementation	This may be undertaken under a “Watching brief” of an existing network. Document the learning’s , implementation and commercial framework for a template of ManageMyHealth as a shared record for patient information look-up between different settings of care.	Many of the BSMC business cases highlighted this a core plank in their strategy. This will involve Privacy and access, implementation and commercial considerations that the sector is at risk of repeating and calling on the same resource to do so. This provides some level of coordination and dissemination of the learning’s from a “beacon site” implementation that others can apply or adapt.
Innovation Award	Provide a pool of funding and channel for publishing/broadcasting some of the good grass-roots activities that others could adopt and adapt. This could be a nominal amount of $ (token) as a prize pool accompanied by some seed funding for others to implement the initiative. Use an independent, clinically focussed group to select the winners and existing journals/publications to publish the results.	A good method of keeping an active inventory of some of the innovations happening within the sector at the same time as rewarding innovation and others adopting it.

5.5.1 Information to Support Quality Outcomes

Quality Stream	Description	Rationale
Integrated Indicator Library (QUALITY)	To provide a common focal point, accessible library and set of definitions and governance framework over Clinical Quality Indicators and Quality indicators – initially starting with PPP and Clinical Quality Indicators from RNZGP.	There are different interpretations of PPP indicators and, currently, the RNZCGP commissioned WSoM Clinical Quality Indicators are a framework that is not embedded in an accessible tool that can be applied to PMS system for use. Creation of a common library allows the governance group to consider if

Quality Stream	Description	Rationale
		existing measures will meet new demands (rather than another silo of compliance and reporting requirements being created) It creates a common reference point for definitions (a single source of truth) and makes the library accessible for primary care providers and PMS vendors to access for implementation and embedding in practice.
Clinical coding data quality (QUALITY)	Targeting quality of information around relevant quality indicators to ensure the information is robust enough to facilitate the right discussions around care delivery and measures of quality and outcome. This project complements the Library of Indicators and Toolset for reporting projects.	Consistency of measurement is not enough to ensure good quality indicators. The other essential ingredient is the quality of the information, especially clinical coding. As we develop of common dataset to use, clinical data quality ensures it is “fit for sharing” which underpins an effective patient-centred model of care and quality practice.
Toolset for reporting (QUALITY)	There is a high degree of duplication in mining toolsets and mining of information to report against quality and effective patient flows. This project will look at the opportunity to leverage off a common indicator library to see what tools exist to effectively mine and present the information. This project complements the Library of Indicators and Clinical coding quality projects.	International and local research has shown that few organisations use native reporting functionality within PMS systems to mine information. Taking a clinical practice, network, Regional or national view also means analysing information from various sources and systems. This project seeks to provide some consistency of reporting and sharing regarding toolsets that exist locally and internationally and have been proven to be able to derive information out of clinical practice (i.e. do not increase clinical administration burden) and have good analytical and presentation capability.

6 Next Steps

The next steps of implementing the strategy and plan are:

1. Sector consultation – taking the results of the sector scan and response to the sector to engage in active confirmation, participation and refinement
2. Prioritisation and work-up of projects – develop and evolve plans and secure funding for agreed projects.
3. Deliver the Plan