

Bay of Plenty Integrated Healthcare Strategy 2014 - 2020

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Foreword

Our vision is that by 2020 Bay of Plenty health services will be centred on the needs of people, their families and whānau. People will be able to easily access services when required and healthcare workers will be able to seamlessly transfer care between settings when needed. People will be empowered to manage their own health and to share in decision making.

Our vision can be achieved through greater integration of healthcare.

The Strategy and Action Plan has a six year horizon to 2020, and is intended to provide strategic direction to foster the whole Bay of Plenty health system to work together to plan and make improvements for the benefit of the people of the Bay of Plenty. It has been developed through collaboration between Nga Mataapuna Oranga Primary Health Organisation (NMOPHO), Eastern Bay Primary Health Alliance (EBPHA), Western Bay of Plenty Primary Health Organisation (WBOPPHO) and the Bay of Plenty District Health Board (BOPDHB) - referred to as 'The Partners' – being key organisations that have core responsibilities to the Minister of Health for the performance and management of health services. The document is primarily aimed at health professionals.

The purpose of this Strategy is to:

1. Be a lens that can be applied to all healthcare related activity, both current and future, so we can be certain that activity is systematically and deliberately building towards an integrated healthcare system.
2. Identify specific actions that will build foundations for developing integrated healthcare consistently throughout the Bay of Plenty;
3. Support and enhance critical decision-making within, and provide direction to, the Health Alliance (BOP)¹.

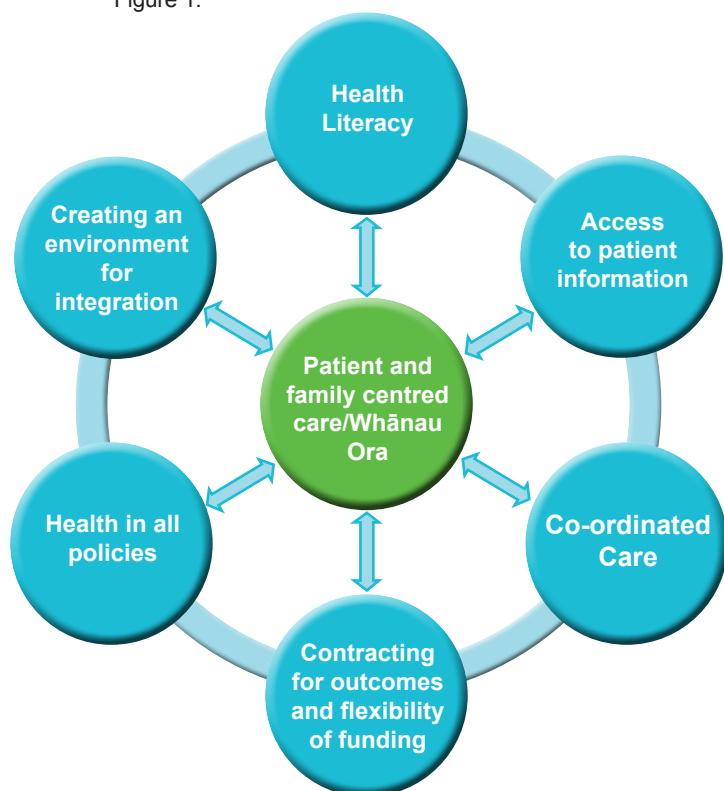
The Strategy will have its presence felt in, and be implemented through key strategic planning documents such as the BOPDHB Statement of Intent, Annual Plan, Māori Health Plan and Regional Services Plan². In time, it is envisaged that these and future strategic documents will themselves reflect an aligned direction.

¹ Pursuant to the Ministry of Health's expectations, a Bay of Plenty wide Alliance Leadership Team (ALT) is in development. The proposed parties are BOPDHB, NMOPHO, EBBPHA and WBOPPHO, potentially to be known as the Health Alliance (BOP).

² Refer to Section 7 - Action Plan for a list of strategic planning and operational documents.

What is integrated healthcare?

There is no single, accepted definition of integrated healthcare³. However, most definitions include references to seamlessness, co-ordination, patient centeredness, and whole-of-system working together. During the course of this work, we have developed our approach to integrated healthcare which is encompassed in seven themes depicted in Figure 1.



The themes are the foundations for developing integrated healthcare consistently throughout the Bay of Plenty. They are interdependent and the associated activity as set out in the Action Plan is intended to be progressed concurrently.

Why integrated healthcare matters

The case for integrated healthcare is becoming well-recognised in New Zealand, alongside most nations which are facing an unprecedented challenge to improve health care systems in response to an unsustainable increase in demand, due to the ageing of the population, increasing longevity and increases in the burden of chronic diseases. The Bay of Plenty, with a population that features higher than average proportions of Māori, older people, people living in rural areas and areas

of high deprivation⁴ presents unique challenges to improve the overall health of our population, improve quality and achieve best value for public health system resources.

Health and disability services are delivered by a complex network of organisations and people. Integrated healthcare is seen as essential to transform the way that care is provided for people with long term chronic health conditions. It will enable people with complex medical and social needs to live healthy, fulfilling, independent lives⁵. People living with multiple health and social care needs often experience highly fragmented services which are complex to navigate, leading to less than optimal experiences of care and outcomes. Our response to the challenge requires a strong re-orientation away from the current emphasis on episodic and acute care towards prevention, self-care, better co-ordination, and care that addresses social determinants of health. The following experiences of Alice and William demonstrate why integrated healthcare matters. Alice's story is an example of the potential negative impacts for a person when services are not integrated. William's story is an example of the potential benefits of integrated healthcare.

Alice's story

Alice is a 71 year old lady who lives alone. Her daughter passed away earlier this year and she has no informal support. Weekly assistance from a home support provider has enabled her to live independently. She has hypertension and a cognitive impairment. She has weekly visits from mental health services. She is on a number of medications but can't remember what they're all for and often she forgets to take them. Recently she developed pneumonia and was admitted to hospital. After she was discharged from hospital she had to take different tablets which has made things more confusing for her. Due to a car accident a number of years ago she has metal plates in her ankles. Poor circulation means she sometimes develops ulcers which need dressing by District Nursing.

She does not like changes to her routine and the number of people coming into her home has been confusing her. She has trouble remembering who they are, when they are coming and why they are there. She is starting to refuse 'all these people' from coming in. Her home support carer has noticed she doesn't seem to be doing so well lately and is worried she may end up in hospital again.

3 The King's Fund: Lessons from experience - Making integrated care happen and scale and pace.

4 BOPDHB Annual Plan 2013/14

5 A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together <http://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together>

William's story

William lives in the Eastern Bay of Plenty and has been visiting his GP frequently for recurring bronchial symptoms. During the consultation, the GP asks "How are things at home?" William mentions that the whole whānau is always getting sick – the kids aren't going to school because they are always sick. He reports that his wife is always sick and William has to take time off work, which is starting to really annoy his boss. The GP decides to refer William into a Whānau Ora service. The Whānau Ora service receives the referral and a navigator (kaimanaaki) visits William at home. While there, the navigator notices that the home has no curtains or insulation. The navigator then contacts William's landlord to seek out options for insulation and curtains. The navigator contacts William's children's school to find out how they are doing at school and if they need additional support.

The navigator sits down with William and his whānau and asks them "What are your goals/aspirations for your whānau? What matters most to you?" Together they work out a Whānau plan. That was three months ago. Since then, the house has been insulated and has new curtains. The health of the whole whānau has improved. William has not needed to visit the doctors as much, his sick leave has reduced at work; the school has provided extra support for the children to catch up on the lessons they missed, and his wife is now also much better and able to attend study on weaving (raranga).

