Hauraki PHO Quality Plan

1st July 2017 – 30th June 2018

HAURAKI PHO
HAURAKI PRIMARY HEALTH ORGANISATION NETWORK

Matua Rōpu Hauora

Quality Plan 2017-2018 CONTENTS

Kia koutou katoa e nga rōpu o hauora

Welcome to the Hauraki Primary Health Organisation (HPHO) – Matua Rōpu Hauora

HPHO welcomes new practice partner teams to work collectively for the greater good of the enrolled population we are both here to collectively support.

Established in 2003, HPHO operates under five founding foci:

- Addressing Māori health needs and the low health status of all high needs populations.
- Improving access to quality health services for rural communities.
- Promoting the value and contribution of the Hauraki PHO General Practice teams to the health of Hauraki PHO whanui (enrolled population).
- Valuing the diversity of and engagement with the Hauraki PHO General Practice teams and the communities they serve.
- Continuously striving for quality and excellence in all aspects of professional service provision and workforce development.

With over 130,000 people enrolled with 23 practice partners operating from 38 sites (from 1 July 2016), HPHO supports communities from Colville in the north to Tokoroa in the south; from Huntly in the west to Waihi in the east.

During 2017-18, PHOs have the huge challenge of recording and making a real difference to psycho-social indicators of wellbeing (particularly for Māori whanau). Reducing avoidable hospital admissions for children is a key concern amongst the System Level Measures (SLMs) that general practice teams are expected to make a difference with. While a lot is beyond general practice's ability to influence (e.g. poorly insulated homes) we can record and rectify by working collaboratively with HPHO's teams and other allied health and social agencies. It is a big step up from where we have been but working collaboratively we can make a difference in the lives of the most vulnerable amongst our next generation.

I look forward to working with you for the future good of our communities and nation. Should you ever have any question at all, please do not hesitate to call me on 021 979 350.

Naka noa na

Hugh Kininmonth
Chief Executive

Quality Plan 2017-2018
QUALITY IN GENERAL PRACTICE

Providing high quality primary health care is a core objective for all general practices but it is difficult to measure. One of the markers used is achievement of RNZCGP Cornerstone accreditation which provides a framework for quality assurance and quality improvement standards encouraging practices to deliver the best possible care to patients. The other marker we use is achievement of Ministry of Health targets which are focused on population health goals. Hauraki PHO practices have made considerable gains in this area over recent years and as we move forward to the new System Level Measures Framework (SLMF) we must be careful to embed this work into business as usual in our daily practice. The new measures cover wider aspects of health and socioeconomic status but the building blocks remain our previous targets. Just as we need accurate and consistent recording of demographic data and clinical information to provide basic reporting, we need to keep a focus on clinical targets to help in achieving new SLMF goals.

To support practices in target achievement, Hauraki PHO provides a suite of electronic support tools to help practices – they need to be used regularly, consistently and accurately to be of benefit. Hauraki PHO also has nominated champions for each of the health target areas – their job is to connect with the named practice champions to provide advice, resources and support to assist them in their role. As a base line for practices this year we have provided some benchmarking data for SLMFs with this plan.

Dr Wendy Carroll
Clinical Director
Hauraki PHO

There are multiple and varying definitions of quality in general practice, but most emphasise patient experience as their primary focus.

Quality is an improvement journey and *Aiming for Excellence* accommodates practices wherever they are on this pathway. Cornerstone Accreditation is seen as the Gold Standard that all Hauraki PHO practices have completed or are working towards.

A list of Hauraki PHO practices' Cornerstone status is listed below. The College had requested that all accreditation be completed by the end of June this year, however due to the unprecedented demand on the College to conduct assessments, this timeframe has been set back. All Hauraki PHO practices will be Cornerstone assessed by November this year at the latest.

Hauraki PHO is extremely proud of the effort and commitment from all practice partners in regard to the work they have all undertaken to achieve this goal.

Continuous quality improvement underpins Cornerstone Standards and encourages a focus on driving change that benefits patient care in the first instance. For this reason, involving patients in evaluating health needs and health care performance is an essential part of improvement strategies. This will help ensure that the vision and goals of improvement activity are sufficiently focused on patients' best interests,

Effective quality improvement ensures practices themselves invest some time in order to perform the tasks of reviewing and interpreting policy and procedure, agreeing priorities for improvement, and planning change projects. These multi-disciplinary activities are carried out on a regular basis involving not only staff from medical, nursing and managerial backgrounds but also encompass a wide range of skills, such as leadership, data analysis and quality improvement.

Hauraki PHO practice partners who have achieved Cornerstone accreditation are:

- Contributing to safer care and a better experience for patients
- Showing a commitment to on going quality improvement
- Improving practice business processes and
- Supporting compliance with national contract requirements
- Enhancing teamwork in the practice
- Enhancing clinical processes
- Contributing to continuing professional development (CPD points)

Sentinel Events Recording and Reporting

All adverse incidents, be they clinical or corporate in nature, need to be managed carefully to ensure appropriate reporting, investigation and follow up occurs in a timely and logical way. Hauraki PHO practices have well established policies and processes for reporting and managing events at practice level.

Recording and reporting of Sentinel Events is a requirement of Cornerstone Accreditation and risk management. All practices have a responsibility to report these to the Hauraki PHO on a three monthly basis.

Lynne Courtney
Quality Manager
Hauraki PHO

Cornerstone Status of all Hauraki PHO Practices as at June2017

Town/City	Clinics	CS Accr Date
Coromandel Peninsula & Hauraki	Colville Community Health Centre	Achieved
	Doctors Surgery Whitianga	Achieved
	Paeroa Medical Centre	Achieved
	Te Korowai Hauora O Hauraki Thames, Paeroa, Te Aroha, Coromandel	Achieved
	Waihi Family Doctors	Assessment September 2017
	Waihi Health Centre	Achieved
Waikato District	Avalon Medical	Achieved
	Cambridge Family Health	Assessment August 2017
	Drs@42 (Dr AJR Gates)	Achieved
	Five Crossroads Medical Centre	Assessment by November 2017
	Grey Street Family Health Centre	Assessment October 2017
	Hamilton Lake Clinic	Assessment by November 2017
	Health and Medical Clinic	Assessment September 2017
	Matamata Medical Centre	Achieved
	Putaruru-Tirau Family Doctors	Achieved
	Raukura Hauora O Tainui – Te Rengarenga, Waahi, Nga Miro, Medical Clinics	Achieved
	Rototuna Family Health	Achieved
	Te Kohao Health Hamilton	Achieved
	Tokoroa Family Health	Assessment September 2017
	Tui Medical Centres, Central, Davies Corner, Huntly, Parkwood, Rototuna, Te Rapa	Achieved
	University Student Health Services	Assessment by November 2017

System Level Measures Improvement Plan 2017/18

Contents

Introduction

The creation of the System Level Measures in 2016/17 and their accompanying contributory measures provided the Waikato Health System as a whole with a fantastic opportunity to address key local health priorities for our population. As a system we are making progress with ASH 0-4 and acute bed days for 'other', however we are committed to improving the health outcomes of all of our population, in particular, radically improving the health outcomes of our Maori population. This second Improvement Plan for 2017/18 has been developed in response to the Ministry of Health's requirements for continuing System Level Measures improvement, along with our desire to address equity.

Our district alliance and individual clinically led SLM working groups have worked collaboratively to set and agree our improvement milestones, contributory measures and activity for 2017/18 in order to contribute to the national outcomes and also align with our priority areas. They are based on analysis of local trends, while considering the needs and priorities of our population.

While the Inter Alliance will oversee and monitor this improvement work, the working groups will be the vehicles for driving improvement against the measures.

Dr Nigel Murray Chief Executive Officer Waikato DHB	John Macaskill-Smith Chief Executive Officer Pinnacle Midlands Health Network	Hugh Kininmonth Chief Executive Officer Hauraki PHO	Simon Royal Chief Executive Officer National Hauora Coalition	Cath Knapton Chief Executive Officer Midlands Pharmacy Group

Background

System Level Measures are high level aspirational goals for the health system that align with the five strategic themes of the Health Strategy and other national strategic priorities such as Better Public Service Targets. They have a focus on children, youth and vulnerable populations. System Level Measures are part of Waikato DHB's annual planning process and provide an opportunity to work across our primary, secondary and community care providers to improve health outcomes of our local populations. The Ministry of Health worked with the sector to co-develop a suite of system level measures to support this whole-of system view of performance.

This Improvement Plan includes the addition of two developmental System Level Measures - Proportion of babies who live in a smoke-free household at six weeks postnatal and youth.

The Plan includes the following:

- Improvement milestones that are a number that shows improvement in performance, for each of the six SLMs.
- A suite of contributory measures for each of the six SLMs along with the end of year quantitative goals for each contributory measure, where appropriate
- Description of specific activities to be undertaken by primary, secondary and community providers to achieve the SLMs
- District alliance stakeholder agreement with the Improvement Plan
- Reporting and accountability framework

System Level Measures

The six System Level Measures (SLMs) are:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates less than 75 years.
- Proportion of babies who live in a smoke-free household at six weeks postnatal (developmental)
- Youth access to and utilisation of youth appropriate health services (developmental)

SLM Plan Development 2017-18

Collaborative Development

2016/17 saw a development phase for the System Level Measures work with a regional focus for Waikato. Because of this a number of the 2016/17 contributory measures have remained.

For 2017/18, a more district focused approach has been undertaken with clinically led working groups engaged in reviewing the available data, determining milestone improvement targets, contributory measures, activity that would likely support improvement and advising on the key metric to be used to monitor performance.
To decide the most effective approach to the issues identified by the data, the groups looked to ensure:

- Alignment to current Alliance work programmes and activities
- Information was available and already collected; and where possible aligned across the region
- Relevance to family and whanau, clinicians and managers
- A focus on reducing inequity
- Relevance to vulnerable populations including but not limited to older people and children
- Impacting on a reasonable sized population

The three Primary Health Organisations (PHO's) – Pinnacle Midlands Health Network, Hauraki PHO and National Haora Coalition, Midland Community Pharmacy Group, along with our Maori Health Team (Te Puna Oranga) and appropriate stakeholder groups, provided representation within the SLM working groups and were all involved in the development of the plan.
Having clinical leads for each SLM was also instrumental in the development of an action-focused improvement plan, with endorsement across the district.

Once the draft plan was developed it was taken to Inter-Alliance for review and approval.
Following approval by the Ministry of Health, appropriate implementation, monitoring and governance for the Improvement Plan for 2017/18 will be carried out.

System Level Measure Overview

System Level Measure	Contributory Measures
1. ASH 0 – 4 years	• Eligible children provided flu vaccination • Influenza and boostrix vaccines for pregnant women • 0-4 ASH condition of cellulitis or dermatitis/eczema • Children with a Lift the lip score of 2-6 are referred to an oral health provider • Number of ECE with water and milk only policies • The number of new-borns fully enrolled in a PHO by 6 weeks • Gastro conditions supported in primary care
2. Acute Bed days	• TBC meeting 30th May
3. Patient Experience of Care	• GP practices using the National Enrolment Service • GP Practices using the primary care patient survey • Patients completing the primary care patient experience survey • Improving patient experience – medication safety and health literacy
4. Amenable Mortality	• PHO eligible population who have had a CVD risk recorded within the last five years • PHO population achieving a 5 year cardiovascular risk of less than 15% • PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months • Registered smokers who have been referred to a smoking cessation service (hospital) • Suicide rates in youth (15 – 24 years) • Proportion of patients assessed for risk of deliberate self-harm in primary care • PHO population estimated to have diabetes that have been identified and coded • PHO eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64 mmol/mol or less • Target population who have had a mammography within 2 years

	• Patients receive 1st cancer treatment within 62 days of being referred with high suspicion of cancer
5. Smokefree Infant (Developmental)	**TBC**
6. Youth Access (Developmental)	• Alcohol-related ED presentations for those aged 10-24 years • Self-harm-related ED presentations for those aged 10-24 years

Quality Plan 2017-2018 TARGETS AT A GLANCE

These "business as usual" Quality Targets contribute to the health of our population and will help us achieve the System Level Measures. Stay focused!

Breast Screening

The National Screening Unit, the Cancer Society of New Zealand and The New Zealand Breast Cancer Foundation recommend that all women are advised to look and feel for breast changes as part of general body awareness and health care. This is known as being 'breast aware'.

Women should be advised that age appropriate mammography is the only screening test that has been proven to reduce breast cancer deaths.

Health professionals should advise women to be 'breast aware' and inform them what changes may indicate cancer and how to seek appropriate advice.

Encourage all eligible women (aged 45-69) to enrol with Breast Screen Aotearoa and attend screening opportunities.

Please utilise the HPHO Support to Breast Screening Service Programme where you may need additional assistance.

Cervical Screening

Together, cervical screening, HPV immunisation and practising safe sex offer the most effective protection against cervical cancer.

Cervical cancer is one of the most preventable of all cancers. Cervical cancer is caused by certain types of HPV, a very common virus passed on by sexual contact. A woman's best protection against developing cervical cancer is having regular cervical smear tests, which can reduce the risk by 90 per cent.

Encourage all eligible women (aged 20-69) to enrol with NCSP and attend for regular smears.

Please utilise the HPHO Support to Cervical Screening Service Programme where you may need additional assistance.

Cardiovascular Disease Risk Assessment

Cardiovascular Disease (CVD) is the leading cause of death in New Zealand – lifestyle advice and management of risk factors can increase life expectancy and improve outcomes for those at moderate or high risk. In order to provide this intervention we need to identify patients in these risk categories.

Consider utilising point of care testing.

Diabetes Follow Up After Detection

Diabetes is a significant and increasing cause of disability and premature death in New Zealand. In New Zealand, it is estimated that the number of people diagnosed with diabetes exceeds 200,000 people (predominantly type 2 diabetes). There are also about 100,000 people who have diabetes but have not yet had it diagnosed. All patients with diabetes should have, as a minimum, an annual review of their disease management – this check includes laboratory testing, a clinical check, review of medications and lifestyle advice.

Ensure accurate Read coding, robust recall system and consider point of care testing

65 Years + Influenza Vaccination Coverage

Around one in four New Zealanders are infected with influenza or 'flu' each year. Many won't feel sick at all, but can still pass it on to others. Getting an influenza vaccination before winter offers patients and their whanau the best protection. Older people and those with certain medical conditions are more likely to have medical complications from influenza. Influenza vaccination reduces these risks.

Patients over age 65 should have their annual flu vaccine before the onset of winter for maximum protection and this must be recorded in NIR.

Age Appropriate Vaccinations

Immunisation is the most effective way to actively protect children from preventable diseases. Very young children are particularly at risk of becoming sick, because their immune system lacks experience and is unable respond quickly. The National Immunisation Schedule provides the best protection for children when they are most at risk.

High immunisation rates provide population protection for other vulnerable groups.

Children must have completed their primary course of immunisations, as outlined in NZ National Immunisation Schedule, on time and this must be recorded in NIR.

Smoking

Continued efforts have seen smoking rates in New Zealand Aotearoa continue to reduce, with 17% of adults currently smoking. Fifteen per cent smoke daily - this has dropped from 25% in 1996/97. Although 605,000 New Zealand adults still smoke, over 700,000 have given up smoking and more than 1.9 million New Zealanders have never smoked regularly.

Stopping smoking confers immediate benefit on those with smoking related diseases and future health benefits on all smokers. Helping smokers to quit continues to be a leading national health goal.

Remember to use your patient dashboard to record smoking status and remember to offer Brief Advice and Cessation Support to all smokers

Quality Plan 2017-2018 ADDITIONAL MEASURES

This section recognises additional work that is already undertaken in all practices but not previously included in targets such as Before School Checks and offering Patient Portal. There is a more defined process for Sentinel Event reporting that incorporates the use of LOGIQC Quality Management System.

As we move forward with SLMFs we need to measure wider practice activity and this includes management of long term conditions and other health parameters. While the details of these measurements are still being decided we are looking at some tools to assist practices. Signposts for the future include care plans for long term conditions, Advance Care Planning, Childhood asthma management (GASP), childhood obesity management (part of B4SC), HbA1c targets for Diabetes – watch out for more information.

B4SC

- Nominated Practice B4SC Champion in place
- At least one B4SC trained nurse per practice
- Attendance at annual refresher updates
- Achieve 80% of eligible children having completed and recorded checks

Patient Portal

- Practice is offering the Manage My Health Patient Portal
- Achieve greater than 5% of eligible enrolled patients having activated accounts

ACP

- Nominated Practice ACP Champion in place
- Relevant staff completed ACP training – minimum level 1
- ACP status Read coded

GASP

- Nominated Practice GASP Champion in place
- Relevant staff completed GASP training
- Monthly Nurse led clinic established
- Asthma plans for all GASP assessed patients in place

LOGIQC

- Practice has implemented and is utilising LOGIQC Quality Management System
- Practice is using LOGIQC to record incidents and sentinel events

HPHO QUALITY TARGET ACHIEVEMENT PAYMENT SCHEDULE

For the 2017/18 plan, HPHO will continue to reward practices for achievement of the 'business as usual' (BAU) health targets along with the new System Level Measures (SLM) targets and associated contributory measures outlined in the Quality Plan. HPHO will receive payment from WDHB on achievement of a number of agreed contributory measures for each of the system level measures listed below. Many of these we are already measuring as part of our BAU targets and some are new targets that we are starting to measure this year.

The total funding pool for target achievement in 2017-18 is $800,000, to be awarded as follows:

- $400,000 ($100,000 per quarter) to be equally shared with practices on achievement of the following BAU targets, paid separately for Māori and Non-Māori achievement:
    - 8 month immunisations (95%)
    - 2 year immunisations (95%)
    - Cervical screening (80%)
    - Smoking Cessation (90%)
    - CVRA (90%)
    - Diabetes Annual Reviews (90%)
    - B4 School checks (80%)
    - Activated patient portal (>5%)

- $400,000 to be equally shared with practices at end of Quarter 4 on achievement of the following SLM targets for Māori and Non-Māori as follows:
    - Reduction in ASH rates for 0-4 (<4% for Māori / Pacific, <2% for other)
    - Reduction in Hospital Bed Days (<2% for Māori / Pacific, <1% for other)
    - Patient Experience Survey offered (>75% during allocated week)
    - Reduction in Amenable Mortality rates (<4% for Māori / Pacific, 2.5% for other)

HPHO Monthly Practice Payment Schedule for Activity to support target achievement

Whilst the focus is shifting to rewarding improvement in outcomes for our people, HPHO acknowledges the commitment and effort required by pratice teams to achieve these.

Monthly practice payments to support this activity will therefore continue in 2017-18 as follows:

- $500 per practice plus 25 cents per enrolled patient.

Building blocks for general practice – why we should READ code

To provide high quality general practice we need to get the foundations right. This is the basis for the development of RNZCGP Cornerstone Accreditation. These programmes provide a framework for us to ensure our practices meet basic requirements; provide essential safe and consistent primary care while also undertaking continuous review and improvement activities to improve patient outcomes.

In order to undertake these review processes and monitor our progress we need to record basic information accurately and consistently. Just like we need to have accurate demographic data to ensure we get the right funding, we need to record accurate clinical data to ensure we get an accurate picture of practice activities and performance. This information is also used by Ministry of Health to make funding decisions and direct research.

Best practice would be for every consultation record to be READ coded – this is a target that we are required to achieve and this will allow us to report accurately on what we do in general practice every day and provide nationally consistent data.

If you do this consistently, it will assist you to comply with HUHC rules and make identification of eligible patients easier.

As a minimum requirement all practices are required to Read Code consistently for all the conditions below: To facilitate this we have collated them under the code HPHO.

Preferred READ Codes for General Practice Guide to standardisation

Cardiovascular	
Hypertension	G2
Ischaemic Heart Disease	G3
Heart Failure	G58
Peripheral Vascular Disease	G73
Cerebrovascular Disease	G66
Lipid Disorder	C32

Endocrine & Metabolic	
Diabetes Type1	C108
Diabetes Type2	C109
Gestational Diabetes	L180
Pre-diabetes	R102.11
Obesity	C380
Gout	C34

Respiratory	
Asthma	H33
COPD	H3.11

Mental Health	
Depression	E2B
Anxiety	E200
Dementia	E00
Postnatal depression	E204.11
Alcohol abuse	E23
Other substance abuse	E24
Post-Traumatic Stress disorder	Eu431
Bipolar disorder	Eu31

Smoking	
Current smoker	137R
Trying to stop smoking	137G
Never smoked	1371
Ex-smoker	137S
Health-Ed smoking	6791.00
Brief cessation advice given	ZPSB10
Referral to cessation support	ZPSC10
Prescribed cessation support	ZPSC20
Provided cessation support	ZPSC30
Declined cessation support	ZPSC90

BREAST SCREENING COVERAGE

Description

Early detection and treatment of breast cancer improves patient outcomes and reduces the mortality rate, Breast Screen Aotearoa recommends 2-yearly mammograms for women age 45 to 69.

Encouraging all eligible women to enrol with Breast Screen Aotearoa and attend screening opportunities will assist with meeting this target.

- **ABCs:**
  - **A – Awareness saves lives, teach women to be breast aware**
  - **B – BSA enrolment for all eligible women**
  - **C – Cancer education: create trust and dispel myths about breast cancer**

Target Population

- All women aged 50 to 69 years who are within the high need population (identified as Māori, Pacific Island and/or Quintile 5).

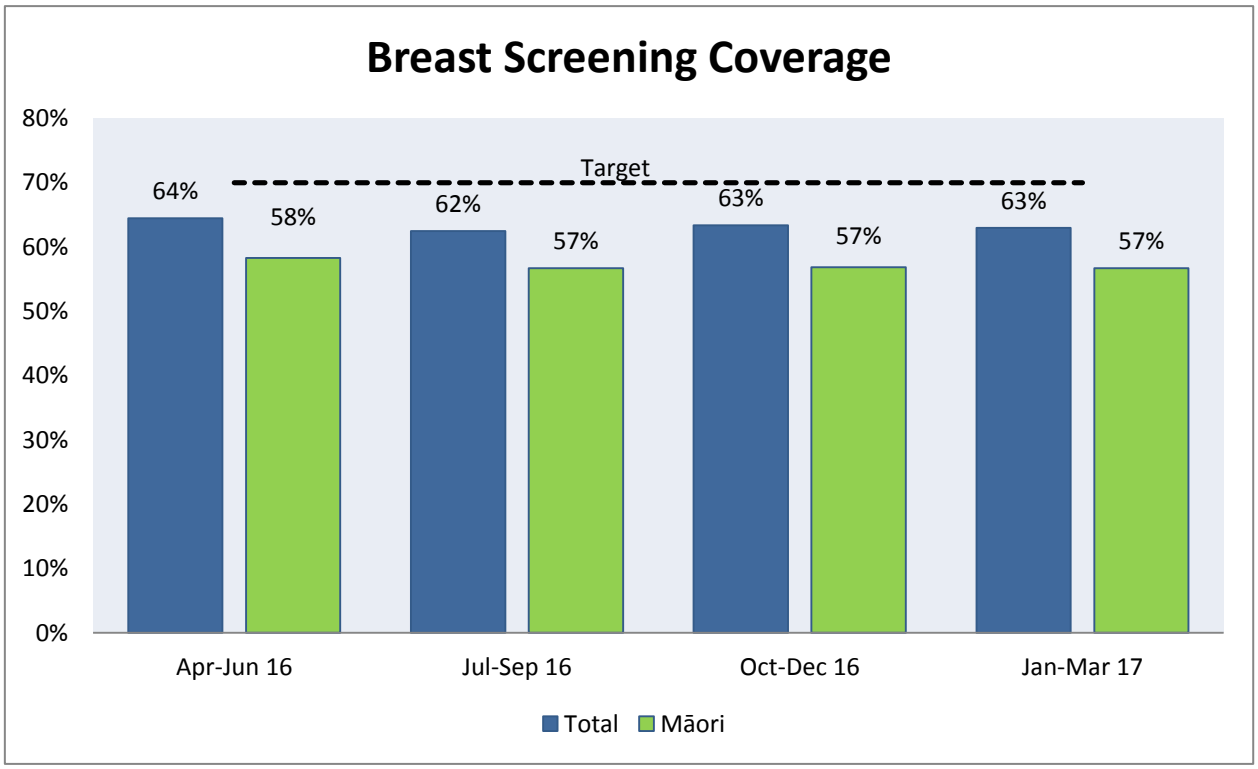
Programme Goal

70% or more of the PHO's target population have had a mammography within 2 years.

Data Source

To measure this indicator the Programme depends on data provided by the national screening programme.

PHO Performance Graph



CERVICAL SCREENING COVERAGE

Description

Early detection and treatment of cervical cancer and other abnormalities improves patient outcomes and reduces the mortality rate. The national cervical screening programme recommends 3 yearly screening for women age 20 to 69. The screening interval is reduced if there is any abnormality.

Encouraging all eligible women to enrol with NCSP and attend regular for smears will assist with meeting this target.

- **ABCs:**
  - **A – Active engagement with the patients is the starting point**
  - **B – Be brave and try something new – innovation can reap rewards**
  - **C – Comfortable smear taking environment is key**

Encouraging all eligible women to enrol with NCSP and attend for regular smears will assist with meeting this target.

Target Population

- All women aged 20 to 69 years.
- All women aged 20 to 69 years within the high need population (identified as Māori, Pacific Island and/or Quintile 5).

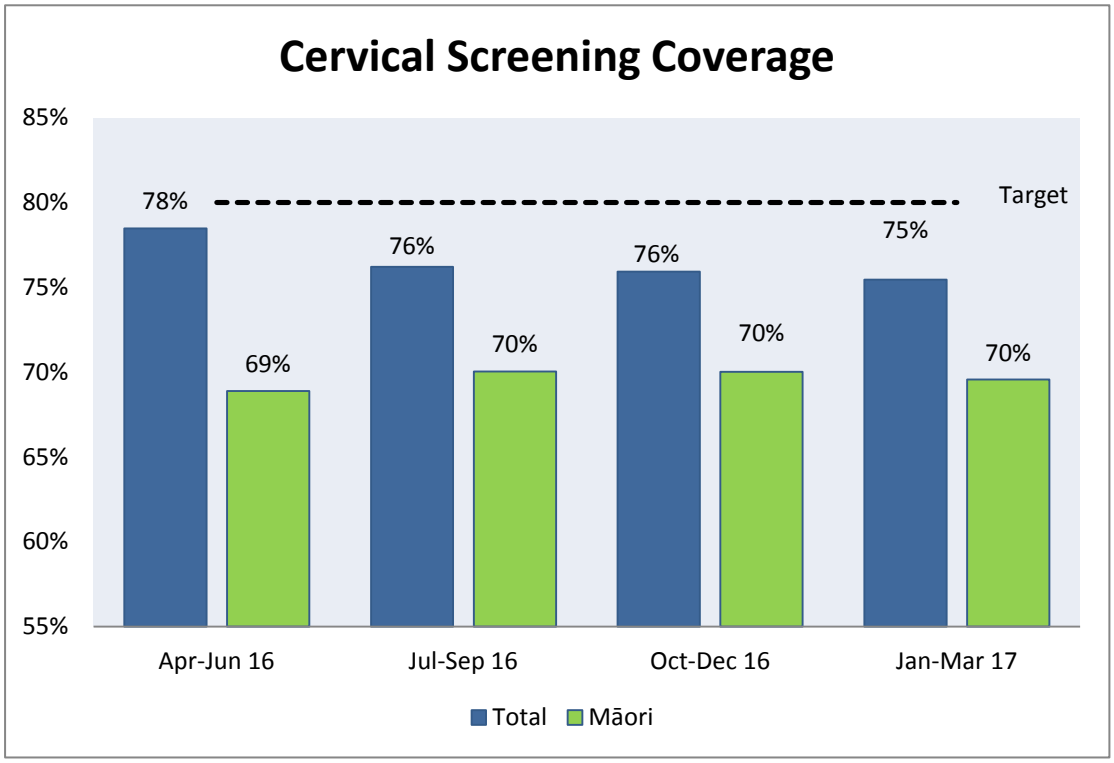
Programme Goal

80% or more of a PHO's target population have had a cervical screen within 3 years.

Data Source

To measure this indicator, the Programme depends on data provided by the national cervical screening programme.

PHO Performance Graph



CARDIOVASCULAR DISEASE RISK ASSESSMENT

Description

Cardiovascular Disease (CVD) is the leading cause of death in New Zealand – lifestyle advice and management of risk factors can increase life expectancy and improve outcomes for those at moderate or high risk. In order to provide this intervention we need to identify patients in these risk categories.

To meet this target, information must be recorded in your PMS in a specific format using BPAC common form – blood pressure check, lipid testing and diabetes screening.

- **ABCs:**
  - **A – Advise – diet, exercise and lifestyle**
  - **B – BP checks and blood tests – always record in BPAC common form**
  - **C – Consider off-site Community events to complete CVRAs**

Target Population

- Males of Māori, Pacific or Indian sub-continent ethnicity aged 35 to 74 years.
- Females of Māori, Pacific or Indian sub-continent ethnicity aged 45 to 74 years.
- Males of any other ethnicity aged 45 to 74 years.
- