COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING (CPHAC)

Wednesday, 3 May 2017

Venue: Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland
Time: 9.00am

Committee Members
Colleen Brown – Committee Chair
Dr Ashraf Choudhary – CMDHB Board Member
George Ngatai – CMDHB Board Member
Dianne Glenn – CMDHB Board Member
Katrina Bungard – CMDHB Board Member
Rabin Rabindran – CMDHB Board Member
Apulu Reece Autagavaia – CMDHB Board Member

CMDHB Management
Gloria Johnson – acting Chief Executive
Benedict Hefford – Director Primary Community and Integrated Care
Margie Apa – Director Population Health Strategy and Investments
Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer
Dinah Nicholas - Secretariat

APOLOGIES

REGISTER OF INTERESTS
• Does any member have an interest they have not previously disclosed?
• Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

PART 1 – Items to be considered in public meeting

AGENDA

1. AGENDA ORDER AND TIMING

2. CONFIRMATION OF MINUTES

9.05am 2.1 Confirmation of Previous Minutes of the Community and Public Health Advisory Committee Meeting – 22 March 2017
2.2 Action Items Register/Response to Action Item

3. BRIEFING PAPERS

9.15am 3.1 Age Related Residential Care Overview (Dana Ralph-Smith)
9.45am 3.2 Before School Check Overview (Carmel Ellis)
10.15am 3.3 Localities and Integrated Care Overview (Benedict Hefford)

10.45am 4. RESOLUTION TO EXCLUDE THE PUBLIC

Morning Tea Break (10.45 – 11.00am)
# BOARD MEMBER ATTENDANCE SCHEDULE 2017 – CPHAC

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>Feb</th>
<th>22 Mar</th>
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<tr>
<td>Ashraf Choudhary (Deputy Chair)</td>
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<td>Colleen Brown (Chair)</td>
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<td>Dianne Glenn</td>
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<td>George Ngatai</td>
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<td>Katrina Bungard</td>
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<td>Rabin Rabindran</td>
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## CPHAC MEMBERS
### DISCLOSURE OF INTERESTS
### 3 May 2017

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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</table>
| Colleen Brown (CPHAC Chair) | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Chair, IMuch Trust  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group |
| Dr Ashraf Choudhary (CPHAC Deputy Chair) | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| Dianne Glenn | • Member, NZ Institute of Directors  
• Member, District Licensing Committee of Auckland Council  
• Life Member, Business and Professional Women Franklin  
• Member, UN Women Aotearoa/NZ  
• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
• Life Member, Ambury Park Centre for Riding Therapy Inc.  
• Vice President, National Council of Women of New Zealand  
• Justice of the Peace  
• Member, Pacific Women’s Watch (NZ)  
• Member, Auckland Disabled Women’s Group |
| George Ngatai | • Director, Transitioning Out Aotearoa  
• Director, The Whanau Ora Community Clinic  
• Chair, Safer Aotearoa Family Violence Prevention Network  
• Board Member, Manurewa Marae  
• Huakina Development Trust (Partnership Clinic)  
• Community Organisation Grants Scheme (Auckland)  
• Lotteries Community (Auckland) |
| **Katrina Bungard** | • Chairperson MECOSS – Manukau East Council of Social Services.  
• Deputy Chair Howick Local Board  
• Member of Amputee Society  
• Member of Parafed disability sports  
• Member of NZ National Party |
| **Rabin Rabindran** | • Chairman, Bank of India (NZ) Ltd  
• Director, Auckland Transport  
• Director, Solid Energy NZ Ltd  
• Director, Swift Energy NZ Ltd  
• Director, Swift Energy NZ Holdings Ltd  
• Director, Kowhai Operating Ltd  
• Director, NZ Liaoning International Investment & Development Co Ltd  
• Singapore Chapter Chairman – ASEAN New Zealand Business Council |
| **Reece Autagavaia** | • Member, Pacific Lawyers’ Association  
• Member, Labour Party  
• Member, Tangata o le Moana Steering Group  
• Employed by Tamaki Legal  
• Trustee, Epiphany Pacific Trust  
• Trustee, The Good The Bad Trust  
• Member, Otara-Papatoetoe Local Board |
| **External Appointee TBC** | |
## COMMUNITY and PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS’
### REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 3 May 2017

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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<tbody>
<tr>
<td>Ms Dianne Glenn</td>
<td>Item 5 on the CPHAC agenda - hazardous alcohol use.</td>
<td>Ms Glenn is a member of the District Licensing Committee of Auckland Council</td>
<td>22 March 2017</td>
<td>That Ms Glenn’s specific interest is noted and the Committee agreed that she may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making, if applicable.</td>
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Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 22 March 2017 at 9.00 – 12.30pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau

Present: Ms Colleen Brown (Committee Chair), Dr Ashraf Choudhary, Ms Dianne Glenn, Mr George Ngatai, Mr Rabin Rabindran, Apulu Reece Autagavaia.

In attendance: Mr Benedict Hefford (Director Primary Health and Community Services) and Ms Jenny Parr (Director Patient Care, Chief Nurse Advisor and Allied Health Professions Officer).

Absent: Ms Katrina Bungard.

Apologies: Ms Margie Apa and Mr Geraint Martin.

1. Welcome

Apulu Reece Autagavaia opened the meeting with a prayer.

The Chair welcomed all those in attendance to the meeting noting that everyone is here because we all have important reaches into our own communities which we can capitalise on and bodes well for the work of this Committee. This Committee will have a strategic focus which will feed through good, sound recommendations to the Board on issues which affect our population. The Committee have all had specific interests assigned by the Board Chair which will also give us huge opportunities and areas to pursue through this Committee.

2. Governance

2.1 Attendance and Apologies

Noted.

(Mr Hefford and Mr Rabindran arrived 9.08am)

2.2 Disclosure of Interest/Specific Interests

Apulu Reece Autagavaia advised he is no longer employed by Tamaki Legal.

The Committee noted that Ms Dianne Glenn had a Specific Interest in regards to Item 5 on today’s agenda. This will be noted on the Specific Interest Register.
2.3 Confirmation of Public Minutes (9 November 2016)

Resolution
That the Public Minutes of the Counties Manukau District Health Board Community and Public Health Advisory Committee meeting held on Wednesday 9 November 2016 were taken as read and confirmed as a true and accurate record.

Moved: Ms Dianne Glenn Seconded: Mr George Ngatai Carried: Unanimously

2.4 Action Item Register Public

The Committee requested that Auckland Regional Public Health Service (ARPHS) attend the next CPHAC meeting (3 May) to provide an update.

The Committee agreed to remove the update from the Southern Initiative from the Action Item Register.

3. Resolution to Exclude the Public

Individual reasons to exclude the public were noted.

Resolution
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000, the public now be excluded from the meeting as detailed in the above paper.

Moved: Ms Colleen Brown Seconded: Apulu Reece Autagavaia Carried: Unanimously

9.20am Public Excluded session.

9.25am Open meeting resumed.

4. Briefing for Incoming Committee

Mr Hefford, Ms Marianne Scott and Dr Doone Winnard took the Committee through the briefing document highlighting the following:

What Does Population Health Mean – for us it means understanding who we serve, the context of their lives, the health issues they are living with (and dying from, their strengths and resilience) and working with others to address social and economic determinants of health.

Who Do We Serve - overall CM Health has the 3rd largest population, after Waitemata and Canterbury DHBs. Counties Manukau has the highest number of 0-14 year olds, the 2nd lowest proportion aged 65-years and over, the second highest number of Maaori (Waikato DHB highest), the highest number of Pacific people, the second highest number of Asian people (Auckland DHB highest) and by far the highest number of people living in NZ Dep13 decile 9 and 10 areas.

Key Issues for our Population – smoking prevalence, CVD/diabetes management, alcohol-related harm and childhood obesity.

Funding - the DHB is funded per head of population. The last census counted our population as 545,000. This is then weighted by age and by socio-demographic factors - 36% of our population live in Dep 9-10 (196,460 people). Funding for 2016/17 funding is $1.6b:
  • $836m DHBs hospital services
  • 378m NGO contracted services including PHOs - includes $75m to GPs

3 May 2017 007
• $283m services that sit outside Counties Manukau – includes $254m IDFs
• $12m governance and funder activities

**Key National Strategies** - the Committee might like to read and be familiar with the following national strategies:
- NZ Health Strategy Future Direction, April 2016
- NZ Healthy Ageing Strategy, December 2016
- The New Zealand Disability Strategy 2016-2026
- The Guide to He Korowai Maori Health Strategy, June 2014
- ‘Ala Mo’ui 2014-18 Pathways to Pacific Health and Wellbeing
- UN Convention on the Rights of Persons with Disabilities

5. **Case Study – Bowel Screening Programme**

Mr Brad Healey, General Manager, Emergency Department Medicine & Integrated Care took the Committee through his presentation highlighting the following:

New Zealand has one of the highest rates of bowel cancer in the developed world. It is the second most commonly registered cancer and second most common cause of cancer death. New Zealanders are more likely to be diagnosed with advanced stage bowel cancer than people in Australia, USA and the UK.

In November 2016, the MoH informed the DHB that the bowel screening programme would be implemented at Counties Manukau in April 2018 rather than the initially proposed date of 2019.

Screening is about looking for a condition in people who don’t have any symptoms so that you can find the condition early and make a difference in outcomes. Screening is a pathway, not an event – we have to make sure the whole pathway is in place, is equitable and costed appropriately. Weighing up benefits, harms and opportunity costs (including investigation and treatment for people who do have symptoms) is very important.

The national screening programme (for 60-74-year olds) is expected to result in significant cost savings from reduced treatment of bowel cancer which outweighs the cost of the screening. The service has established a plan to deliver the programme within these timeframes and believe it will contribute greatly to achieving our goal of adding 500,000 life years by 2020.

6. **General Business**

7.1 The Committee agreed that any confidential items would be scheduled at the end of future agendas.

7.2 Ms Colleen Brown circulated an article from Stuff.co.nz entitled ‘Free Vision Tests for Youngsters’ which talked about some local optometrists who had recently donated their time to conduct eye screening on more than 600 children from four Manurewa schools as part of an initiative funded by international charity Essilor Vision Foundation. A full copy of the article is attached. Ms Brown asked why the DHB is putting money into screening children through the Before School Checks when children’s eyes may not be mature enough until they reach the age of eight years. The Committee asked Mr Hefford to provide a report which gives a thorough understanding and analysis of the Before School Check programme at the next CPHAC meeting (3 May).

7.3 Ms Glenn commented on a recent article in the Waiuku Post ‘Franklin Towns in Trial’ which described NZ’s first social bond that will help 1700 people with mental illness into work over the 60 month duration of the bond. The bond will be delivered by APM Workcare and available to those living in Pukekohe, Waiuku and several other South Auckland suburbs.
APM Workcare is an experienced and successful provider of vocational rehabilitation and disability services. Ms Glenn further commented that Ms Ahern, GM Mental Health had advised HAC (8 March) that there has been no consultation or discussion with the DHB in relation to this and understood it is not for people with severe or enduring mental illness but more about supporting people into employment with mild-moderate mental illness. Mr Hefford confirmed that he would make sure the Mental Health team had visibility of this issue.

The next meeting of the Community and Public Health Advisory Committee will be held on Wednesday, 3 May 2017 in the Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau.

The Minutes of the meeting of the Counties Manukau District Health Board Community and Public Health Advisory Committee held on Wednesday, 22 March 2017 are approved.

Signed as a true and correct record on Wednesday, 3 May 2017.

(Moved: /Seconded: )

Chair 22 March 2016
Ms Colleen Brown Date
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<tr>
<td>19.8.15</td>
<td>Locality Updates: Manukau Otara/Mangere Franklin Eastern</td>
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<td>14 June</td>
<td>Lynda Irvine</td>
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<td>26 July</td>
<td>Sarah Marshall</td>
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<td>6 September</td>
<td>Kathryn du Luc</td>
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<td>18 October</td>
<td>Penny Magud</td>
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<td>25.5.16</td>
<td>Population Health Plans (Asian, Pacific &amp; Māori) – quarterly update.</td>
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<td>14 June</td>
<td>Marianne Scott</td>
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<td>6.7.16</td>
<td>ARPHS - six-monthly update.</td>
<td></td>
<td>3 May/14 June</td>
<td>Mr Hefford</td>
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<td>22.3.17 (tx from HAC 8.3.17)</td>
<td>Q2 Non-Financial Summary Report – Rheumatic Fever – report back on how many schools are connected to Dr Lance O’Sullivan’s programme in schools where there is no school nurse.</td>
<td></td>
<td>3 May</td>
<td>Mr Hefford</td>
<td>Refer Item 2.4 on today’s agenda.</td>
<td>✓</td>
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<td>22.3.17 (tx from HAC 8.3.17)</td>
<td>Mental Health – provide an update on the MH Integrated Pathway.</td>
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<td>3 May</td>
<td>Ms Ahern</td>
<td>Refer Item 4.1 on today’s agenda.</td>
<td>✓</td>
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<td>22.3.17</td>
<td>7.2 Before School Check – provide a report which gives a thorough understanding and analysis of the programme.</td>
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<td>3 May</td>
<td>Mr Hefford</td>
<td>Refer Item 5.2 on today’s agenda.</td>
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Responses to Action Items

Actions previously assigned by the Community and Public Health Advisory Committee are reported back on in this section.

HAC Meeting 8.3.2016
Report back through CPHAC on how many schools are connected to Dr Lance O’Sullivan’s programme in schools where there is no school nurse.

Dr Lance O’Sullivan is the Founder and Managing Director of iMOKO, an iPad and smartphone-based app that enables the remote diagnosis of non-serious conditions such as skin and strep throat infections, to enable faster assessment and treatment for children who may not be able to easily visit a medical clinic.

iMOKO works by having trained volunteers in schools send photos and notes about the condition to Dr O’Sullivan and his clinicians. After making a diagnosis and prescribing appropriate medication, the clinicians then send advice on managing the condition via app to the child’s whaanau or caregivers. The aim is to increase access to high quality basic health services with a focus on communities with high needs – particularly vulnerable children.

iMOKO is currently across 110 sites nationally with 6,000 children involved in the programme.

In South Auckland iMOKO is being used by two primary schools:
Tuakau Primary and Te Kohanga Reo o Te Awamarahi (161 children)
Pukekohe North School and Te Puna Reo (352 children)

In addition it is in the following Te Kohanga Reo in South Auckland:
Reo Rangatira - Otara (20 children)
Kupenga - Clover Park (15 children)
Papatoetoe Whanau (20 children)
Tahuri Mai - Weymouth (53 children)
Pukeroihi - Papakura (15 children).

iMOKO in these schools is not funded by CM Health.

The National Hauora Coalition (NHC) is currently the lead agency funded by the Ministry of Health and CM Health, providing Mana Kidz (a school-based programme with a focus on reducing rheumatic fever rates through intensive sore throat management) in Counties Manukau. Recently, the Alliance Leadership Group, the NHC and iMOKO have been working to pilot iMOKO at one school in Papatoetoe, Holy Cross School (approximately 550 children). It is anticipated that child consent and training of School Health Aids will commence in term two of 2017.

The iMOKO team is keen to explore any further opportunities to work with CM Health and expand the reach of iMOKO in Counties Manukau.
Counties Manukau District Health Board  
Community and Public Health Advisory Committee  
Age Related Residential Care Overview

Recommendation

It is recommended that the Community & Public Health Advisory Committee:

Receive the information provided giving an overview of age related residential care.

Prepared and submitted by: Benedict Hefford, Director of Primary, Community & Integrated Care

Purpose

Age related residential care (ARRC) is a term used to describe residential care services for older people. Funding processes for this service is determined by the Social Security Act 1964. District Health Boards contract with residential care facility owners to provide long-term age related residential care to people who have been Needs Assessed by a District Health Board Needs Assessment and Service Coordination agency as eligible to receive Age Related Residential Care Services. This paper provides CPHAC with a summary overview of age related residential care at Counties Manukau Health.

Summary

Only residential care facilities that have achieved Certification under the Health and Disability Services (Safety) Act 2001 and comply with the Health and Disability Sector Standards 2001 can be contracted to provide ARRC services for District Health Boards.

District Health Boards are responsible for ensuring that there are sufficient contracted care beds available to people assessed as requiring long-term residential care.

To enter District Health Board contracted residential care:

- the person must be needs assessed through an interRAI Home Care assessment, as having high, or very high needs which are indefinite (i.e., the person’s condition is not reversible;
- it must be determined that the person cannot be safely supported within the community;
- the person must be aged 65 or over; or be aged between 50 and 64 with needs closely related to those of an older person;
- the person must be eligible for publicly funded health and disability services (a New Zealand citizen or permanent resident, or eligible under the Eligibility Direction made under the New Zealand Public Health and Disability Act 2000).

There are four levels of care provided in age related residential care, which is determined by the needs assessment.

- rest home care
- hospital care
- dementia (secure) care
- specialised hospital care (secure psychogeriatric care)

Once a person has been assessed as eligible to receive Age Related Residential Care they are able to choose to move to any New Zealand Age Related Residential Care facility which has the appropriate certification and contract for their level of care.
Once in Age Related Residential Care, if the ARRC Long Term Care Facility interRAI assessment identifies changes in a resident’s needs over time, and they require a higher level of care, a referral is made to the District Health Board Needs Assessment Service Coordination agency and a needs assessment will confirm the appropriate level of care. The person may need to move to another facility if the current residential care facility cannot provide the level of care required.

All people receiving residential care are required to pay a contribution toward their care. The maximum a person is required to pay toward their Age Related Residential care [Maximum Client Contribution] is set by the Social Security Act. The Maximum Client Contribution varies between Territorial Land Authorities and is around $950 per week in the Counties Manukau Health region, and is the equivalent of the rest home day rate in that Territorial Land Authority. The District Health Board automatically pays the balance between the Maximum Client Contribution and the higher contracted day rate for dementia, hospital and psychogeriatric care. Approximately 40% of all Age Related Residential Care residents in Counties Manukau Age Related Residential Care pay the Maximum Client Contribution toward their care.

Residents can apply to Work and Income for an Income and Asset financial means test to establish if they are eligible for assistance toward payment of the Maximum Client Contribution. The financial means threshold is applied to the resident’s income and assets, including any Superannuation or benefit payments, and establishes the amount the resident is required to pay to toward their care. The District Health Board pays the balance as a Residential Care Subsidy. If a resident’s income and assets fall below the financial means threshold, they will be required to pay a component of their Superannuation toward their care while retaining a small personal and clothing allowance.

At Counties Manukau Health there are currently approximately 2700 ARRC beds in 45 contracted facilities across the Counties Manukau region. There are 212 dedicated secure dementia beds in eight units, and 38 dedicated secure psychogeriatric beds in two units. These units provide residential care for residents with dementia who demonstrate behaviours which need to be supported in a specialised, secure environment.

The balance of the Age Related Residential Care beds are either dedicated rest home or hospital (each approximately 750 beds), or in dual service beds which are certified and contracted to provide both service. The majority of residents with dementia are able to be supported in a standard open rest home or hospital unit without the requirement to be detained in a secure environment. Current occupancy across all Age Related Residential Care facilities is approximately 90%.
Counties Manukau District Health Board
Community and Public Health Advisory Committee
Before School Check Overview (B4SC)

Recommendation

It is recommended that the Community & Public Health Advisory Committee:

Receive the report on the Before School Check programme.

Prepared and submitted by: Carmel Ellis on behalf of Benedict Hefford

Purpose

The Community and Public Health Advisory Board requested a detailed description of the Before School Check (B4SC). This paper provides a description of the various components, coverage and issues related to specific areas of the check.

Background

The B4SC is a Ministry of Health mandated and funded programme which commenced in 2008 and replaced the School New entrant check. The B4SC is the 12th and final Well Child check delivered as part of the universal Well Child Tamariki Ora programme. The intention of the check is to offer a comprehensive health, development and behaviour screening assessment for four year olds. Its purpose is to identify problems which may impair a child’s ability to learn, prior to school entry. It further aims to ensure that appropriate and timely referrals are made and that action is taken to address these problems before starting at school. The check screens for medical, dental, vision and hearing problems as well as questioning parents and teachers about developmental and behavioural problems. It also collects data on growth and immunisation status.

Targets are set by the Ministry of Health on an annual basis. The target is to deliver checks to 90% of the eligible population, with a particular focus on children living in high deprivation areas (quintile five).

For the 2016/17 financial year Counties Manukau Health’s target is to complete a total of 7,985 checks with 3,692 from quintile five areas. As at the end of quarter three 16/17, coverage for Counties Manukau Health is 82.9 % overall and 76.5% for quintile five.

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The B4SC is made up of a number of components. These include:

- **A general child health questionnaire**
  This includes a two page questionnaire which seeks general information about the child and their family, including information about existing health conditions and access to services. Immunisation status is included as a part of the child health questionnaire and any concerns are sent as a referral onto the child’s General Practitioner or respective child specialist service.

- **Hearing and Vision screening**
  Children are also screened for hearing problems and some vision problems. This vision screen includes amblyopia (lazy eye) however, does not detect all vision problems, including some problems which may affect reading.

  Hearing screening includes a check of whether the child can hear soft sounds across a range of pitches in each ear. Only sounds which are important for speech are tested. If the child has difficulty hearing the soft sounds in the screening, the vision and hearing technician will also screen for middle ear problems (such as glue ear).

- **Growth - measurement of height and weight**
  Height and weight is measured to ascertain Body Mass Index. Children who have a weight >98th percentile for their age and who have a Body Mass Index of 21 or over are referred onto community based providers for weight monitoring and management. Children who are in the lower third percentile for height or weight are also referred for assessment of unrecognised growth problems.
• An oral health screen
The dental component of the B4SC comprises ascertainment of whether the child is enrolled with a dental service, promotion of oral health to parents and a ‘Lift the Lip’ check for dental caries. Children who are not enrolled are enrolled with the Auckland Regional Dental Service.

• Behavioural and developmental assessment
The strengths and difficulties questionnaire tool is designed to assess whether a child has difficulties with emotions, concentration, behaviour, or getting along with others. The strengths and difficulties questionnaire comprises five scales that relate to different psychological attributes; conduct, emotional, peer problems, hyperactivity and pro-social behaviour. The strengths and difficulties questionnaire is undertaken by parents and teachers (if enrolled in an early childhood centre).

The parental evaluation of development status tool is a questionnaire for parents to detect developmental and behavioural problems. The parental evaluation of development status has 10 general questions about behaviour, development, speech and language, fine and gross motor skills.

• Health promotion and education
Parents/caregivers are provided with information resources, advice and support as appropriate including referrals to health, education or social services. This encompasses a range of topics identified by either parents/caregivers or nurses and provides an opportunity for further discussion.

At Counties Manukau Health, Plunket is the main provider of the B4SC programme however there are three smaller providers that also deliver the B4SC to children that have generally been under their care for the previous seven core Well Child checks. The Hearing and Vision components are tested separately by dedicated vision and hearing technicians. The vision and hearing technicians are employed by the Counties Manukau Health Kidz First Community team. They visit early childhood education centres on rotation to undertake the tests. They also run clinics and do home visits for children not attending early childhood centres. The hearing and vision components are therefore generally completed on a different day to the nurse led components (can either be before or after). Saturday clinics are run from the Manukau Super clinic weekly which allow for the completion of the entire check in one visit.

Within Counties Manukau Health there is a full time B4SC co-ordinator. The B4SC co-ordinator sends out B4SC invitations to children resident in Counties Manukau DHB, in the month the child turns four years old. Most components of the B4SC are carried out in a one hour long appointment with a nurse. The Coordinator is also responsible for the collaborative working relationships between the various providers delivering the check.

If issues are identified, referrals are made to secondary services, as appropriate by the Well Child nurse or vision and hearing technician. More difficult cases are discussed with the provider’s clinical leader or the vision and hearing technician team leader. Clinical leaders are able to refer appropriate cases for discussion to the Paediatric intake meeting, Kidz First, for further advice.

Whilst uptake and coverage appear to be optimal, Counties Manukau Health still has concerns about certain components of the check. These concerns have been raised with the Ministry of Health on a number of occasions. The Issues identified include;
The current timing at four years of age is not ideal. It is later than ideal for picking up developmental issues that would benefit from early intervention and too early for many children to appropriately complete the hearing and vision components of the check. This is evident in the high number of vision and hearing rescreens that are required (~7%). This is partially due to the timing of the check as children are not mature enough to comprehend and cooperate with testing. The figures below show the number of children who require a re-screened for vision and hearing services. A comparable percentage is then referred onto secondary services for further follow-up. Of those referred to Ophthalmology, 25% of the retests are normal, 45% require glasses and a further 30% require ongoing follow-up which includes rescreening.

**Vision**

<table>
<thead>
<tr>
<th>Vision Checks Completed 2016/17</th>
<th>Failed Vision &amp; Under Care</th>
<th>Failed Vision &amp; Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>4,197</td>
<td>7.8%</td>
<td>305</td>
</tr>
</tbody>
</table>

**Hearing**

<table>
<thead>
<tr>
<th>Hearing Checks Completed 2016/17</th>
<th>Failed Hearing &amp; Under Care</th>
<th>Failed Hearing &amp; Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>4,197</td>
<td>7.3%</td>
<td>262</td>
</tr>
</tbody>
</table>

The percentage of children with potential problems identified in the parental evaluation of developmental status is low compared with international norms. This raises questions over the validity of this tool in the Counties Manukau Health population. In addition if a child is identified as having a potential issue a second screen is meant to be offered to help clarify if there is an issue or not. The Ministry of health does not currently include the second screen as part of the funded programme. The advantage of a second check (such as Ages and Stages) is that it avoids over referral of children (no need to refer those who pass the second check) as well as providing additional information to secondary services on those who do require referral. This enables secondary services to prioritise those most in need of intervention. The table below shows numbers referred with developmental concerns.

**PEDS**

<table>
<thead>
<tr>
<th>PEDS Checks Completed 2016/17</th>
<th>Pathway A &amp; Under Care</th>
<th>Pathway A and &amp; Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>4,131</td>
<td>3%</td>
<td>47</td>
</tr>
</tbody>
</table>

In contrast to the parental evaluation of developmental status component the strengths and difficulties questionnaire component identifies many children with problems however these were not being referred to secondary services in adequate numbers. There also appears to
be a lack of suitable interventions on offer. The Incredible Years parenting programme is of a high standard but requires a substantial time commitment by parents. Although evidence suggests that families need to be fully engaged in a long term course such as Incredible Years to achieve change, it may be that for some families, a shorter more intensive course tailored to our Counties Manukau Health population would be a more realistic alternative if there was adequate evidence of effectiveness.

Referrals are predominantly to services outside of Health and are not captured within the B4SC information system.

Strength and difficulties Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Concerning &amp; Under Care</th>
<th>Concerning &amp; Advice Given</th>
<th>Concerning &amp; Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SDQ - P Checks</strong></td>
<td><strong>Number</strong></td>
<td><strong>Percent</strong></td>
<td><strong>Number</strong></td>
</tr>
<tr>
<td>Completed 2016/17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4,131</td>
<td>192</td>
<td>44</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Concerning &amp; Under Care</th>
<th>Concerning &amp; Advice Given</th>
<th>Concerning &amp; Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SDQ - T Checks</strong></td>
<td><strong>Number</strong></td>
<td><strong>Percent</strong></td>
<td><strong>Number</strong></td>
</tr>
<tr>
<td>Completed 2016/17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2,346</td>
<td>70</td>
<td>14</td>
</tr>
</tbody>
</table>

- The current programme has a focus on coverage with limited visibility on outcomes. Counties Manukau Health has regarding increasing inequities due to coverage of the groups of children at highest risk of poor health outcomes and the ability of those families to navigate the system for follow up. The Counties Manukau Health B4SC Coordinator undertakes a significant amount of follow-up for those children referred to Audiology and Ophthalmology however does not have the capacity to undertake the equivalent for referrals to other sectors. Uptake of these services is therefore unknown.

**Conclusions**

In its current format the B4SC programme appears to be very costly in terms of the effort expended for the impact on health achieved. Many of the issues identified need to be resolved at a national level and are not unique to Counties Manukau Health.
Counties Manukau Health
Community and Public Health Advisory Committee
An overview of Localities and Integrated Care

Recommendation

It is recommended that the Community and Public Health Advisory Committee:

Receive the information provided regarding the model of care and indicators of the benefits of primary and community care within the localities approach.

Note that the Audit Risk and Finance Committee has considered this information and decided to actively monitor progress with implementation of the localities’ models of care and indicators of its financial impacts.

Note that further in-depth information will be presented at future CPHAC meetings regarding localities initiatives and integration of care

Prepared by: Benedict Hefford, Director of Primary, Community & Integrated Care.

Purpose

“Localities” is a term used to describe an approach to joining up services at a local level to help people better manage their health and stay well in the community. This paper provides CPHAC with a summary overview of the initiatives for primary and community care within the localities approach. It outlines an assessment of benefits from a health outcome and demand perspective, delivery against these benefits, and recommended next steps.

Summary

• CM Health has a growing, diverse and complex population with escalating health needs
• International evidence is supportive of an integrated primary and community based model of care to manage populations with complex characteristics, to deliver better population health outcomes, higher patient satisfaction, and lower aggregate costs
• Based on this evidence, in CM Health we are creating a functional, integrated community model that supports General Practice to deliver more proactive care to better prevent and manage disease
• We are currently investing $4.5m pa incrementally to fund the new model of care
• Whilst it is always difficult to identify attribution of benefits and the counter-factual, there are indications that the model of care is having an impact on patient outcomes and producing savings in avoided hospital admissions

Our Population

We have a growing and complex population characterised by diversity (the largest numbers of Maori and Pacific people in the country), deprivation (36% living in areas defined as the most socioeconomically deprived -the highest in the country), rapid growth (by 2026 there will be an additional 103,000 people living in the district), transience, and ageing (almost 3,000 additional people aged over 65 years each year).
This means we have high levels of ill health and inequitable outcomes. In 2011, for example, we had 33,220 people with diabetes in the district and by 2016 this had risen to 38,198 - of which 9,000 had poor control\(^1\) of their condition potentially leading to eventual problems like kidney failure, blindness, and amputations. Maori and Pacific people are more likely to suffer from poorly managed chronic disease like diabetes, and these types of factors contribute to a 10 year gap in life expectancy between Maori and non-Maori in Counties.

Demands for some acute services are also rising rapidly (in 2012 we had 101,516 ED presentations and in 2016 this had risen to 114,161, a 12.5% increase). Based on population growth and ageing alone, an additional 26 bed hospital ward should be needed every 12 – 18 months at an incremental cost of circa $3M. Until recently, some high cost services like renal dialysis have been growing at 7% volume year on year.

75% of our DHB’s revenue is expended on hospital services, and most of this demand and expenditure is associated with chronic disease in adults, and frailty/dementia in older people. Preventing and managing chronic and age related conditions like diabetes and heart disease is key to improving population health, reducing inequalities, and ensuring a financially sustainable health service in Counties Manukau.

**The Evidence Base**

There is strong evidence gathered from over 20 developed and developing countries across three decades that health systems with a strong primary health care orientation and focus have better population health outcomes, higher patient satisfaction, and lower aggregate costs (see Appendix 1 for a summary of the evidence base). Primary health care in this context means General Practice, community nursing and allied health, maternity, and health promotion services. The main reason for this impact is that primary health care delivers:

- **Coordination**: access to appropriate further services and interventions
- **Comprehensiveness**: prevention, health promotion and chronic care management, rather than just episodic treatment of the presenting illness
- **Continuity**: knowledge of a patient’s clinical and social context over time allows practitioners to improve patient’s health literacy and their self-management capability.

Whilst the evidence is clear that improving population health and managing cost growth is best achieved through primary health care, the evidence about which specific programmes, services, and interventions contribute to outcomes is more mixed. Every system starts from a different baseline and attribution of costs and benefits and identifying the counter-factual are long standing challenges. In addition, the social determinants of health (levels of poverty, housing supply shortages and costs) can rapidly shift the baseline and therefore expected outcomes despite the efforts of health services.

Nonetheless, international experience and studies do give some indications of approaches which are more likely to succeed. These include being primary health care centric (for the above reasons), having a ‘place-based’ approach (because local area gives a focus to target cohorts and interventions), and having a multi-faceted approach that embeds improved patient confidence, competence, and motivation to self-manage their own health. These are core facets of the approach we have taken, as described further below.

\(^1\) Defined clinically as HBA1C greater than 75
We have been cautious in applying experience from other places to our local situation and context, and we are continuing to reassess and review the evidence base as it emerges. In 2012 the Nuffield Trust peer-reviewed the localities plans. In summary, the review noted that the plans were consistent with emerging evidence and experience of effective approaches, but that clinical engagement would be key and we should mainly aim for improved long term health outcomes rather than expecting rapid reductions in hospital demand or associated financial savings in the short to medium term.

For all these reasons we have been conservative when setting targets and budgets and used the following ‘factoring down’ methodology:

**Benefits Modelling Methodology: Factoring in time and scale (example only):**

<table>
<thead>
<tr>
<th>Reduction in hospital admissions</th>
<th>Impact assumption</th>
<th>Scale for patient segment</th>
<th>Scale for time factor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-8%</td>
<td>60-80%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-2.2%</td>
</tr>
</tbody>
</table>

- **Rationale**
  - Impact assumption obtained from academic research and case studies
  - Assume that data points from case studies reference ‘optimal’ scenarios
  - Full benefits of the programme may take some time to be realised
  - US Patient centred medical home data shows range from 4% to 15%
  - Our base case assumes we achieve 60% of the ‘optimal’ impact for older people and 80% for people aged 45-64 years
  - For this group we estimate 40% of the benefit will be achieved by the 5th year
  - We model a 2.2% reduction in baseline hospital admissions for the target groups for Year 5

**The Localities Approach**

We have been progressively implementing an integrated ‘localities approach’ since 2012/13. In the new system, patients receive planned and coordinated care via locality based multi-disciplinary teams (MDTs). The MDTs are centred around clusters of general practices but include specialists, community nursing, allied health, pharmacists, and other workers from various organisations and disciplines.
The core of the model of care is planned, proactive care for patients with health needs that put them at risk of unplanned hospitalisation. The model includes identifying the patients with the greatest ability to benefit through risk stratification and clinical criteria, an extended consultation with a clinician (often a practice nurse) to undertake an assessment using ‘Partners In Health’, a validated assessment tool, and development of a goal based, patient-centred care plan which includes both medical (for example, ensuring medications and diagnostic tests are consistent with clinical pathways) and psycho-social aspects (for example, referral to health psychology or self-management education).

The care plan is shared electronically so that it can be accessed by clinicians throughout the system when needed, and the MDT can securely access results and message and assign tasks to each other and the patient through the e-shared care system. In the Emergency Department the plan is shown in summary form so that clinicians can quickly see diagnosis, medications, usual vital signs levels, patient goals and their nominated care coordinator contact details (the care coordinator is usually the clinician that completed the plan with the patient, often their practice nurse or GP). The care process is shown diagrammatically below:

![Diagram showing care process](image-url)
Localities MDT Model of ‘Planned and Proactive’ Care:

As this proactive care coordination role has been progressively implemented in the last couple of years, it has highlighted that core general practice needs to change its business processes so that it has the capability to deliver new care models. We are working with PHOs and nine larger practices to test enhanced ways of operating general practice which improve efficacy and efficiency. New business processes include: implementation of medical telephone triage resulting in resolution of patient’s issues virtually (without the need for face-to-face consultation); advanced telephony systems and a reduction in dropped calls; rolling out video & email consultations, and patient portals for appointments and access to results to increase ‘self-service’. Practices that have advanced these new ways of organising their general practices have seen a 20% to 25% increase in their capacity, which is consistent with experiences in Midlands, Canterbury, and the UK.

We have also improved the way that CMH community nursing and allied health (and mental health) services are delivered to support the new localities MDT approach. These services cover 15,400 patients and 120,000 patient contacts per year, and they are the gatekeepers to $120m pa of long term home and residential care for older people and adults with chronic health needs. CMH community teams are being re-organised and re-focused as core members of locality MDTs to:

- Actively support general practice with proactive planned care coordination & care delivery
- Intervene rapidly to help avoid unnecessary hospitalisation when patients in the community are deteriorating
- Support earlier and safer discharge from hospital and prevent unnecessary institutionalisation by delivering reablement, rehabilitation, and discharge support to patients who have been acutely unwell. The targeted patient flows are shown below:
Patient Flows Across Community Services

The MDTs are supported by a logistics centre, which we call ‘Community Central’. Community Central is a key enabler for these services as it manages referrals, triage, and resourcing (staff scheduling) and patient tracking across the CMH teams, and coordinates the contracted providers such as homecare services. Currently 60% of our community workforce is now using mobile computers (tablets) and they have achieved a 5% increase in productivity since roll out of the Community Central approach last year.

Investments and Benefits

Our main objective is to improve health outcomes over the longer term whilst managing demand for (and the flow of) hospital care in the short to medium term. Better control of blood pressure and blood glucose levels, for example, mean that over a ten year period on average patients are less likely to suffer a stroke or end up with kidney failure needing dialysis. However, in the short term interventions such as additional GP visits, treatments, and health coaching may actually increase costs.

There are multiple factors influencing the supply, utilisation, costs, and health outcomes in our complex and adaptive health system, so linear ‘cause and effect’ scenarios with direct attribution of specific outcomes to specific interventions are unrealistic. Instead, we track a range of leading clinical and utilisation indicators over time and triangulate these with more qualitative information (such as clinical experiences and patient case studies) to monitor progress and adjust the approach as we learn.

The material incremental investments are: additional general practice time with patients to assess, plan and coordinate care with them ($2.5 million pa); additional CMH community nursing and allied health staff (mostly health assistants and OTs and physiotherapists); and Community Central operational costs including mobile devices for clinical staff to improve safety and productivity. We have also invested in some change management assistance to general practices to help them release capacity through enhanced business and care delivery models, as described above. These investments are summarised below:
The main sources of economic benefit (avoided costs) relate to delayed/reduced residential care admissions, and reduced hospital bed days (through reduced admissions and re-admissions and lower length of stay). The expected 10 year ROI calculation is shown below:

The profile of benefits realisation is not linear, and increases towards the end of the ten years.

---

2 This funding is distributed via a multiplier to ‘Care Plus’ capitation funding. Under the contract terms, practices must develop e-shared care plans to a minimum standard for at least 3% of their enrolled population and participate in quality improvement activities, or the funding can be withheld. It should be noted that general practices are also able to access further additional funding for specific primary care interventions such as GP home visits, where needs identified in a patient’s care plan justifies the intervention.
Progress with Benefits Realisation

Nearly 30,000 patients have benefited from the new approach and now have e-shared care plans, an identified care coordinator, and a wider care team focussed on helping them achieve their goals and stay well at home. In addition, over 600 patients have received reablement care post discharge from hospital. This makes the localities model of care one of the largest scale initiatives of its kind outside of North America.

It is relatively early days to be talking about tangible demand reductions and improved health outcomes, however, most data indicate a positive impact on patient care. For the 30,000 patients that have benefited, there has been a statistically significant improvement in their self-rated ability and confidence to self-manage their chronic conditions, according to data collected through the ‘Partners in Health’ assessment tool. Likewise, the 600 patients that have received reablement have more functional ability, a higher quality of life, and greater confidence to manage at home, according to standardised measures collected through Euroqol, VAS, and NEADL assessments. These data are shown in the dashboard in Appendix Two.

For patients receiving the new model of care who were previously high attenders at hospital (3+ admissions in the previous year), we are seeing a 52% reduction in their inpatient episodes 12 months post intervention, and 56% reduction in ED presentations 12 months post intervention. Overall our aggregate rate of admissions and re-admissions to hospital has reduced along with total bed days. The table below is benchmarking data from the Health Roundtable indicating that Counties now has the lowest rate of acute (unplanned) hospital bed days once the data are standardised to account for population demographics.

2016/17 Acute bed days

<table>
<thead>
<tr>
<th>DHB of Domicile</th>
<th>Year to Jun 2014</th>
<th>Year to Jun 2015</th>
<th>Year to Jun 2016</th>
<th>Rank (Year to Jun 2016)</th>
<th>Year to Jun 2016 (Non-standardised)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland (4)</td>
<td>472.4</td>
<td>466.1</td>
<td>436.6</td>
<td>4</td>
<td>386.5</td>
</tr>
<tr>
<td>Bay of Plenty (10)</td>
<td>447.3</td>
<td>435.0</td>
<td>414.6</td>
<td>10</td>
<td>498.3</td>
</tr>
<tr>
<td>Canterbury (16)</td>
<td>409.7</td>
<td>372.4</td>
<td>367.8</td>
<td>16</td>
<td>392.1</td>
</tr>
<tr>
<td>Capital and Coast (19)</td>
<td>385.3</td>
<td>344.0</td>
<td>331.3</td>
<td>19</td>
<td>317.6</td>
</tr>
<tr>
<td>Counties Manukau (1)</td>
<td>494.0</td>
<td>483.1</td>
<td>463.4</td>
<td>1</td>
<td>407.5</td>
</tr>
<tr>
<td>Hawke’s Bay (15)</td>
<td>429.7</td>
<td>398.3</td>
<td>377.3</td>
<td>15</td>
<td>423.5</td>
</tr>
<tr>
<td>Hutt (12)</td>
<td>410.9</td>
<td>392.6</td>
<td>378.5</td>
<td>12</td>
<td>385.0</td>
</tr>
<tr>
<td>Lakes (9)</td>
<td>434.1</td>
<td>405.0</td>
<td>417.2</td>
<td>9</td>
<td>432.4</td>
</tr>
<tr>
<td>Midcentral (8)</td>
<td>487.6</td>
<td>465.5</td>
<td>421.9</td>
<td>8</td>
<td>474.1</td>
</tr>
<tr>
<td>Nelson Marlborough (20)</td>
<td>271.6</td>
<td>277.3</td>
<td>241.8</td>
<td>20</td>
<td>287.7</td>
</tr>
<tr>
<td>Northland (11)</td>
<td>393.5</td>
<td>399.3</td>
<td>382.0</td>
<td>11</td>
<td>428.6</td>
</tr>
<tr>
<td>South Canterbury (3)</td>
<td>414.7</td>
<td>398.8</td>
<td>456.8</td>
<td>3</td>
<td>581.7</td>
</tr>
<tr>
<td>Southern (17)</td>
<td>405.2</td>
<td>365.4</td>
<td>354.7</td>
<td>17</td>
<td>384.9</td>
</tr>
<tr>
<td>Tairawhiti (5)</td>
<td>476.3</td>
<td>436.5</td>
<td>443.4</td>
<td>5</td>
<td>439.1</td>
</tr>
<tr>
<td>Taranaki (14)</td>
<td>378.6</td>
<td>379.4</td>
<td>377.4</td>
<td>14</td>
<td>421.0</td>
</tr>
<tr>
<td>Waikato (2)</td>
<td>467.9</td>
<td>466.2</td>
<td>461.6</td>
<td>2</td>
<td>488.0</td>
</tr>
<tr>
<td>Wairarapa (18)</td>
<td>367.3</td>
<td>342.4</td>
<td>332.7</td>
<td>18</td>
<td>390.7</td>
</tr>
<tr>
<td>Waitomata (7)</td>
<td>456.0</td>
<td>448.0</td>
<td>425.8</td>
<td>7</td>
<td>422.1</td>
</tr>
<tr>
<td>West Coast (13)</td>
<td>364.0</td>
<td>391.0</td>
<td>377.7</td>
<td>13</td>
<td>421.1</td>
</tr>
<tr>
<td>Whanganui (6)</td>
<td>425.2</td>
<td>455.3</td>
<td>430.6</td>
<td>6</td>
<td>522.3</td>
</tr>
<tr>
<td>NATIONAL</td>
<td>435.0</td>
<td>418.9</td>
<td>403.3</td>
<td>4</td>
<td>413.4</td>
</tr>
</tbody>
</table>

Similarly, our ED presentations growth rate had been 4.5% per year but tapered to 2% (less than demographic) growth in 2016. Health Roundtable benchmarking data are showing a similar picture to inpatient stays:
In terms of financial savings, in the past year the model of care has delivered significant benefits of around $3M from reduced demand for hospital and rest home care:

### Hospital savings

<table>
<thead>
<tr>
<th>Benefit type</th>
<th>Volumes reduction</th>
<th>$000s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Target</td>
</tr>
<tr>
<td>Acute Admission</td>
<td>29,000</td>
<td>28,322</td>
</tr>
<tr>
<td>Acute 28 day Readmissions</td>
<td>4,327</td>
<td>4,257</td>
</tr>
<tr>
<td>Bed Day - LoS reduction</td>
<td>105,699</td>
<td>107,170</td>
</tr>
<tr>
<td>ED Presentations</td>
<td>39,954</td>
<td>40,010</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>178,981</strong></td>
<td><strong>179,759</strong></td>
</tr>
</tbody>
</table>

### Aged residential care savings

<table>
<thead>
<tr>
<th></th>
<th>Qtr Jan-Mar 16</th>
<th>Qtr Apr-Jun 16</th>
<th>Qtr Jul-Sep 16</th>
<th>Qtr Oct-Dec 16</th>
<th>Total 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest Home Cost</td>
<td>$3,944,002</td>
<td>$3,954,059</td>
<td>$4,056,310</td>
<td>$3,993,287</td>
<td>$15,947,657</td>
</tr>
<tr>
<td>Savings</td>
<td>$194,439</td>
<td>$184,382</td>
<td>$82,131</td>
<td>$145,154</td>
<td>$606,107</td>
</tr>
</tbody>
</table>

In terms of clinical indicators, longitudinal data taken from the 30,000 patient cohort 18 months pre-enrolment onto planned proactive care and two years post-enrolment (the red line indicating enrolment) shows that the model of care is having an impact on Hba1c control, bringing it back to ‘controlled’ levels.
The same is true of control of blood pressure

This is consistent with analysis from Procare PHO that compares management of diabetics across metro Auckland districts and suggests Counties patients receiving the planned, proactive care model have (statistically significant) better control of their diabetes.

**Next Steps**

The information presented in this report is necessarily summarised. The localities model has evolved since its original design and planning in 2012 and this will continue as we learn what works and how to make system improvements. Qualitative evaluations of the localities programme have been undertaken by Victoria University (available on request) and further reports are due this year. Ultimately however, we simply don’t know what the counter-factual is to our approach – it is possible that the data trends presented in this report would have materialised without any intervention, but it seems unlikely.

We do know that we now have an entire primary and community sector focussed on the same goals and motivated to improve outcomes for our high needs population. We also know that the relatively modest investments to date will need to be scaled up if we’re to achieve significant further benefits – a challenge in the current financial environment. We will continue to monitor, evaluate, and improve these initiatives as more results are received.
## Appendix 1 – REVIEW OF EVIDENCE

<table>
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<tr>
<th>AUTHOR</th>
<th>STUDY</th>
<th>PUBLICATION</th>
<th>STUDY TYPE</th>
<th>FINDINGS</th>
<th>LINK</th>
<th>RELEVANT CM HEALTH STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lewin, G.F., Alfonso H.S &amp; Alan J.J.</td>
<td>Evidence for the long term cost effectiveness of home care reablement programmes</td>
<td>Clinical Interventions in Aging 2013:8 1273-1281</td>
<td>Retrospective cohort study was conducted to analyse the home care service records over 57 months of 10,500 older individuals who were referred to a home care provider for assistance with personal care and received either a reablement or a conventional home care service</td>
<td>Individuals who had received a reablement service were less likely to use a personal care service throughout the follow-up period or any other type of home care over the next 3 years. This reduced use of home care services was associated with median cost savings per person of approximately AU $12,500 over nearly 5 years</td>
<td><a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3794867/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3794867/</a></td>
<td>Reablement of older people - reduced long term care costs</td>
</tr>
<tr>
<td>Parson, M., et al</td>
<td>The Assessment of Services Promoting Independence and Reovy in Elders Trial (ASPIRE): a pre-planned meta-analysis of three independent randomised controlled trial evaluation of ageing in place initiatives in New Zealand</td>
<td>Age and Ageing, 2012</td>
<td>Prospective meta-analysis of three initiatives designed to promote independence and continued living in the community for elderly people (aging-in-place) to assess their cost effectiveness relative to the elderly receiving conventional health care services (usual care) in each region. The study design was based around 3 randomised controlled trials with a total sample size for analysis of 564 older people assessed as having high or very high needs, across the 3 centres;</td>
<td>The adjusted hazard ratio for the combined primary outcome of death or residential entry was 31% lower with a 95% confidence interval of (9%, 47%) for the intermediate care initiatives compared with usual care.</td>
<td><a href="https://www.health.govt.nz/system/files/documents/pages/aspire-research-report-section1.pdf">https://www.health.govt.nz/system/files/documents/pages/aspire-research-report-section1.pdf</a></td>
<td>Reablement of older people - reduced long term care costs</td>
</tr>
<tr>
<td>Tinetti M.E., et al</td>
<td><strong>Evaluation of restorative care versus usual care for older adults receiving an acute episode of home care</strong></td>
<td>JAMA 2002 487(16): p 2098-2015</td>
<td>Intervention using prospective individual matching conducted between November 1, 1998, and April 30, 2000. Six offices of a home care agency in Connecticut were used. One branch office served as the restorative care unit and the other 5 served as usual care. 712 restorative care patients matched with 691 usual care patients based on age, sex, race, baseline self-care function, cognitive status, whether hospitalization preceded the home care episode, and date of the home care episode.</td>
<td>Compared with usual care, and after adjusting for baseline characteristics and other factors, restorative care was associated with a greater likelihood of remaining at home (82% vs 71%; odds ratio [OR], 1.99; 95% confidence interval [CI], 1.47-2.69) and a reduced likelihood of visiting an emergency department (10% vs 20%; OR, 0.44; 95% CI, 0.32-0.61). Home care episodes were shorter (mean [SD], 24.8 [26.8] days vs 34.3 [44.2] days; S = -17 821; P&lt;.001). Restorative care patients had better mean (SD) scores than usual care patients in self-care (11.0 [2.1] vs 10.7 [2.5]; P =.07 after adjustment), home management (9.5 [2.9] vs 9.2 [3.0]; P =.05 after adjustment), and mobility (3.3 [0.8] vs 3.2 [0.9]; P =.02 after adjustment).</td>
<td><a href="https://www.ncbi.nlm.nih.gov/pubmed/11966384">https://www.ncbi.nlm.nih.gov/pubmed/11966384</a></td>
<td>Reablement - reduced ED visits, reduced home and community support costs</td>
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<tr>
<td>Styrborn, K.</td>
<td><strong>Early discharge planning for elderly patients in acute hospitals - an intervention study</strong></td>
<td>Scan J Soc Med, 1995 23(4): p 272-85</td>
<td>Multidisciplinary early discharge planning for patients 75+ years. One health care district formed the intervention group, while two comparable districts became two control groups.</td>
<td>The intervention proved to be effective, giving better utilization of acute hospital beds through reduced numbers of bed-blocking patients, shorter waiting times for bed-blockers and reduced expenditure for district health authorities who were financially liable for that group. This was true when the cost of the intervention was included.</td>
<td><a href="http://journals.sagepub.com/doi/abs/10.1177/140349489502300409?journalCode=sjpa">http://journals.sagepub.com/doi/abs/10.1177/140349489502300409?journalCode=sjpa</a></td>
<td>Early supported discharge service - reduced bed days</td>
</tr>
<tr>
<td>Culiffe, A.L. et al</td>
<td><em>Sooner and healthier: a randomised controlled trial and interview study of an early discharge rehabilitation service for adults</em></td>
<td>Age and Ageing 2004. 33(3): p 246-252</td>
<td>A randomised controlled trial comparing an early discharge and rehabilitation with standard hospital aftercare. Outcome measures assessed at 3 and 12 months were the Barthel Index, Nottingham Extended Activities of Daily Living and EuroQol (for patients) the General Health Questionnaire (for patients and carers). Use of services over 12 months was recorded. An interview study of patients and staff was conducted.</td>
<td>Subjects in the early discharge rehabilitation service group used fewer days in hospital at 3 months (mean difference 9, median difference 4 days, 95% CI of median difference 2-8). At 3 months the early discharge and rehabilitation service patients had better Barthel scores (mean difference 1.2, 95% CI 0.4-1.9), Nottingham Extended Activities of Daily Living kitchen scores (mean difference 1.2, 95% CI 0.2-2.3), Nottingham Extended Activities of Daily Living domestic scores (mean difference 1.1, 95% CI 0.2-2.0) and General Health Questionnaire scores (mean difference 2.4, 95% CI 0.7-4.1). Significant Nottingham Extended Activities of Daily Living domestic and General Health Questionnaire benefits remained at 12 months. The early discharge and rehabilitation service carers had better General Health Questionnaire scores at 3 months (mean difference 2.0, 95% CI 0.1-3.8). The interviews suggested that the early discharge and rehabilitation service was patient-centred, set clear goals, worked as a team, and considered physical, psychological, social and environmental issues. It was found to be highly satisfactory.</td>
<td><a href="https://www.ncbi.nlm.nih.gov/pubmed/15082429">https://www.ncbi.nlm.nih.gov/pubmed/15082429</a></td>
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<td>NHS Evidence</td>
<td><em>Rapid Response Services: intermediate tier, multidisciplinary health and social care services</em></td>
<td>Care Services Efficiency Delivery Programme, Feb 2011</td>
<td>NHS evaluation of a Bristol multi-disciplinary health and social care rapid response service which assesses, treats and supports the individual in their own home, avoiding an unnecessary and more costly admission into hospital or residential care. Focussed primarily on ambulatory care sensitive conditions - where there is evidence for safe and successful community treatment.</td>
<td>Financial savings were calculated by comparing the cost of treatment in hospital, using HRG codes, against the cost of providing the community-based service. In 2008/09, the service achieved savings for the PCT of £3.6m, having taken into account the cost of providing the service. Over 60% referrals came from GPs.</td>
<td><a href="https://www.google.co.nz/search?q=NHS+evidence+rapid+response&amp;ie=utf-8&amp;oe=utf-8&amp;gws_rd=cr&amp;ei=IYK3WOKTJMOW8QWp1Y_YAg">https://www.google.co.nz/search?q=NHS+evidence+rapid+response&amp;ie=utf-8&amp;oe=utf-8&amp;gws_rd=cr&amp;ei=IYK3WOKTJMOW8QWp1Y_YAg</a></td>
<td>Early supported discharge service - reduced bed days</td>
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<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Journal</td>
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<td>Observations study - Retrospective evaluation of a state-wide rollout of a population-based transitional care initiative in the Medicaid recipients enrolled in the Community Care of North Carolina enhanced primary care case management program. 21,375 Medicaid recipients with complex chronic conditions and a hospital discharge in the period July 2010–June 2011 met the study’s inclusion criteria (see Appendix Exhibit 2 for further details). Of those, 13,476 received a transitional care assessment or intervention by a program care manager. Transitional care patients were discharged from 120 different hospitals, were enrolled with 1,325 primary care medical homes. Interventions where there is evidence of positive effect on 1. Reducing admissions: Continuity of care with a GP; Hospital at home as an alternative to admission; Assertive case management in mental health; Self-management; Early senior review in A&amp;E; Multidisciplinary interventions and tele-monitoring in heart failure; Integration of primary and secondary care; 2 Reducing re-admissions: Structured discharge planning; Personalised health care programmes Enhanced primary care; Integrated 'whole of system' care teams; Rapid response hospital at home services; Supported Discharge</td>
<td><a href="https://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf">https://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf</a></td>
<td><a href="https://www.communitycarenc.org/media/files/transitional-care-cut-hospital-readmissions-north-carolina-medicaid-patients.pdf">https://www.communitycarenc.org/media/files/transitional-care-cut-hospital-readmissions-north-carolina-medicaid-patients.pdf</a></td>
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<td>Author(s)</td>
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<tr>
<td>Laylor M., et al</td>
<td>Early discharge care with ongoing follow-up support may reduce hospital re-admission in COPD</td>
<td>Int J Chron Obstruct Pulmon Dis</td>
<td>2009</td>
<td>4</td>
<td>33-60</td>
<td>Two hundred and forty-six patients, acutely admitted with exacerbations of COPD, were recruited to the respiratory outreach programme that included early discharge care, follow-up education, telephone support and rapid future access to respiratory out-patient clinics. Sixty of these patients received self-management education also. Emergency department presentations and admission rates were compared at six and 12 months after, compared to prior to, participation in the programme for the same patient cohort.</td>
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<td>Caplan G.A., Williams A., Daly B., Abraham K.A.</td>
<td>A randomised controlled trial of comprehensive geriatric assessment and multi-disciplinary intervention after discharge of elderly from emergency department: The DEED 2 study</td>
<td>J Am Geriatr Soc.</td>
<td>2004</td>
<td>52</td>
<td>1417-23</td>
<td>739 patients aged 75 and older discharged home from the ED were randomized into two groups. The treatment group underwent initial Comprehensive geriatric Assessment and were followed at home for up to 28 days by a multi-disciplinary outreach team. The team implemented or coordinated recommendations. The control group received usual care.</td>
</tr>
<tr>
<td>Avellar S., et al</td>
<td><strong>Home Visiting Evidence of Effectiveness Review: Executive Summary</strong></td>
<td>US Department of Health and Human Services, Office of Policy, Research and Evaluation, Washington D.C., September 2013</td>
<td>Comprehensive literature review and evaluation of 23,192 unduplicated citations related to home visiting program models serving pregnant women or families with children from birth to kindergarten entry (that is, up through age 5). Subsequent prioritisation of 45 program models for review and completion of impact reviews of 337 studies and implementation reviews of 259 studies related to these programs. 19 home visiting models that meet criteria for an evidence-based early childhood home visiting service delivery model Numerous favourable impacts on primary and secondary measures were shown for at least one year after program enrolment. Results were not limited to subgroups; the study samples were racially, ethnically, and socioeconomically diverse. Nine outcome areas were assessed - Child health; Child development and school readiness; Family economic self-sufficiency; Linkages and referrals; Maternal health; Positive parenting practices; Reductions in child maltreatment; Reductions in juvenile delinquency, family violence, and crime</td>
<td>[<a href="http://homvee.acf.hhs.gov/HomVEE_Exe">http://homvee.acf.hhs.gov/HomVEE_Exe</a> cutive_Summary_2016_B508.pdf](<a href="http://homvee.acf.hhs.gov/HomVEE_Exe">http://homvee.acf.hhs.gov/HomVEE_Exe</a> cutive_Summary_2016_B508.pdf)</td>
<td>Integrated home and community support services for complex families; Reduction in unnecessary ED visits for children</td>
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<td>Fergusso n D., Boden J., &amp; Horwoor J.</td>
<td><strong>Early Start Evaluation Report: Nine year follow-up</strong></td>
<td>Ministry of Social Development 2012</td>
<td>A randomised trial in which 220 families receiving Early Start were compared with a Control group of 223 families not receiving the service. Both groups have been followed up over a nine year period to determine the extent to which children and families receiving Early Start gained benefits when compared with the Control group families. Lower rates of hospital attendance for non-intentional injury (accidents) (p &lt;.01). These differences were most marked for the 0–3 year period; Lower rates of parental reported physical child abuse (p &lt;.01). These differences were most marked for the 0–3 year period. The outcomes were similar for Māori and non-Māori families. There was no evidence to suggest benefits for a range of parental and family outcomes that included: maternal depression; parental substance use; family violence; family economic circumstances; family stress and adversity</td>
<td><a href="https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/evaluation/early-start-evaluation-report-nine-year-follow-up.pdf">https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/evaluation/early-start-evaluation-report-nine-year-follow-up.pdf</a></td>
<td>Integrated home and community support services for complex families; Reduction in unnecessary ED visits for children</td>
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<td>Starfield B &amp; Shi L</td>
<td><strong>Policy relevant determinants of health: an international perspective</strong></td>
<td>Health Policy 60 (2002) 201–218</td>
<td>Thirteen industrialized countries, all with populations of at least 5 million, were characterized by the relative strength of their primary care infrastructure, the degree of national income inequality, and a major manifestation of a behavioral determinant of health that is amenable to policy intervention (smoking), using international data sets and national informants. Health system and The stronger the primary care, the lower the costs. Countries with very weak primary care infrastructures have poorer performance on major aspects of health.</td>
<td><a href="http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.61.67521&amp;rep=rep1&amp;type=pdf">http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.61.67521&amp;rep=rep1&amp;type=pdf</a></td>
<td>Enhanced primary care</td>
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<td>Methodology</td>
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<tr>
<td>Macinko J, Starfield B &amp; Shi L</td>
<td>The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998</td>
<td>HSR: Health Services Research 38:3 (June 2003)</td>
<td>Pooled, cross-sectional, time-series analysis of secondary data using fixed effects regression. Secondary analysis of public-use datasets. Primary care system characteristics were assessed using a common set of indicators derived from secondary datasets, published literature, technical documents, and consultation with in-country experts.</td>
<td>The strength of a country's primary care system was negatively associated with (a) all-cause mortality, (b) all-cause premature mortality, and (c) cause specific premature mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease, and heart disease (p &lt; 0.05 in fixed effects, multivariate regression analyses). This relationship was significant, albeit reduced in magnitude, even while controlling for macro-level (GDP per capita, total physicians per one thousand population, percent of elderly) and micro-level (average number of ambulatory care visits, per capita income, alcohol and tobacco consumption) determinants of population health.</td>
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<td>Davies GP et al</td>
<td>Coordinating primary health care: an analysis of the outcomes of a systematic review</td>
<td>MJA 2008; 188: S65–S68</td>
<td>A systematic review of the literature (January 1995 to March 2006) relating to care coordination in Australia, the United States, the United Kingdom, New Zealand, Canada and The Netherlands. The review was supplemented by consultations with academic experts and policymakers.</td>
<td>Six types of strategy were identified at patient/provider level, falling into two groups: (i) communication and support for providers and patients, and (ii) structural arrangements to support coordination. These were broadly consistent with existing typologies. All were associated with improved health and/or patient satisfaction outcomes in more than 50% of studies, and interventions using multiple strategies were more successful than those using single strategies.</td>
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<td>Liu S</td>
<td>The Impact of Primary Care: A Focused Review</td>
<td>Article</td>
<td>The objective of this focused review paper is to identify research evidence on the value of primary care both in the USA and internationally, focusing on the importance of effective primary care services in delivering quality healthcare, improving health outcomes, and reducing disparities. Literature searches were performed in PubMed as well as “snowballing” based on the bibliographies of the retrieved articles. The areas reviewed included primary care definitions, primary care measurement, primary care practice, primary care and health, primary care and quality, primary care and cost, primary care and equity, primary care and health centers, and primary care and healthcare reform. In both developed and developing countries, primary care has been demonstrated to be associated with enhanced access to healthcare services, better health outcomes, and a decrease in hospitalization and use of emergency department visits. Primary care can also help counteract the negative impact of poor economic conditions on health.</td>
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<td>Ham C &amp; Alderwick H</td>
<td>Place-based systems of care: A way forward for the NHS in England</td>
<td>Report</td>
<td>This paper argues that providers of services should establish place-based ‘systems of care’ in which they work together to improve health and care for the populations they serve. The argument of this paper is that collaboration through place-based systems of care offers the best opportunity for NHS organisations to tackle the growing challenges that they are faced with. It will, however, require organisational leaders to surrender some of their autonomy in pursuit of the greater good of the populations they collectively serve, and national leaders to act urgently to enable systems of care to evolve rapidly.</td>
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Enhanced primary care

http://dx.doi.org/10.6064/2012/432892

https://www.kingsfund.org.uk/publications/place-based-systems-care

Organisations collaborating to manage the common resources
<table>
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<tr>
<th>WHO</th>
<th>What Are the Advantages and Disadvantages of Restructuring a Health Care System to Be More Focused on Primary Care Services?</th>
<th>Copenhagen: World Health Organisation Health Evidence Network (2004)</th>
<th>This report is HEN’s response to a question from a decision-maker. It provides a synthesis of the best available evidence, including a summary of the main findings and policy options related to the issue. International studies show that the strength of a country’s primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases. The available evidence demonstrates some advantages for health systems that rely relatively more on primary health care and general practice in comparison with systems more based on specialist care in terms of better population health outcomes, improved equity, access and continuity and lower cost.</th>
<th><a href="http://www.euro.who.int/__data/assets/pdf_file/0004/74704/E82997.pdf">http://www.euro.who.int/__data/assets/pdf_file/0004/74704/E82997.pdf</a></th>
<th>Enhanced primary care</th>
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<td>Schoen C et al</td>
<td>Toward higher performance health systems: adults’ health care experiences in seven countries</td>
<td>Health Aff (Millwood). 2007 Nov-Dec;26(6):w7 17-34.</td>
<td>This 2007 survey compares adults' health care experiences in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. In all countries, the study finds that having a &quot;medical home&quot; that is accessible and helps coordinate care is associated with significantly more positive experiences. There were wide country differences in access, after-hours care, and coordination but also areas of shared concern. Patient-reported errors were high for those seeing multiple doctors or having multiple chronic illnesses. The United States stands out for cost-related access barriers and less-efficient care.</td>
<td><a href="https://www.ncbi.nlm.nih.gov/pubmed/17978360">https://www.ncbi.nlm.nih.gov/pubmed/17978360</a></td>
<td>Enhanced primary care and healthcare at home</td>
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<tr>
<td>WHO</td>
<td>What is the evidence on effectiveness of capacity building of primary health care professionals in the detection, management and outcome of depression?</td>
<td>Copenhagen: World Health Organisation Health Evidence Network (2004)</td>
<td>Several high quality sources of evidence-based information were used. Evidence relating to the clinical and cost effectiveness of a broad range of strategies designed to enhance organization and delivery of primary care for depression was sought. The initial source was high quality systematic reviews of literature supplemented by an overview of new primary research. Evidence from randomized controlled trials, controlled clinical trials and interrupted time series was</td>
<td><a href="http://www.euro.who.int/__data/assets/pdf_file/0011/74684/E85243.pdf?ua=1">http://www.euro.who.int/__data/assets/pdf_file/0011/74684/E85243.pdf?ua=1</a></td>
<td>Enhanced primary care</td>
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considered, in line with guidance for the Cochrane Effective Practice and Organization of Care (EPOC) group (15). Primacy was given to evidence from randomized trials.

| WHO | What is the effectiveness of home visiting or home-based support for older people? | Copenhagen: World Health Organisation Health Evidence Network (2004) | This synthesis is based on systematic reviews, meta-analyses and meta-regression analyses of the effectiveness of home visiting to older people. | There is consistent evidence that home visits could reduce mortality and nursing home admissions. There is some evidence that the reduction in mortality may be greater among the younger elderly, and that nursing home admissions may be reduced to a greater extent with a greater number of visits. Home visiting has not been shown to reduce functional decline, except amongst those with a low mortality rate and in programmes providing multidimensional geriatric assessment and follow up. Home visiting programmes have the potential to be cost-effective due to their low cost compared to long-term institutional care. | http://www.euro.who.int/__data/assets/pdf_file/0005/74696/E83105.pdf?ua=1 | Home-based support for older people |

http://www.euro.who.int/__data/assets/pdf_file/0005/74696/E83105.pdf?ua=1
Reablement Service Dashboard

* Supporting individuals to ‘do things for themselves, rather than having things done for them’.

**Reablement Approach Snapshot**

- **659 Patients Enrolled**
- **505 Transitioned From Reablement**

**Reablement Enrolments by Gender**
- Female: 58%
- Male: 42%

**Number of Reablement Referrals & Enrolments by Ethnicity**

- **Pacific**: 100 referrals, 624 enrolments
- **Maori**: 81 referrals, 52 enrolments
- **Asian**: 86 referrals, 65 enrolments

**Reablement Referrals Per Month**

**Reablement Enrolments by Locality**
- Manukau: 39%
- Eastern: 28%
- Franklin: 22%
- Mangere/Otara: 11%

**Reablement Referrals & Enrolments by Age**

**% of Enrolments compared with % Share of CM Health Est. Population**

**Dashboard # 15: March 2017**

For further information [www.countiesmanukau.health.nz/integrated-care](http://www.countiesmanukau.health.nz/integrated-care)
Number of Weeks on Reablement
- Transitioned patients

An improvement is indicated by a decrease in the EuroQol score

An improvement is indicated by an increase in the NEADL score – a high score equals a high level of independence

Readmissions

Readmitted within 7 Days: 20
Readmitted within 28 Days: 62
Readmitted within 90 Days: 123

Readmission criteria:
Acute casemix funded admissions only to the same health specialty as initial admission. Transfers are excluded. EC admissions with LOS <1 day are excluded. Only patients who are currently active or who have completed the reablement programme are included.

Note: These numbers are cumulative e.g. the patients who are readmitted within 7 days are also included in the readmitted within 28 days total
### Resolution to Exclude the Public

Resolution:
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
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<tr>
<td>2.1 MH&amp;A System Overview and Integrated Update</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [NZPH&amp;D Act 2000 Schedule 3, S32(a)] [Official Information Act 1982 S9(2)(i)]</td>
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<td>2.2 Population Health Plans</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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