ALLIANCE HEALTH+

Alliance Health Plus Trust

Submission to the New Zealand Productivity Commission

More Effective Social Services

Submitted 2 December 2014

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Introduction

Alliance Health Plus Trust (AH+) makes this submission as one of two Primary Health Organisations (PHOs) currently working with District Health Boards in Auckland to commission health services through integrated contracts. We are pleased to see that the Government is interested in how government agencies might improve current practice in the commissioning and purchasing of social services. We would like to contribute some of our learning as a current non-government organisation (NGO) that is commissioning services for high needs populations.

Key points we wish to make in our submission include:

- Siloed funding streams continue to be a hindrance to working in integrated and family centred ways where providers are only able to deliver what is specified in their contract despite being well placed to address a range of needs for a family.
- Government policy and commissioning activities have not kept up with developments at the coalface which has meant providers often deliver significant levels of service that are:
  - not included in service specifications
  - should be funded from other sectors
  - not captured or reported on as results achieved for a family.
- Within health and social care services, organisational leadership is fundamental to achieving a shift in culture that will lead to effective integrated models of commissioned care. The focus of change efforts must be on improving outcomes and not on changing organisational structures, however where structural change is required, commissioning agencies must be able to support/resource those changes to occur.
- Investment in IT solutions that are 'user friendly' for frontline staff that provide up-to-date data collection and timely analysis is essential for guiding the decisions made by commissioning agencies. It also allows providers to make evidence based judgements about their models of care and informs business planning processes (eg: number of FTEs required).
- In addressing health inequalities, the commissioning process should take a 'population-based' approach. This approach is informed by data and analysis of population need and budgets. However, this has been somewhat difficult to achieve where funding for populations has not been devolved.
- Coproducing commissioning will enable greater patient/client involvement and will create opportunities for innovation and a diversity of approaches in designing and delivering services. However this needs to be adequately resourced in order to be implemented effectively.
- New models of NGO commissioning for high needs populations have demonstrated some positive findings overseas, however, require suitable investment up front to support NGO commissioners to implement support to enable organisations to delivering outcomes. This sees the role of commissioner extending beyond the traditional funder–provider (master-servant) relationship.

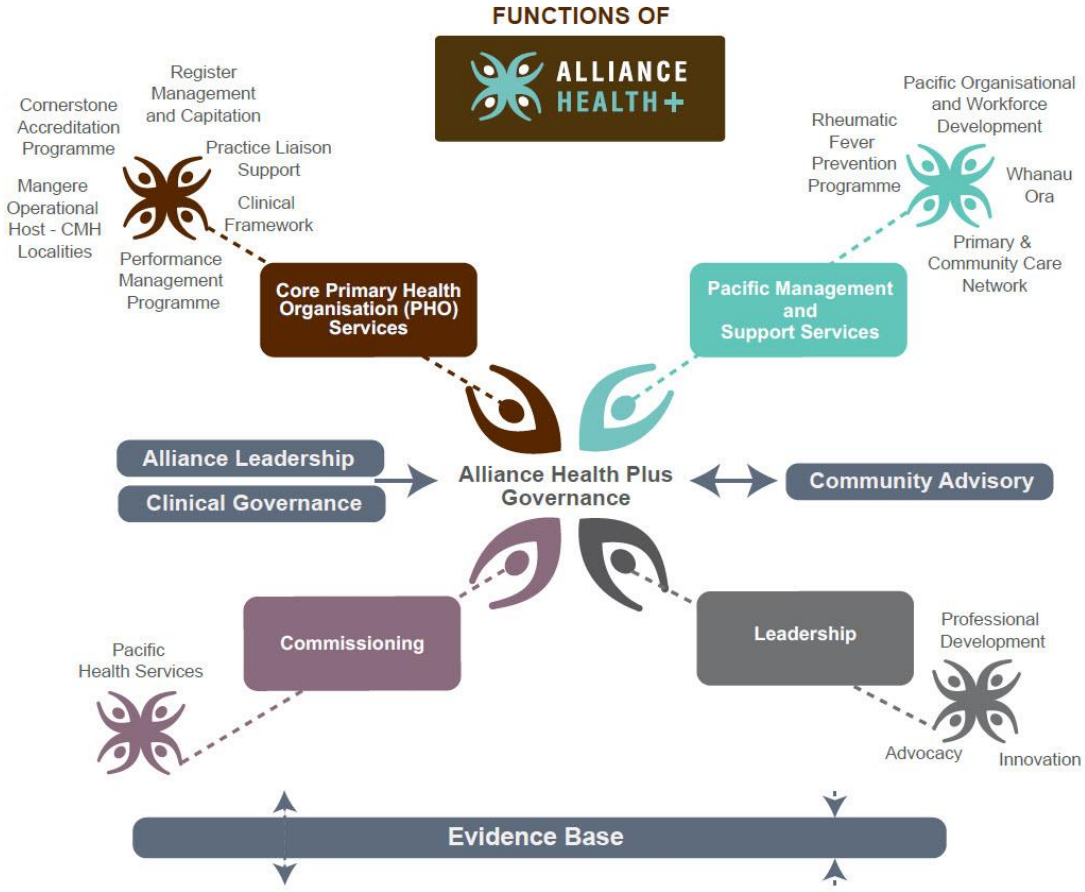
We make reference to the submission from the Tangata o le Moana Network and its relevance to the AH+ submission. Where possible, we have tried to not duplicate information contained in the Tangata o le Moana submission which represents a provider level view. We have focused our submission from a commissioner's perspective.

About Alliance Health Plus Trust

Established in August 2010, Alliance Health Plus Trust (AH+) is a primary and community care organisation, and is the only Pacific-led PHO in New Zealand. While AH+ as an organisation is relatively new, its provider network represents a long history of Pacific Health and Primary Care contributions to the NZ health system. AH+ has an enrolled population of approximately 93,000 across 26 General Practices in the Counties Manukau and Auckland districts.

AH+ has a particular focus on Pacific and high needs populations which has seen its role expand from providing core PHO services to a more integrated model of health and social care management. In addition to being a PHO, the organisation also supports Tangata o le Moana (a regional Pacific provider network), the Rheumatic Fever Pacific Engagement Strategy, a Whanau Ora collective, and is a commissioner of Pacific Health services for the Auckland and Counties Manukau District Health Boards.

The core functions of AH+ include:



Issues for consideration

Innovations in commissioning

In partnership with Pacific providers and communities, Auckland District Health Board and Counties Manukau Health, AH+ has been working to transition an agreed tranche of Pacific health contracts from DHBs to AH+ for commissioning purposes.

This section responds to:

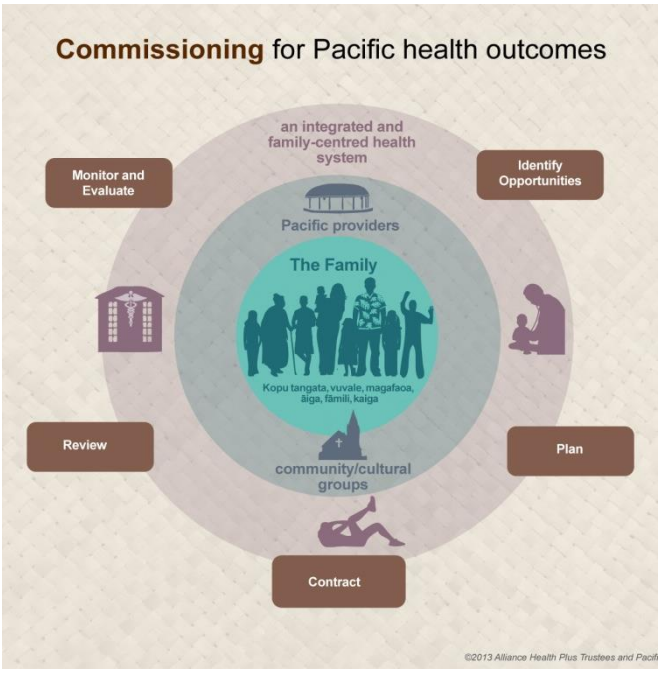
- Are there other innovations in commissioning and contracting in New Zealand that the Commission should explore? What lessons could the Commission draw on from these innovations?
- Do crown entities and non-government commissioning agencies have more flexibility to design and manage contracts that work better for all parties? Are there examples of where devolved commissioning has led to better outcomes?
- How can the benefits of flexible service delivery be achieved without undermining government accountability?
- What are the opportunities for and barrier to using information technology and data to improve the efficiency and effectiveness of social service delivery?

The impetus for the devolution of these contracts has been the Government's Better Public Services programme with a greater focus on results based contracting as opposed to 'widget counting'. The process has resulted in the reconfiguration of 22 contracts to purchase a set of outcomes based on four packages of care. The approach sees a reorientation of services to be more aligned with the needs of Pacific families and improving the patient experience, while being mindful of demonstrating value for money.

An outcomes framework has been developed to guide purchasing decisions as a way of reducing fragmentation in service provision and to support planning and investment decisions for Pacific health services across Auckland. The AH+ Outcomes Framework incorporates the views of Pacific patients, families and community representatives from 12 focus groups that were held in 2014. The Framework also draws on the Ministry of Health Outcomes Framework and evidence base for Pacific populations across metro-Auckland (Ministry of Health, 2012).

The AH+ commissioning model

Important elements to our commissioning model which make it different from traditional commissioning approaches include the following:

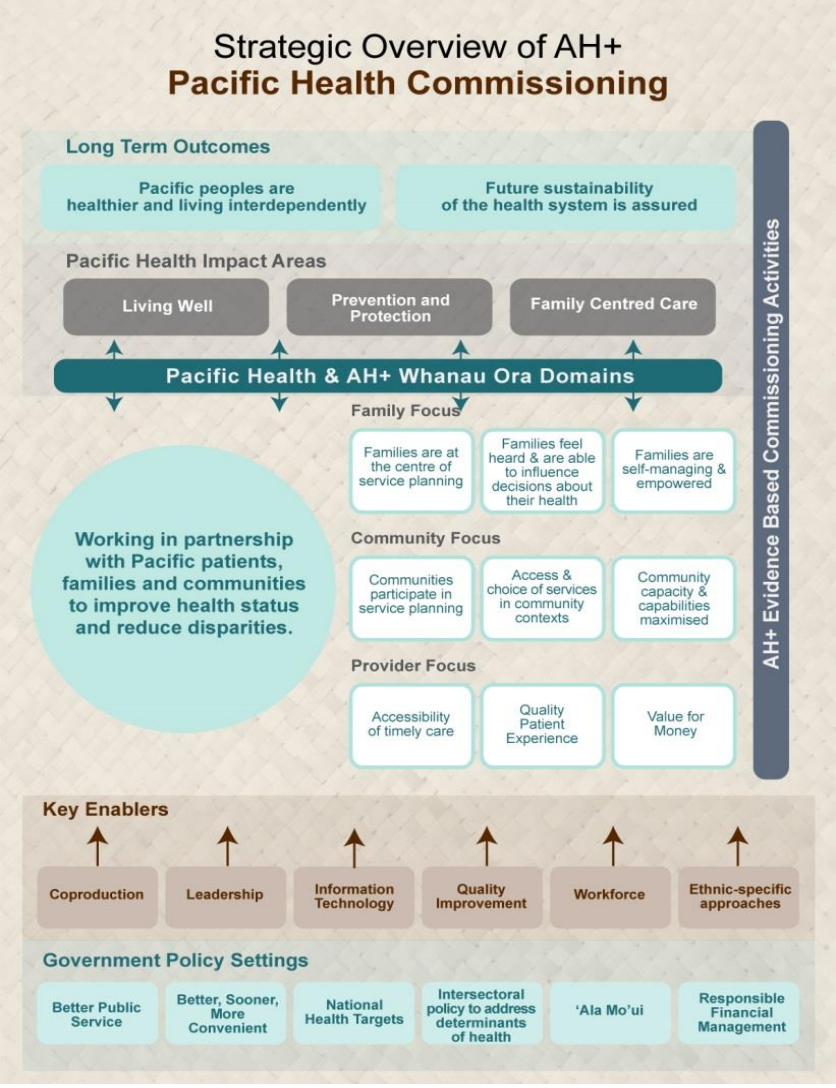


- It has been important to us to place the needs, preferences, values, and beliefs of Pacific families at the centre of our approach. Engagement with Pacific patients, community leaders and providers in the development of the outcomes sought has been critical. Our approach includes our ongoing commitment to engagement and input by patients/families, communities and providers into our commissioning activities.
- Allowing providers the flexibility to identify how they reach the intended outcomes for their families is essential to the approach. This shifts away from prescriptive contracts for providers and allows them to implement Pacific models of care which often require customised solutions to meet the complex and diverse needs of Pacific families (eg: ethnic specific approaches, drawing of community infrastructure to support families, use of navigators and community health workers).

- We have sought to factor into our commissioning model the ability to address Pacific inequalities as part of a population approach. This approach is informed by data and analysis of population need and budgets. We are still in the formative phase of this approach as it has been difficult to progress without a clear funding pathway to allow us to plan and fund services across a population.
- A CRM solution is in development to provide support for frontline staff and managers to capture the information required to tell a better performance story. This will allow frontline staff to work across multiple packages of care in a home setting with several clients (the family) at one time. The service will be seamless to the family, however the CRM will capture and map information directly back to families, packages of care and contracts.
- The shift to a new way of working recognises that there are some critical investments that service providers need to make in order to maximise opportunities for families. Subsequently, AH+ has worked collaboratively with providers to develop a change programme which is being supported through the Pacific Provider Development Fund (PPDF). This organisational and workforce development support provided through PPDF has been critical to enabling the shift to an integrated contracts environment.

It allows us to implement the following:

- Implementation of a provider workforce development programme to support the new skills required of frontline staff for integrated contracting. This workforce development programme is being jointly designed by providers who have been asked to identify their training needs.
- Support for senior management and governance through a mentoring and leadership programme.
- External support to assist with the documentation and review of models of care for both clinical services and integrated contracting.



Learning from implementation of the model

This section identifies important learning over the past 18 months of implementing our commissioning model.

We note the importance of engaging with organisational leadership as this is fundamental to achieving a shift in culture that will lead to effective integrated models of commissioned care. We are clear that the focus of change efforts must be on improving outcomes and not on changing organisational structures, although we have found that sometimes this has been required in order for providers to implement integrated contracts. When this occurs, it is important that providers are well supported to make the changes they require (eg: reconfiguration of workforce resulting in training needs and possible redundancies).

There is a significant amount of effort and resource that goes in to the implementation of a new NGO based commissioning model. As this has been new for DHBs, AH+ and providers, this has been somewhat a discovery learning approach. We feel that there could have been more investment and support in the formative phase of the devolution. There is a significant amount of resourcing and support that goes into delivering a new commissioning model that is quite different from the way in which DHBs have traditionally operated. Subsequently we feel that new ways of commissioning should be funded based on the actual cost of delivering the model and not a direct transfer of FTE funding from government agencies.

A key learning that we have gained from the implementation of an integrated contracting model is that not all contracts were able to readily fit into our contracting model because they were based on a National Services Framework, such as the Well Child/Tamariki Ora Services. Hence, we identified an important characteristic for Pacific integrated contracting for outcomes is the need to have a good degree of flexibility that enables the service provider to deliver local solutions for local needs.

Another key learning has been that in order to effectively address the complexity of needs that our families face, and support them to achieve their health and wellbeing goals, there needs to be a critical response in terms of substantially robust and sophisticated systems and analysis. This includes contracting that enables efficient and accurate reporting on service activities and the outcomes achieved from family perspectives. The capture of data and its conversion into information that enables 'real time' intelligence is crucial for effectively responding to the needs of families. Therefore, we have identified the need for IT infrastructure that:

- focuses on outcomes for families
- is robust, efficient, effective and secure
- enables 'real time' reporting and analysis
- enables integration of services across sectors
- has a user-friendly interface
- recognises the need for flexibility that enables localised solutions

This fundamentally signals a new way of working both within the sector and intersectorally so that there is a seamless approach and response to the needs of families. We have also recognised that working intersectorally will require a workforce that possesses a wider set of skills that encapsulates the following competencies and capabilities:

- relational and social skills across families, communities, service providers and sectors
- clinical and/or social/community work
- a strong level of IT including the use of CRM and IT interfaces e.g. portable electronic devices, mobile phones, laptops
- Ethnic specific competencies
- Strong relational links within local communities

As outlined above we have invested in a change programme which AH+ has coordinated and supported through the Pacific Provider Development Fund (PPDF). However, the readiness of the sector in transitioning to a new integrated environment will require a wider concerted and collaborative approach both within the social services sector and across sectors.

We strongly aspire to implement a commissioning model based on the principles of coproduction. However the full cost of family centred commissioning has not been factored into what DHBs purchase from AH+, and the current scope of commissioning activities is relatively restrictive. While we would like to implement a coproducing commissioning model, it is unclear whether there is the appetite from government agencies to go down such a pathway. A coproducing commissioning model would require government agencies to consider a broader range of activities and agencies would need to be comfortable with family aspirations not always lining up with a set of predetermined outputs and outcome measures. It will require commitment from multiple funding streams and a commitment to innovation, as well as government agencies becoming less risk averse.

One of the key challenges in transitioning to contracting for outcomes for families (as opposed to a primary client) is that the intensity of resources needed for family centred approaches significantly increases. We have not found a standardised pricing methodology across the state sector that reflects the true cost involved in delivering health and social care services for vulnerable families. There is a very real risk that services become unsustainable as the cost of delivery outweighs the level of funding available for family centred care.

The case for integration

This section responds to:

- Where and when have attempts to integrate services been successful or unsuccessful? Why?
- What needs to happen for further attempts at service integration to be credible with providers?
- Are there examples of service delivery decisions that are best made locally? Or centrally? What are the consequences of not making

In recent times there has been a significant focus in the health sector to move towards both vertical and horizontal integration. Our experience is that integration is happening at varying levels in communities, providers and in DHBs. Integration efforts could be greatly enhanced by removing the silos from funding streams and policy processes across the state sector. With reference to the Tangata o le Moana submission, Pacific providers often deliver services that meet the complex needs of families outside of the scope of service specifications (and is subsequently unfunded activity). A commissioning system that allows providers to deliver services across better public service targets, government policies and programmes would enable Pacific providers to capture the full extent of the comprehensive services delivered in order to achieve results. It would also allow government agencies to capture information about families accessing support and services which they may not have been aware of.

The patient and family experience is said to be central to achieving integrated care. It has been difficult for AH+ and its providers to implement integrated contracts which meet family needs when the system does not allow providers to respond (or be compensated for) delivering services that contribute to a range of outcomes outside of health. It would be fair to say that we have been asked to implement a family centred commissioning model and services which are not supported by government policy or funding mechanisms. Anecdotal evidence from Pacific health providers has shown that approximately 70 percent of their patients/clients presenting for healthcare require assistance to address the social determinants of health.

However, we do wish to point out that a recent literature review conducted to inform approaches to health service delivery for Pacific populations (Pacific Perspectives, 2014) found that the evidence base for integration and populations with characteristics like Pacific is weak. It is likely that multiple strategies tailored for local contexts are required. Adaptation, flexibility, transparency and capacity for learning from what has been tried elsewhere is also required. There is a need for improved monitoring and evaluation, and health services research based on honest and robust data and evidence. Pacific peoples and communities participation in these processes will be essential in order to address the longstanding inequalities in health outcomes and access to quality health services that meets their needs.

An issue we have encountered is that the commissioning of services based on District Health Board boundaries does not necessarily meet the needs of Pacific families who access services for a number of reasons, and not just because of location (Alliance Health Plus, 2014).

Reporting across two DHBs has meant additional compliance for essentially the delivery of the same services. It also limits our ability to implement a family centred approach where families can only access services if they live (and remain in) a specific locality. This is sometimes challenging for Pacific families who may be transient or have multiple living arrangements in place for family members (eg: children stay with grandparents who live in Manukau by the parents live in Auckland central).

Measuring outcomes

This section responds to:

- What is the best way to specify measure and manage the performance of services where outcomes are not easy to observe or to measure?

The Treasury has made a distinction between 'contracting for outcomes' and 'outcomes focused contracts'. They define 'contracting for outcomes' as funding that is linked to performance or results. Outcomes focused contracts, on the other hand, are specified in terms of inputs or outputs, but there is an emphasis on how an activity improves higher level population or client outcomes. AH+ has applied Results Based Accountability (RBA) methodology to assist with collecting information to inform Pacific service reporting and quality improvement activities. We have found that RBA provides a common language for assessing outcomes to drive greater accountability for the outcomes. RBA allows us to specify population level and organisational performance results to demonstrate how services contribute to overall patient/family/community results.

When developing and measuring outcomes for Pacific populations it is important to gain a full understanding of how their home, cultural and community environments impact on achieving those outcomes and that they are not viewed in isolation. It is often difficult to capture the extent to which our providers provide additional support to families. The development of tailored CRM solutions would enable organisations to capture data that drills down not only to the services engaged, but also the time spent on each service component, including the administrative time spent setting up appointments, follow up, referrals etc. This rich data can be analysed to provide metrics on what it actually takes to work with an individual/family around particular services, and can be translated into actual cost. We believe that such tools will greatly support quality improvement activities, and enhance patient/family experiences. With better planning around family requirements as well as organisational capacity and capability we see that achieving better outcomes for Pacific and high needs populations as achievable.