


Clinical Advisory Group (CAG)

Minutes

Of the meeting held on Wednesday, 16th September 2009, Meeting Rooms 1&2, 19 Lambie Drive at 1800 - 1930 hrs

Agenda Item		ACTION
<p>Present</p> <p>Apologies</p> <p>Minutes of August 2009 meeting</p>	<p>Peter Gow, (Chair), Michael Clark, Pam Williams, Tanu Toso, Soli Henare, Jenni Coles, Sam Cliffe, , Denise Kivell, , Tom Bracken, Stella Ward, Campbell Brebner, John Savory, Karyn Sangster, David Hughes, Pauline Hanna</p> <p>In attendance: Val McCullough.</p> <p>John Roke, Allan Moffitt, Don Mackie, Paula Nes</p> <p>Passed as true record. Approved Karyn Sangster Seconded Pam Williams</p>	
<p>Action Point</p>	<p>Future role of CAG and ToR</p> <p>Allan and Sam to amend Terms of Reference from discussion and feedback and bring to September meeting.</p> <p>Feedback to be sent to Alan Moffitt by Friday August 28th</p>	
<p>Strategic Forum Update</p>	<p>Nil update given</p>	
<p>Use of Éclair for Accessing Own/Authorised Others Test Results</p>	<ul style="list-style-type: none"> • Current situation requires you to ring clinical records and complete a form. • Great temptation to look up own results • Propose to trial a patient portal to look up own results. • Initially looking at éclair results e.g. bloods, x-rays etc. • Will be mirroring current éclair access process, giving a log in which expires after 12 months. • Initially looking at own records then authorised family member records. • Only for staff within the organisation. • Will pilot and evaluate probably by staff surveys <p>Discussion</p> <ul style="list-style-type: none"> • What happens if result abnormal? • Potential to increase anxiety. • Potential to increase GP visits • Need education about self responsibility • Process to start with giving consent • Decreases inappropriate accessing <p>Recommendation</p> <p>CAG recommends the trial goes ahead</p>	
<p>Integrated nursing centre including nurse walk in clinic Karyn Sangster, Pam Williams</p>	<p>Community nursing clinic</p> <ul style="list-style-type: none"> • Set clinics which will be booked by services • Walk in clinic for minor illness, advice, • Utilisation by additional services • Allied health • NASC • Social worker <p>Opportunities</p> <ul style="list-style-type: none"> • Collaborative • Complementary not competitive to existing services 	

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	<ul style="list-style-type: none"> • Flexible to respond to needs of community • Opportunistic • Recognise importance of medical home • Intervention and interactions email to medical home <p>Future</p> <ul style="list-style-type: none"> • Part of integrated family centres • One in every town centre • Access to nursing knowledge and interventions • Learning centre with strong links to MIT for undergraduate education • Nurse Practitioner internship <p>Need robust evaluation process. MIT to do evaluation</p>	
MoH EOI Process	<ul style="list-style-type: none"> • PHOs and other primary health providers to submit proposals by October 14th. • Only cover 30% of country with Eoi – Procure are submitting and have sought consultation on an initiative focused on cardiovascular disease and diabetes across the Auckland region • Wholesale transformation of care. Primary Care taking lead. • Better and more robust communication • Better handovers of care • Ability to make a difference and improve relationships therefore patient better off • DHB not doing any more work around Eoi but will influence what it will look like. <p>Discussion included:</p> <ul style="list-style-type: none"> • Confused about what is wanted and where we are to get to. • Need to understand what Primary Care does and does well • In past worked in teams – have lost this • Workforce to patient ratio has shrank • Financing of general practices is disruptive to good patient care • Competing for patients and with PHOs for funding. Much more splintering of Primary care. Secondary Care has taken some of things Primary Care used to do. • Patients see too many people – get mixed messages or same message over and over. PHO of less relevance to patients in Mangere than clinical providers. Disconnect from service • Do Primary Care want to be the navigators of care? Traditionally done well over years. Solo GPs vanished. GPs take funding directly if big enough to sustain. • Whatever the structure communication is core • A lot more services available now. • Practices that are patient centred do better • Want nursing to go forward. Complexity of patients in community is as never been before. Integration critical across sector. Nursing take on mantra of long term conditions. Some amazing things happening in PHOs. Cherry pick some great things that have happened and take them forward. <p>Sam asked Michael:</p> <ul style="list-style-type: none"> • Where does your clinical support come from? <p>Response</p> <ul style="list-style-type: none"> • 7 GPs, 8 Practice Nurses, surgeon, midwife, counsellors • Peer review group of 10 meet every 3-4 weeks • CME fortnightly • Networking • Up to individual to engage • There is nothing that rewards or incentivises this • Need to come up with a funding model that fits different criteria and drivers • Funding models drive behaviours. • Wrap up targets for chronic care. Judge on outcomes. • Wouldn't be hard to look at funding models that would incentivise me to create the exact practice or behaviours that I would like to see. Heres the 	

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	<p>targets, algorithms, heres how you are doing, heres the numbers and structures, where do we fall out, where are we different – understanding the business of general practice better.</p> <ul style="list-style-type: none"> • I would want you to wrap up one parcel of funding for all the chronic care, give me some outcome targets and pay me quarterly bulk, take all my administration of funding and application, invoicing everything out of the equation and judge me on my outcomes and let me employ as many nurses I like to get there and reward me by direct booking into your outpatient lists, if I can do FSAs and be credentialed to do that. Require incentives to reward me up-skilling and driving my behaviours • Sam encouraged Michael to talk to his PHO re this kind of approach as this is what is being talked about now. • DHB would like outcomes based purchasing, outcomes based commissioning, handing over stuff that needs to be managed much better by general practice teams. Currently not hearing this from PHOs • Need a system that makes it easier for you to look after your patients and get the best outcomes and if you can be rewarded for achieving that, all the better. The simple way to understand where it goes wrong is to ask anyone what they hate to do day to day i.e. having to manage complex patients within 15 minute slots in order to be paid. Am driven constantly by a structure that I have nothing to do with. 	
Standing Agenda Items Community Panel - TanuToso	 CP AUGUST MINUTES The Community Panel review is not yet completed. The Community Panel will see it this Friday. Once it is completed it will be presented to Sam.	
Other Business	<p>FYI <u>Free interpreting services are now available to all General Practices in the Auckland Region.</u></p> <p>For Information about the Waitemata District Health Board Primary Health Interpreting Service see: http://www.watis.org.nz/info/aboutus.php</p> <p>Contact the WDHB call centre on: Phone: 442 3211 Fax: 486 8307 Email: watis@waitematadhb.govt.nz</p> <p>For Information about the Auckland District Health Board Primary Health Interpreting Service please see the above flyer: Contact the ADHB call centre staff on: Phone (09) 6236453 Fax (09) 6234695 Email: phip@adhb.govt.nz</p> <p>For Information about the Counties Manukau District Health Board Primary Health Interpreting Service: Phone (09) 2771660 Fax (09) Email: its@middlemore.co.nz</p>	
Next Meeting:	<p>October 21st 2009 ♦ 1800 - 1930 hours ♦ In Meeting Rooms 1& 2 ♦ Counties Manukau DHB, 19 Lambie Drive, Manukau</p>	