Principles

The following principles underpin this Strategy:

Partnership – This Strategy advances a new way of working together between the three Bay of Plenty PHOs and the BOPDHB with leadership from the Strategic Partnership Group. The actions in the Strategy are aimed at further developing this relationship and promoting a more collaborative, whole-of-system approach to health service delivery. The principle of partnership is further extended to promote the concept of co-design and co-delivery - that all those who experience health services, including people, their families and whānau will have a say and a role in how services are designed and delivered.

Eliminating inequalities – We will seek to eliminate disparities in health between groups that results in an unequal distribution of good health. Further, that those actions aimed at eliminating inequalities 'do so in a way that benefits all members of society but with preferential benefits to those who experience more suffering. This is known as proportionate universalism'⁶.

The New Zealand Triple Aim⁷ – The Triple Aim is a framework for achieving quality improvement in the New Zealand health system that pursues three dimensions: Improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health system resources. This is depicted in Figure 2.



Figure 2: New Zealand Triple Aim

Whānau Ora – We adopt the principles and values of Whānau Ora, an inclusive and culturally anchored approach that promotes that improvements in an individual's wellbeing can be brought about by focusing on the family collective and vice versa.

Whānaungatanga – We will foster interconnectedness through relationships and shared experiences and working together which provides people with a sense of identity and belonging.

Values – There is a mutual respect for and acceptance of each Partner's values which are set out in Appendix 1.

Look for bright spots – 'When it's time to change, we must look for bright spots...We need to ask ourselves a question that sounds simple but is, in fact, deeply unnatural: What's working and how can we do more of it?'⁸

We want to recognise our 'bright spots', and build on these because they are more likely to sustain our approach to systematic improvement. However, if we are to meet the challenges of the future we cannot underestimate the amount of effort, the time required to develop relationships and a deeper understanding of new ways of working.

6 New Zealand Medical Association's Position Statement 'Health Equity'.

7 Health Quality and Safety Commission

8 Dan Heath 'Switch'

Development of the Strategy

Developing this Strategy has been as much a process of discovery as it is design and this is on-going. We are building up our picture of integrated healthcare from the bottom up as well as the top down. The following approaches were incorporated:

Governance and leadership – Leadership for this project and its implementation is provided by the Strategic Partnership Group. A Project Group has overseen the development of the Strategy and provided guidance to a Programme Manager. Membership of the Project Group includes leaders from the partner organisations, clinical and management leads from primary and secondary care, and representatives from a Māori Health NGO provider, BOPDHB's Planning & Funding, Public Health Unit, Information Management, and the Ministry of Health.

Stakeholder engagement – It was important for us to understand our local context and the challenges specific to the Bay of Plenty. We sought input and advice from various stakeholder forums, provider networks, consumer and advocacy groups, governance groups, technical advisory groups, professional clusters, clinical committees and regional forums. The list of stakeholder forums visited is attached as Appendix 2.

We asked our stakeholders to define what integrated healthcare means to them; identify barriers to overcome; identify strengths and where we are doing well; and what they saw as priorities over the next couple of years. A summary of the feedback is attached as Appendix 3.

Literature scan – A comprehensive literature review has not been undertaken as it was not within the scope of this work. We have gathered together a number of articles and resources which we found useful and had relevance to the New Zealand context.

Health needs analysis and priorities – We have drawn on and incorporated the Ministerial, DHB and PHO priorities, and existing base-line health needs information, data and performance monitoring information. This information is contained in a range of readily available documents and so is not repeated in this Strategy.

Learning from our own experience and others – We have linked with other DHBs and Alliance Leadership teams throughout the country to learn from their efforts to enhance our own learning. Several staff members of the partner organisations have attended international and local forums on integrated healthcare including those hosted by the Ministry of Health, Ko Awatea and the Institute for Healthcare Improvement (IHI). Our own successes and experiences,

particularly through Whānau Ora, the SmartGrowth Partnership, Better Sooner More Convenient Business Case, and Bay Navigator have provided us with valuable experience and insight. Where formal evaluations of services have been undertaken, lessons and recommendations have been considered.

Implementation, Evaluation and Reporting


The Strategic Partnership Group will provide governance for the implementation of the Strategy. The Action Plan outlines the activity that has been agreed to progress the strategic direction. Overall programme management support for implementation will be provided by BOPDHB Planning and Funding.

The Partners accept shared responsibility for achievement of outcomes in the Strategy and agreed activity will be reflected in the following strategic and operational plans:

- BOPDHB Statement of Intent
- BOPDHB Annual Plan
- BOPDHB Māori Health Plan
- Midland Regional Services Plan
- BOPDHB Health of Older People Strategy
- BOPDHB Palliative Care Strategy
- BOPDHB Child and Youth Strategy
- CIRCA – Care Improvement Recognition Criteria Improvement Awards
- PHO Annual Plans
- Bay Navigator pathway development proposals and processes
- Toi Te Ora Public Health Annual Plan
- Health Alliance (BOP).

Reporting and accountability to the Minister of Health will be undertaken as part of our statutory obligations through the key accountability documents being the Statement of Intent and Annual Plan, Māori Health Plan, Quality Accounts and Public Health Unit Plans.

These accountability documents and performance frameworks currently contain a suite of measures many of which we expect will be indicators of integrated healthcare and progress towards the outcomes sought in this Strategy. Current examples include health target achievement, rates of presentations to the emergency department, acute readmission, avoidable admissions, and ratios of older people living independently at home.



We anticipate that as we progress towards a whole-of-system approach, new or different measures may need to be developed or agreed that are more indicative of performance. Examples of measures to be developed include indications of patient experience and care co-ordination.

Methodology for evaluating and measuring performance will be developed as part of the work to implement the Strategy. Work currently being undertaken at a national level by the Health and Quality Safety Commission on the framework for achievement against the New Zealand Triple Aim and the Integrated Performance and Incentive Framework are examples and will inform our Strategy further. BOPDHB Planning and Funding will work with all Partner organisations to develop the evaluation and performance framework.

Action Plan

The following sections set out the activity we have planned to achieve our vision. Actions are grouped in the Themes of the Strategy. Each section outlines the outcomes expected and a rationale for the actions, supported by international evidence where available, local experience and expertise and stakeholders input. The Action Plan indicates timeframes within which we estimate activity will be completed, the organisation or department which has agreed to take a lead in the activity and which ones can provide support. Leads have been identified on the basis that they have experience and/or expertise in a particular area. Leads will act as sponsors to oversee or co-ordinate activity on behalf of the Partners. They also agree to prepare or collate progress reporting.

Expected time frames for completion are:

Short - By 30 June 2015

Medium – By 30 June 2017

Long – By 30 June 2020

Theme 1: Patient and family centred care/Whānau Ora

'It's more important to know what sort of a person has a disease than what sort of disease a person has.' Hippocrates 400BC

In response to the question 'What does integrated healthcare mean to you?' overwhelmingly our stakeholders told us it means patient and family centred care.

For Māori in the Bay of Plenty, integrated healthcare is encompassed in the principles and values of Whānau Ora. Whānau Ora is an inclusive and culturally anchored approach based on a Māori view of health that assumes changes in an individual's wellbeing can be brought about by focusing on the family collective and vice versa. It is not a new viewpoint, but has become further entrenched in New Zealand's health and social delivery sector with the 2010 introduction of the 'Whānau Ora Approach to Social Service Delivery'.

The Institute of Healthcare Improvement (IHI), an independent not-for-profit organisation based in Cambridge, Massachusetts, a leading innovator in health and health care improvement worldwide, promotes engaging patients by changing the relationship that we have with people in our care from 'What's the matter with you?' to 'What matters to you?'.

'Actually, it's surprising that it has taken us this long to focus on patient engagement because the results we have thus far are nothing short of astounding. If patient engagement were a drug, it would be the blockbuster drug of the century and malpractice not to use it' ⁹.

Kaiser Permanente HealthConnect™ Collaborative Cardiac Care Case Study¹⁰ involving more than 12,000 patients, reported the following results achieved through collaborative team work and engaging patients in their care:

- 135 deaths and 260 costly emergencies prevented
- Patients meeting cholesterol goals went from 26% to 73%
- Patients screened for cholesterol went from 55% to 97%
- Clinical care teams reduced overall mortality by 76% and cardiac mortality by 73%.

In the Bay of Plenty, our story of William's experience demonstrates the benefits in health and wellbeing for a whole family when care is focused on what matters most to patients and addresses social determinants of health.

Almost all the people we spoke to told us that a paradigm shift is required to really understand the meaning of, and deliver, truly integrated healthcare where people, family, and whānau are at the centre of all service delivery and decisions, and where people's preferences and goals matter as much as the medical diagnosis of their disease.

Outcomes for Patient and family centred care/ Whānau Ora:

1. 'What matters to you and/or your family and whānau' is the underpinning approach of all health service delivery.
2. Those who experience health services will have a say and a role in how services are designed and delivered/ During the design process there is an opportunity for a patient voice.
3. Patients' and family/Whānau take greater responsibility for their health.
4. Patients' and family/Whānau decisions are respected.

⁹ Leonard Kish – Principal and Co-Founder of VivaPhi (August 2013)

¹⁰ <http://xnet.kp.org/future/ahrstudy/032709cardiac.html>

1	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
1.1	<p>1.1.1 Identify or develop training for providing patient and family centred care (PFCC).</p> <p>1.1.2 Incorporate PFCC values and principles into core training for all staff, new and existing.</p>	<p>Short</p> <p>Long</p>	<p>Suitable training will be indentified.</p> <p>All staff will have completed training.</p>	<p>BOPDHB Governance & Quality/CIRCA</p> <p>All Partners and all providers.</p>	<p>Theme 5 Patient and Family Centred Care Project, DHB (Quality and patient safety).</p> <p>CIRCA Midland Region Training Network.</p>
1.2	<p>1.2.1 Identify and develop training for providing Whānau Ora care.</p> <p>1.2.2 Incorporate Whānau Ora values and principles into core training for all staff, new and existing.</p>	<p>Short</p> <p>Long</p>	<p>Suitable training will be identified.</p> <p>All staff will have completed training.</p>	<p>NMOPHO / BOPDHB Education Centre</p> <p>All Partners and all providers.</p>	<p>NMO Whānau Ora training package.</p> <p>Midland Region Training Network</p> <p>The Whānau Ora Tool</p> <p>Te Tumu Whānau Ora Framework</p>
1.3	<p>1.3.1 Identify and develop care planning approaches that include patient's preferences and goals.</p> <p>1.3.3 Develop policies and protocols that support and embed care planning approaches that include and support patient's preferences and goals for all providers.</p> <p>1.3.2 Enhance care planning systems to include patients' preferences.</p>	<p>Short</p> <p>Short</p> <p>Medium</p>	<p>Care Planning approaches are identified.</p> <p>All providers have policies and protocols in place.</p> <p>All patients care plans record patient's preferences.</p>	<p>NMOPHO/ Provider Arm/ BOPDHB Planning & Funding</p> <p>BOPDHB/All Partners</p> <p>BOPDHB Information Management/ NMOPHO</p>	<p>Future Care Planning Project.</p> <p>Flinders</p> <p>Whānau Ora plans</p> <p>Theme 3</p>

1	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
1.4	1.4.1 Explore mechanisms that incentivise and promote PFCC and Whānau Ora care delivery and incorporate these mechanisms into service design and contracting processes.	Medium	Mechanisms are identified and incorporated into core. service design and contracting processes.	BOPDHB Planning & Funding	Link to Themes 5 & 6
1.5	1.5.1 Enhance systems and processes to incorporate the patient's voice and view into all future service design and development.	Short	<p>All service design processes capture the patient's view.</p> <p>All Bay Navigator pathways have method of capturing the patients view.</p>	Bay Navigator/ BOPDHB Planning & Funding/All Partners	<p>Bay Navigator</p> <p>FMC processes</p> <p>Provider Arm - Volunteer Patient Experience Advisory Group</p>
1.6	Identify effective components for supporting patients and Whānau to take greater responsibility for their health. This action would inform our longer term approach towards health promotion and policy development that prevents people developing long term conditions and promotes self-care. Options such as social marketing, incentives and policy drivers should be explored.	Long	Components are identified and endorsed to inform future health education activities, policy development and service design.	WBOPPHO	<p>Whānau Ora</p> <p>Theme 2</p> <p>Theme 7</p>

Theme 2: Health Literacy

'I hear and I forget. I see and I remember. I do and I understand.' Confucius, Chinese philosopher & reformer (551 BC - 479 BC)

Health literacy means the ability to access, process and utilise information to make appropriate and informed decisions. People with good health literacy can make informed and appropriate health decisions, and better manage their own health. This leads to better patient outcomes and more effective use of health resources. Several studies show that patients chose different treatment options after they become well informed¹¹. In addition there are gaps between what patients want and what clinicians think their patients want. Studies show that the health system aspires to excellence in diagnosing disease, but does not aspire to the same standards of excellence in diagnosing people's preferences. Health literacy and people, family and whānau centred care are therefore closely linked. If our vision is for people to feel more empowered to manage their health, then they need to have the right information and tools to do so, and clinicians need to have the support and tools to diagnose what people want.

We need to close the information gap so that patients receive the care they need (and no less) and the care they want (and no more).

Around half of New Zealand adults have low health literacy, which results in a wide range of problems and challenges for the health system, individuals, their whānau and families.¹²

Access to the right information and tools are essential to supporting self-care. We live in a world where there is an overwhelming amount of information accessible through the internet, but this may not be the most appropriate information. Sometimes information is not in a format that people understand or engages them. International and local research indicates that 50- 80% of patients walk out of the doctor's office NOT KNOWING what they were told or supposed to do.¹³

Interventions need to be aimed at reducing complexity and making tasks easier to understand. Communication needs to be delivered in a way that engages people and makes it more likely they will understand. Advances in technology present new opportunities for both patients and clinicians to engage patients and communicate effectively. The potential of peer support and social networking has not been fully harnessed in this regard.

Our Strategy aims to progress national initiatives to improve health literacy through local implementation and develop solutions of our own to address this complex area.

Outcomes for Health Literacy:

1. Our population is better informed about their health and health services.
2. Providers are better informed about health services and the value and importance of health literacy.
3. Patients are able to easily access quality, reliable, appropriate and local information.
4. Patients understand the options that are available to them and are able to make informed decisions about their health.
5. People are clear about what the health system can provide.
6. People are supported in the decision-making process.

11 'Patient Preferences Matter' – The King's Fund 2012.

12 Workbase NZ.

13 Orca Health – Centres for Disease Control and Prevention.

2	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
2.1	<p>2.1.1 Undertake an evaluation and gap analysis of the current services in the Bay of Plenty that provide electronic health information to meet the needs of populations and maximise technology.</p> <p>2.1.2 Implement recommendations from 2.1.1</p> <p>2.1.3 Establish a leading source of web-based electronic health information for patients, family and Whānau in the Bay of Plenty.</p>	<p>Short</p> <p>Medium</p> <p>Long</p>	<p>Evaluation and gap analysis complete.</p> <p>Recommendations from 2.1.1 implemented.</p> <p>Lead website identified.</p>	<p>Communications Team BOPDHB/ Bay Navigator Governance Group/ BOPDHB Planning & Funding/CIRCA Steering Group</p>	<p>CIRCA BOPDHB website Health Navigator Toi Te Ora Public Health Krames WebHealth All PHO Websites Bay Navigator Tauranga City Council Age Friendly City Strategy Clinical School Disability Information Advisory Services (DIAS)</p>
2.2	<p>2.2.1 Identify best practice approaches that effectively promote and improve health literacy for different age groups and populations.</p> <p>2.2.2 Development of new health information services and products in the future is undertaken incorporating recommendations from 2.2.1.</p>	<p>Medium</p> <p>Long</p>	<p>Best practice approaches are identified for different groups and populations.</p> <p>All new health information is developed in line with best practice.</p>	<p>Communications Team BOPDHB/ Toi Te Ora Public Health/ BOPDHB Clinical School</p> <p>All providers</p>	<p>Health Navigator Workbase CIRCA Midland Health Network</p>
2.3	<p>2.3.1 Establish expected competencies for health literacy for all healthcare workers.</p> <p>2.3.2 Create expectations for providers to implement agreed competencies for health literacy for all staff.</p>	<p>Short</p> <p>Long</p>	<p>Competencies identified.</p> <p>All providers have implemented competencies for all new and existing staff.</p>	<p>BOPDHB Clinical School Provider Arm</p> <p>BOPDHB Planning & Funding</p>	<p>CIRCA</p> <p>Workbase</p> <p>Midland Region Training Network</p>
2.4	<p>Create expectations for all providers to review their processes to ensure a health literacy approach is incorporated in service delivery.</p>	<p>Short</p>	<p>All providers incorporate health literacy approach to service delivery.</p>	<p>BOPDHB Planning & Funding</p>	<p>Theme 6</p> <p>Midland Region Training Network</p>

Theme 3: Access to patient information

In order to make informed decisions quality information is required. People require information on which to base their healthcare choices (Theme 2) and clinicians require information regarding individual patients in order to provide appropriate advice and treatment.

Giving people access to their own information creates a greater sense of ownership over that information, empowering people to play a far greater role in their health related decisions and supporting them to better self-manage.

To provide integrated care, clinicians have told us that the ability to view and share information about patients across a range of settings is critical to being able to provide the right care at the right time safely. People have told us they get frustrated having to repeat their story over and over again and that they are subject to repeat assessments for seemingly similar things from almost every healthcare service or professional they meet. Our story of Alice's experience demonstrates the potentially negative impact on a person's health where multiple service providers are involved in a patient's care without being able to easily access or share information.

There is a large amount of activity underway across New Zealand developing information systems that support patient care. A key function is the connectivity of those systems; the ability for systems operated by different providers to talk to each other.

There is some confusion regarding the terminology that is used. The terms "shared care", "shared care record", "portal" and "views" are at times not used consistently. For clarity this strategy uses the following definitions:

- Shared care record – A record into which multiple providers, and potentially patients, can record notes that contribute to the care of that patient building towards a shared care plan.
- Shared access/view – A repository of information that draws data from a range of systems and displays that information for multiple providers and patients to view. Some projects are seeking to define a core set of data that should be available to all providers. This is essentially a "read-only" view.
- Portal – A way for providers and/or patients to look into another organisation's information systems to view a complete or defined portion of a record. Again this is "read-only".

In the Bay of Plenty we are already making significant progress towards providing access to data repositories to a range of healthcare disciplines. General practice access to DHB electronic records through CHiP is an example of a

portal. The Éclair database which can be viewed by clinicians working both in the hospital and in the community is an example of a shared view. Some general practice patient information system providers, i.e. Medtech, are developing a module for patients to access their general practice medical record. This can include the ability to exchange information with their practice and interact with the record (shared care).

Whānau Tahī¹⁴ supports the Whānau Ora model through a line of business software applications that supports caseworkers, management, and whānau collaboratively in the achievement of aspirational outcomes. Nga Mataapuna Oranga PHO is a Whānau Ora collective and among the first Whānau Ora providers in the country to be rolling out the information platform with its providers. Valuable lessons are being learnt about developing whānau plans and sharing care where multiple parties are involved in supporting whānau to achieve their outcomes. Work in this area can support and inform our Strategy further.

There is a range of activity occurring at both a national and regional level in the information management area. Work being led by the National Health IT Board includes the National Share Care Programme¹⁵. This encompasses the development of a core set of electronic patient data that is intended to be able to be accessed (a portal), and interacted with (potentially shared care), by patients. The core set of information (shared view) is likely to include allergies, medications and diagnosis. The National Health IT Board appears to support a single system for shared care and that solution is being piloted in the Northern region.

Regional collaboration within Midland is focused on progressing a sector wide information programme called eSPACE (Supporting Patients and Clinicians Electronically) that intends to deliver regional information resources for use across the care spectrum. The major areas of focus are:

- Regional clinical data repository (CDR) – to primarily enable access to community and hospital diagnostic results with expansion to cover event/encounter data and clinical documents (shared view or portal);
- Regional clinical workstation – initially supporting secondary care clinical workflows, subsequently enabling primary/community care access (this is an organisational information system but may include a portal so that external providers can view information);
- Transfer of care – regional electronic referral and discharge systems and processes to support transfer of care between health providers;
- Medications management – initially hospital pharmacy systems but subsequently associated medication management support structures including enabling access to community and hospital medication data.

¹⁴ See www.whānau.tahi.com

¹⁵ See www.sharedcareplan.co.nz

Our preferred approach is not to reinvent and where there are systems in use elsewhere we should be looking to adopt these to support Integrated Healthcare. The challenge will be ensuring we have the appropriate building blocks in place to utilise these systems. For example, if the hospital based care systems are not the appropriate ones, how can the shared care system be made to work in BOP and/or across the Midland region; if community and primary based care has a fragmented approach to practice management systems how does that impact the implementation of the preferred shared care systems?

Our strategy seeks to address these issues by working with our providers to set minimum standards for the management and sharing of information to ensure that all providers in the Bay of Plenty can both access, share and input appropriate information. We propose to develop an appropriate

information governance structure to support the development of information sharing and access initiatives and provide guidance in decision making on information management for the health system.

Outcomes for Access to Patient Information:

1. Healthcare providers will have systems and protocols in place to enable the sharing of patient information.
2. Patients can grant access to, and can interact with, their records to better support self-management.
3. A core set of information is readily accessible to the clinicians involved in a patient's care, regardless of setting, to better support that patient's care.
4. Clinicians can communicate quickly and securely using electronic means.

3	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
3.1	<p>3.1.1 Identify systems and protocols for information sharing, identify minimum standards of IT capability desired for all providers and develop appropriate contractual clauses.</p> <p>3.1.2 Include contract clauses in all provider contracts to specify requirements to share information and set a minimum standard of IT capability for all service providers, including appropriate stakeholder engagement processes. (Note: contractual requirements to share to take into account legal obligations).</p> <p>3.1.3 All providers undertake a review of patient consent and enrolment information to ensure it reflects providers' information sharing requirements and is within the provisions of the Privacy Act.</p>	<p>Short</p> <p>Medium</p> <p>Medium</p>	<p>Systems and protocols for sharing agreed to. Contract clauses drafted.</p> <p>All contracts for all services will contain clauses specifying provider standards and requirements.</p> <p>All patient enrolment information will reflect rights and obligations.</p>	<p>BOPDHB Information Management/ BOPDHB Planning & Funding</p> <p>BOPDHB Planning & Funding/ All Partners</p> <p>BOPDHB Governance and Quality/ All Partners</p>	<p>National Shared Care Plan</p> <p>Whānau Ora Collectives</p> <p>All consent and enrolment forms</p>

3	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
3.2	Investigate options to provide patient access to and the ability to interact with their health record(s). Implement options as part of a district wide roll out of recommendations from pilots.	Medium	Recommended options identified All patients have access to electronic health records.	BOPDHB Information Management/All Partners	Theme 2 National and regional pilots
3.3	Develop a set of core clinical information for all patients available electronically to providers. In addition define those providers that have access. [Investigate enhanced use of Bay Navigator pathway development process as a solution to define core information needs for specified patient groups]	Short	Core clinical electronic information defined and agreed.	Bay Navigator Governance Group	Whānau Ora (NMO) EBPHA CHiP / Éclair Midland E Space District Nursing Integrated Care Record project
3.4	Enhance a governance body to advise and inform strategic direction for all IT development for BOP health care providers. [Note: revise Bay Navigator IT GG TOR]	Short	Governance Body agreed and TOR established.	All Partners	Bay Navigator IT Governance Group Regional IT Governance Group
3.5	3.5.1 Provide training on the Privacy Act and Health Privacy Code to improve knowledge of rights and obligations of health care workers with respect to protection of privacy. 3.5.2 Socialise key messages through media and other mechanisms to increase public's awareness and understanding of sharing patient information.	Short Short and on-going	All staff are aware of the provisions of the Privacy Act and interface with health information.	BOPDHB Governance and Quality/All Partners	Privacy Commissioner

Theme 4: Co-ordinated care

Co-ordinated care, like integrated healthcare, does not have a universally recognised definition¹⁶. It often encompasses 'case management' and 'multi-disciplinary teams' and 'integrated care' itself. This theme focuses on the approach needed to develop our systems, business models and organisational structures to be more attentive to patients with chronic and complex medical conditions who require care and support from multiple clinicians and service providers. Our story about Alice's experience is an example of the need to better co-ordinate services.

International literature suggests that strategies aimed at better co-ordination of care appear to be highly dependent on the way in which care co-ordination is implemented locally. Our stakeholders told us that co-ordinating care relies on developing close working relationships, knowing who is providing services and what they do, and that developing trust with clinicians, patients, family and whānau is essential. Developing trusting relationships takes time and needs to occur at multiple levels. Providers and clinicians told us that they are often unaware of who else is involved in a person's care or what service they may be providing, and that responsibility for care co-ordination is neither clearly defined nor routinely expected. Those who take on this role do so out of a desire to improve care for patients but find that the organisational and system structures do not support or incentivise their efforts to work effectively and consistently in this way.

More successful approaches to co-ordinating care are those that are targeted at patients with complex needs, often with multiple medical conditions and social support requirements. Local examples include Whānau Ora, the Community Response Team, Te Whiringa Ora, Paediatrics services and Health in Ageing. These services focus on a holistic approach which promotes functional independence rather than specific disease management. These approaches are developing new definitions of care teams including a range of disciplines with patients, family and whānau as critical members of the care team. A key success factor is identifying a navigator or key co-ordinator of care. Where people have complex medical needs involving specialist care in the hospital, findings suggest it may be useful to identify a hospital care lead and community care lead. These leads may change during life e.g. a tamariki ora worker; a school nurse; a social worker; a general practice nurse; a district nurse; an occupational therapist; a palliative care nurse; and may be a family member.

These services are also developing new ways for teams to work together, access the advice of specialists or conduct medical consultations. The Bay of Plenty's Telehealth initiative is fostering different approaches to teamwork through the installation of video conferencing equipment in various locations, meaning people do not have to be physically present or travel to see patients, be consulted or involved in team meetings.

Developing new definitions of care teams and different ways of working to co-ordinate care across environments impacts on the business models for all healthcare providers, particularly in general practice. We propose to explore and demonstrate new business models that support co-ordinated care.

Outcomes for Co-ordinated Care:

1. BOP health system functions as one system, working together.
2. Transitions are improved with a co-ordinated care response.
3. Patients' experience is seamless.

¹⁶ Goodwin, Sonola, Thiel and Kodner - The Kings Fund 2013: 'Co-ordinated care for people with complex chronic conditions.'

4	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
4.1	<p>4.1.1 Trial (including evaluation of) sites for extended multi-disciplinary primary healthcare teams including use of new technologies available.</p> <p>4.1.2 Review models of general practice and make recommendations for alternative models that will better support integrated healthcare.</p>	<p>Medium</p> <p>Long</p>	<p>Evaluation of trial sites completed.</p> <p>Recommendations for alternative models of general practice are developed that better support integrated healthcare.</p> <p>All front line staff are competent in multi-disciplinary teamwork.</p>	<p>WBOPPHO All PHOs</p>	<p>CIRCA; Telehealth Project Trina Nixon (MDT Support advisor, Provider Arm)</p> <p>BOP Rural emersion programme (AUT)</p>
4.2	<p>4.2.1 Identify appropriate predictive risk assessment tools to identify specified patient groups for co-ordinated care planning implementation in priority population groups.</p> <p>4.2.2 Embed use of tools in a range of settings to inform service mix and allocation and maximise efficiencies of resource allocation.</p>	Short	<p>Predictive Risk Assessment Tools are identified in priority population groups.</p> <p>Predictive risk methodologies underpin all service assessment and allocation.</p>	<p>BOPDHB Planning & Funding/Toi Te Ora Public Health</p> <p>All Partners/ NASC agencies</p>	<p>Patients at Risk of Re-hospitalisation (PARR) Tool.</p> <p>Ambulatory Sensitive Hospital Admissions (ASH) Project</p> <p>interRAI</p> <p>Children's Action Plan</p>
4.3	<p>4.3.1 Develop processes and practices which identify clinical co-ordinators for adults with complex health needs that cross specialties.</p> <p>Note: Potential for this to be built into Bay Navigator pathway development.</p> <p>4.3.2 Identify support requirements and review practices and protocols to enhance multidisciplinary teamwork across environments e.g. including hospital based care teams and community based care teams. This could include promoting use of new technologies such as telemedicine.</p>	<p>Short</p> <p>Medium</p>	<p>All care plans identify a clinical care co-ordinator.</p> <p>Reduced re-admission rates.</p> <p>Improved transitions e.g. hospital discharges.</p> <p>Improved access to specialist advice.</p>	<p>Bay Navigator Governance Group/Provider Arm/All PHOs</p>	<p>Bay Navigator</p> <p>CIRCA</p> <p>Paediatrics</p> <p>Health in Ageing</p> <p>Telemedicine Project</p>

4	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
4.4	Support patients to identify their own key coordinator or navigator of care to co-ordinate services among multiple providers of care including social and support services.	Short	All care plans identify a lead navigator.	All Partners	Whānau Ora SupportNet Local Area Co-ordinators CIRCA
4.5	Review standardised service responses to requests for referral to ensure all responses advance a patient's care.	Medium	All service responses are reviewed.	Provider Arm/All Partners	Bay Navigator CIRCA

Theme 5: Creating an environment for integration

It is accepted that a re-orientation of the system requires sound leadership and good governance with clarity around decision making and accountability. Effective governance arrangements need to be underpinned by clinical leadership and senior executive support. Evaluations of successful initiatives to improve integrated services also highlight the importance of a sustained investment in providing staff with the skills needed to innovate. Dedicated programme management is required to transform the aspirational goals to real and measureable action.

Workplace culture determines more than anything whether improvement or changes to the current way of doing things are likely to fail or succeed and be sustained. Priorities identified by our stakeholders to progress changes on the scale required included developing leadership capability to engage a workforce to embrace the vision for integrated healthcare, then think and act consistently in a way that puts the patient at the centre of all decisions, responses and services. Barriers to change to be addressed by stakeholders included patch protection, cynicism, fear of losing autonomy, and an ingrained hierarchical model of healthcare.

Addressing the workforce changes desired to achieve an integrated healthcare system will require a co-ordinated, whole-of-system approach. Our strategy does not seek to duplicate or address the overall workforce needs for the Bay of Plenty, but rather to consider what strategies and actions may be required for our current and future workforce to embody the vision and principles of integrated healthcare, and how staff can be incentivised and motivated to work in a different way.

Outcomes for creating an environment for integration:

1. The BOP health system functions as one system, working together.
2. The BOP health workforce has the skills and competencies required to deliver high quality integrated healthcare.
3. There is an agreed, systematic approach to education and training requirements to support integrated healthcare, innovation and improvement across the Bay of Plenty health system.
4. Integrated healthcare is supported, communicated and promoted by all people who work in the BOP health system.

5	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
5.1	<p>5.1.1 The partners will work together to explore options and approaches to education and training that promotes integration, healthcare improvement and innovation across the Bay of Plenty workforce.</p> <p>5.1.2 Explore development of strategic partnerships with leading healthcare improvement organisations (locally nationally and/or internationally) to support Action 5.1.1.</p>	<p>Medium</p> <p>Short</p>	<p>Whole-of-system approach developed.</p>	<p>All Partners/ BOPDHB Clinical School</p>	<p>BOPDHB Clinical School and Education Centre; CIRCA; NMOPHO; WBOPPHO; Te Wānanga o Aotearoa; Waiariki Institute of Technology; Midland Region Training Network; BOP Tertiary Partnership</p>
5.2	<p>5.2.1 Review local and regional workforce training and education strategies to identify training requirements needed to embody the vision and principles of integrated healthcare and to inform Action 5.1.1.</p>	<p>Short</p>	<p>Review completed and recommendations considered.</p>	<p>Midland Region Training Network/ BOPDHB Clinical School/All Partners.</p>	<p>BOPDHB Clinical School/Education Centre</p> <p>Midland Region Training Network</p> <p>CIRCA</p> <p>PHO CME and CNE Education and Training programmes.</p>
5.3	<p>5.3.1 Develop clinical leadership required to engage staff in the vision and principles of integrated healthcare and support the change management required.</p> <p>5.3.2 Provide resources, training to support the change management process required to implement actions identified in this strategy.</p>	<p>Short and ongoing</p> <p>Short and ongoing</p>	<p>Clinical leads are identified, supported and trained.</p> <p>Change management is undertaken and able to be demonstrated.</p>	<p>BOPDHB Clinical School/ All PHOs</p> <p>All partners</p>	<p>Midland Advanced Leadership Programme</p> <p>CIRCA</p> <p>PHO CME and CNE programmes</p>
5.4	<p>Explore levers available through human resource and recruitment policies and protocols to incentivise staff to embody the vision and principles of integrated healthcare e.g. create Key Performance Indicators that reflect progress towards achievement of actions identified in the Integrated Healthcare Strategy.</p>		<p>Recruitment and human resource policies are reviewed and recommendations considered and implemented where appropriate.</p>	<p>All Partners</p>	<p>Midland Region Training Network</p> <p>Union Tri-partite Partnership</p>

5	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
5.5	5.5.1 Identify components (e.g. processes, protocols, mechanisms and organisational structures) to enhance inter-sector and intra-sector alliances and partnerships to provide joined-up care for specified patient groups (e.g. medically and socially complex).	Short	Components are identified and barriers reduced e.g. standard referral protocols; shared goals across services and agencies.	Bay Navigator/ BOPDHB Planning & Funding. All Partners	Bay Navigator Whānau Ora; Te Whiringa Ora; EBOP ALT; Community Response Team; ASH project
	5.5.2 Provide support (e.g. facilitate sharing of current resources) and/or develop resources for providers to encourage development of alliances and partnerships such as opportunities for networking and relationship development; toolkits, policies and protocols, templated forms, instructions and guidelines.	Medium	Increased number of alliances and partnerships are in place.		
	5.5.3 Identify mechanisms that incentivise collaboration and create expectations for providers to formally collaborate.	Short	Contracted outcome measures include the outcome of the collaboration/ alliance e.g. reduced admissions to hospital.		
5.6	5.6.1 Develop a communications plan to promote integrated healthcare.	Short	Communications Plan developed.	BOPDHB Communications Team/BOPDHB Planning & Funding/CIRCA/ All Partners	The Kings Fund IHI Ko Awatea
	5.6.2 Identify and promote a common language, based on international best practice, which supports the communications plan.	Short	Common language identified.		

5	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
5.7	Undertake a stock take and review of existing committees, governance and advisory groups (excluding those that are required by legislation), to determine optimum structures to: <ul style="list-style-type: none"> • support progression of the government's priorities and local priorities and initiatives; • clarify roles and functions; • reduce duplication and streamline accountabilities. 	Short	Review completed and recommendations agreed.	BOPDHB Planning and Funding/All Partners	All Partners

Theme 6: Contracting for outcomes and flexibility of funding

Funding and contracting mechanisms are generally accepted, and frequently confirmed by our stakeholders as drivers for behaviour, fragmentation, gaps in service and at times, inappropriate duplication. Notwithstanding some recent innovations, existing funding and contracting systems are by-in-large built on historic models of purchasing for disease-specific care more suited to episodic and acute events. For example, the vast majority of health services are purchased using a price/volume method with contracts specifying a volume of a defined activity to be delivered (e.g. procedure) for a price per unit of activity. Whilst this method can be effective for analysing and managing demand for services, it can act as a driver to deliver services unfavourably based on quantity.

In an integrated model, funding could be used to enable and incentivise achievement of outcomes (quantity and quality) with responsibility for achievement of outcomes being shared across service providers. In the Bay of Plenty we have been making progress towards developing contracts that enable service providers to deliver services in a flexible way to support achievement of agreed outcomes for their clients and patients, rather than being constrained to deliver a prescriptive service potentially at odds with the outcomes desired. Examples include services where older people with complex needs are supported to live independent lives based on client goals aimed at reducing functional decline. Funding is based on a package of care which the provider can use flexibly to purchase or provide a range of supports tailored

to people's needs. Measures for success include reducing or delaying entry to long term residential care.

For people with multiple chronic conditions, their needs cannot be met by neatly fitting into the parameters or scope of a particular defined funding stream or government department's budget responsibility. The ability to look at overall expenditure for defined populations and user groups and to use budgets flexibly is one of the hallmarks of integrated care¹⁷. Bay of Plenty's experience in integrating contracts for providers who hold contracts with multiple government departments is supporting new flexible services for people with social and healthcare needs and reducing the burden of bureaucracy for providers.

Currently work is being undertaken by the Ministry of Health to streamline and align performance measures across DHBs and PHOs within the framework of the New Zealand Triple Aim. The Integrated Performance and Incentive Framework (IPIF) is aimed at strengthening sector integration, capability and capacity and will inform our strategy and activities further.

As we progress towards a more integrated system, traditional boundaries of service provision will be tested and evolve. For some this will appear as a threat, and for others an opportunity. For example, stakeholders told us that there is still considerable work to do to change the public's perception of what community based care can do and where people go to receive care.

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Outcomes for contracting for outcomes and flexibility of funding:

1. All contracts are outcome focussed.
2. Funding, contracting, monitoring and reporting structures promote and support integrated healthcare.
3. Funding and contracting structures are flexible and enable agreed outcomes to be achieved.
4. Inappropriate duplication is reduced.
5. Reporting is meaningful and aligned with agreed outcomes.
6. System capacity and capability is strengthened.
7. Risks and benefits are shared.

6	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
6.1	<p>6.1.1 Redefine the role and function of the hospital based services and community based services.</p> <p>6.1.2 Review purchasing and contracting mechanisms and strategies to remove barriers and ensure alignment with principles of integrated healthcare.</p> <p>6.1.3 Explore alternatives to the price volume method of purchasing services.</p>	<p>Short</p> <p>Short</p> <p>Short</p>	<p>Every Bay Navigator pathway aligns with the Bay Navigator Framework.</p> <p>Strategies and policies promote and enable integrated healthcare.</p> <p>Alternatives are identified.</p> <p>Pilot services are identified and agreed.</p>	<p>Bay Navigator Governance Group</p> <p>BOPDHB Planning & Funding</p> <p>BOPDHB Planning & Funding/ All Contractors</p>	<p>CIRCA</p> <p>FMC Process RFP Process</p>
6.2	<p>6.2.1 Develop an outcomes framework and measures for contracts that is aligned with the Triple Aim.</p> <p>This work should include developing a set of core outcomes for all contracts including requirements to reduce inequalities.</p> <p>6.2.2 Review all contracts to align with outcomes framework.</p>	<p>Medium</p> <p>Medium</p>	<p>Framework developed</p> <p>All contracts will be aligned.</p>	<p>BOPDHB Planning & Funding/All Contractors</p>	<p>Results Based Accountability Performance and Incentive Framework</p>
6.3	<p>6.3.1 Integrated performance measures across community and hospital based care.</p>	<p>Medium</p>	<p>Health target achievement is integrated across hospital care and community care.</p>	<p>BOPDHB Planning & Funding/All Contractors</p>	<p>ASH Project</p> <p>Performance and Incentive Framework</p>

6	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
			Performance measures are aligned.		Whānau Ora SupportNet Local Area Co-ordinators CIRCA
6.4	6.4.1 Undertake stocktake of contracts to ensure alignment of services and maximising available resource, and opportunities to collaborate.	Short	Stocktake completed. All Bay Navigator pathways identify relevant providers.	BOPDHB Planning & Funding/All Contractors	Bay Navigator MOH DSS contracts Toi Te Ora Public Health
6.5	Collaborate with other key funders to undertake funding and asset mapping to determine collective investment in defined geographical areas. Advance integrated contracts across multiple sectors.	Long	Asset mapping completed. Increased number of integrated contracts	BOPDHB Planning & Funding	MSD CoBOP Whānau Ora Social Sector Trials Community Response Forum

Theme 7: Health in all policies

It has often been cited that health services alone account for only an estimated 10 per cent of variation in life expectancy. Most variation is due to lifestyles and environments, and their determinants. Much of that is amendable to influence through policies – in different sectors, most of which lie outside the health sector and which do not fully realise that much of their work and policy development has a strong impact on the health and well-being of our population.

Health in All Policies (HiAP) is defined as “an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.”¹⁸

New Zealand has a high level of understanding of its own particular set of social determinants of health and reasons for inequalities and, through the efforts at a Government level, is making progress in converting this knowledge into action. The New Zealand Medical Association’s position statement on health equity documents a series of research driven recommendations which, if adopted in full, will result in fundamental changes to the way society in New Zealand as a whole functions.¹⁹ Action to address social determinants of health benefits society in many ways. One of the reasons for the increasing cost of healthcare can be attributed to the increased treatment cost when social determinants are not addressed, for example recurring respiratory conditions that develop into long term conditions and poor oral health or skin infections that deteriorate to the point where hospital treatment is required. Such conditions could have been prevented or reduced if the social determinants were addressed.

Our stakeholders confirmed that much of their ability to do their job well depends on social and environmental factors that negatively impact on people’s lives; typically housing, transport, education and social needs. Factors also included the cost of healthcare services that require a co-payment (e.g. GP fees, medications, dental care), shortage of options outside of usual working hours, and services that don’t engage people or promote prevention as barriers to getting the right care before health issues became more serious. Therefore addressing social determinants of health can be considered a hallmark of true integration across sectors and a critical means of achieving the NZ Triple Aim, and therefore should be a major focus for our work.

Our story of William’s experience demonstrates the positive impact on health that focussing on what mattered most to William and his whānau had, through addressing housing and education needs. A project is currently underway in the BOP

to determine the percentage of admissions to hospital that could have been avoided if such issues were addressed. The Ambulatory Sensitive Hospital Admissions (ASH) project will inform our strategy and resulting actions further.

In the Bay of Plenty, initiatives to work collaboratively across sectors at a governance and policy development level to influence social determinants of health for the population include Collaboration Bay of Plenty (CoBOP) and the SmartGrowth Strategy 2013²⁰. The SmartGrowth Partnership brings together local government, tangata whenua, health and the social sectors to plan for future land use and economic and community development for the Western Bay of Plenty.

Addressing social determinants requires various approaches. Many areas of health work in a collaborative way with other agencies. Examples of cross sector and cross agency work in the BOP that were identified as bright spots by our stakeholders included Strengthening Families, Whānau Ora, and the Mental Health and Addictions Shared Governance Group. These approaches at agency to agency level tend to have the most positive impact on the care of individual patients.

However, efforts that are likely to have impact at the scale and pace required to improve the health of populations are at the governance level to influence policy and establish shared leadership to implement policy. Our strategy seeks to progress integrated healthcare at both policy and agency levels and to ensure that our current direction aligns with the vision and principles of integrated healthcare.

Outcomes for health in all policies:

1. Cross sector partnerships are established to reduce inequalities and address social determinants of health.
2. Government agencies develop policies that seek to minimise negative impacts on the health of the Bay of Plenty population.
3. All health service development and redesign considers impacts on social determinants of health.
4. All health professionals in the BOP act, advise and advocate for action on social determinants of health in addition to supporting individual patients.
5. BOP populations have improved health and equity.

¹⁸ World Health Organisation.

¹⁹ New Zealand Medical Association Position Statement – ‘Health Equity’.

²⁰ <http://www.smartgrowthbop.org.nz/>

7	Actions	Expected timeframe for completion	Indicator of success	Lead /Support	Links
7.1	<p>Advocate and promote the key messages of the NZMA Position Statement on 'Health Equity' and the Helsinki Statement of 'Health in all Policies'.</p> <p>Assist other sectors in developing mechanisms to assess health impacts of their policies (e.g. Health Impact Assessment and/or Health Equity Assessment Tool).</p>	Short	Increased awareness and overt promotion of the key messages.	All Partners	Toi Te Ora Public Health
7.2	<p>Participate at governance level in cross sector partnerships and alliances to formalise collaborative action to align activity to address social determinants of health that have the most impact on the Bay of Plenty population.</p> <p>Develop outcome measures that capture the effectiveness and benefits of cross sector collaboration.</p>	Medium	Cross sector partnerships are formalised with agreed goals.	BOPDHB Board All Partners	Whānau Ora SmartGrowth Midland Child and Youth Action Group CoBOP
7.3	<p>Explore levers (e.g. contractual, HR policies, education strategies) to incentivise contracted providers to incorporate policies that seek to address broader determinants of health into all health service delivery.</p>	Medium	Levers are identified and supported and incorporated into contracts where applicable.	NMOPHO All Partners	Whānau Ora Integrated Contracts
7.4	<p>Support contracted providers to develop policies that address the social determinants of health in all service delivery.</p>	Medium	All contracted providers have policies developed.	BOPDHB Planning & Funding All Partners	
7.5	<p>Develop competencies and educational goals for all healthcare workers to incorporate training that considers the impacts of the social determinants of health, where they are not currently developed.</p>	Medium	Competencies are identified and incorporated into core training requirements.	BOPDHB Clinical School All Partners	

Appendix 1 – Partners’ Values

Nga Mataapuna Oranga PHO



Our values and principles are the core of our organisation. Providing guidance, they are fundamental to the operation of Ngā Mataapuna Oranga.

1. MANA TANGATA - Both collective and individual mana must be presented.
 2. TINO RANGATIRATANGA - Self-determination at both individual and organisational levels will be supported and encouraged.
 3. WHĀNAUNGATANGA - Welcoming, embracing and showing consideration for everyone.
 4. MANAAKITANGA - Show respect, support and kindness in everything we do.
 5. KOTAHITANGA - Maintain unity and purpose in all that we do.
 6. TIKANGA - Provide a basis for all behaviour and action within Ngā Mataapuna Oranga.
 7. WAIRUA AUAHA- Seek to be innovative in all we do.
 8. NGĀKAU PONO- Loyalty and honesty for all people involved with Ngā Mataapuna Oranga - both to each other and to the organisation. It is fundamental tikanga.
-

Eastern Bay of Plenty PHA



Our values are:

- Respect for kotahitanga mo ngā iwi katoa
- Mana atua, mana tūpuna, mana whenua, mana tangata
- Aiming for excellence: quality, results, accountability, and timeliness
- Integrity
- Openness

Western Bay of Plenty PHO



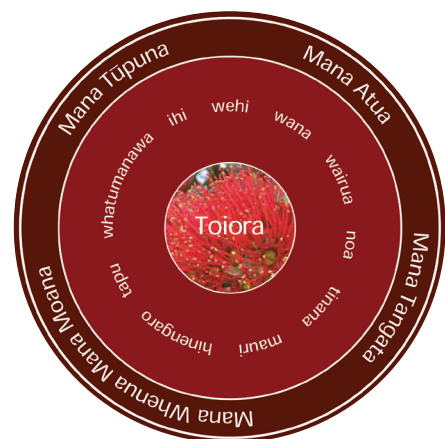
Our values are:

Equity of access	Consensus decision making
Locally driven	Beneficial to both partners
Treaty-based partnerships	Collaboration
Quality service provision	Leadership

Bay of Plenty District Health Board



BOPDHB has adopted the acronym CARE to reflect the organisations values: Compassion, Attitude, Responsiveness and Excellence. The Māori Health Runanga has affirmed He Pou Oranga Tangata Whenua²¹ (HPO). The DHB Board and Runanga believe there is good alignment between the HPO principles and CARE.



²¹ HPO represents the culmination of over two years of consultation, workshops, hui and development work between Te Runanga Hauora o Te Moana a Toi (the Māori Health Runanga), the BOPDHB, Whānau, Hapu, Iwi, the health sector and the wider community of the Bay of Plenty (Te Moana a Toi). HPO provides a conceptual framework for Toiora: optimum health and well-being, that is acceptable to the collective of Iwi within Te Moana a Toi.

Appendix 2 – Stakeholder forums

BOP Nurse Practitioners Facilitation Group
New Zealand College of Primary Healthcare Nurses BOP
Regional Community Services Management Team
Nga Mataapuna Oranga PHO NGO Provider Forum and Clinical Committee
Clinical Nurse Specialists
Grand Round
Eastern Bay of Plenty PHO Clinical Advisors
Mental Health and Addictions Shared Governance Group
Child and Youth Technical Advisory Group
Population Health Technical Advisory Group
BOPDHB Executive Management Team
Te Teo Herenga Waka
Health Liaison Committee
GP and NGO health provider forums EBOP and WBOP
Provider Arm Cluster Leaders
BOPDHB Clinical Board
Merivale Community Centre
WBOP Social Sector Forum
Māori Health Runanga
BOPDHB Board
WBOPPHO Clinical Board
Home Based Support Providers, EBOP and WBOP
BOP Palliative Care Network
Senior Medical Officers Committee, Whakatane
Māori Health Providers Hui
Volunteer Patient Advisory Group
Community Response Team
BOPDHB CPHAC/DSAC
Population Ageing Technical Advisory Group
BOP Branch of the NZ Aged Care Association
SupportNet
BOPDHB Staff Forum
Pacific Island Community Trust
Welcome Bay Community Centre

Appendix 3 – Summary of stakeholder feedback

Q1: What does integrated healthcare mean to you?

Person, family, whānau centred
Whānau Ora
One system, seamless experience
Builds trusting relationships
Changes relationships to 'what matters to you'
More focus on self-management and prevention
Shared care with multi-disciplinary teams, coordinated, with identified leads
Ability to share and access patient information and diagnostics
Flexible funding
Clear information for patients and whānau that is the right information
Clear referral processes
Affordable
Agreed organisational rules/protocols
Addresses social determinants of health

Q2: What do you see are the main issues or barriers that we need to address to improve integration?

Poor health literacy
Barriers to information flow
Disconnected/disengaged populations
Large number of providers to interact with, duplications in service provision, gaps in others
Prescriptive contracts, short term contracts
Traditional funding model not keeping up with integration and technology – need to define new business rules.
Workplace culture, patch protection, cynicism
Siloed, inflexible funding
Disease specific model of care
Business models of primary care, co-payments (cost)
Change fatigue
Misunderstanding about privacy obligations

Q3: Identify some examples of effective integration – where are we now and what are we doing well that we could build on (locally, nationally and/or internationally)?

Bay Navigator
Te Whiringa Ora
Whānau Ora
Strengthening Families
SmartGrowth
CREST and START Models
PRIMHS
Telemedicine
GP access to Éclair
Co-ordinated Primary Options
Risk Stratification models - PARR Tool and ADHB
BOP Community Response Team
Kawerau Suicide Prevention team

Q4: What could we/you do over the next 2 years that would take us the greatest distance towards a more integrated health system?

Develop a shared vision, be courageous
'What matters to you' adopted as underlying approach
Support workplace culture change required
Implement electronic health record (education on privacy)
Extend use of multi-disciplinary primary healthcare teams
Extend
Co-design and co-delivery of care by patients and whānau
Review models of general practice and business rules to support above
Reduce provider fragmentation, duplication, raise expectations
Specify minimum standard of IT competency and capability
Contract for outcomes with flexible funding
Improve health literacy
Develop set of protocols for integration across sectors
Develop a new language to support integration e.g. system, network, pathway

Appendix 4: Acknowledgements

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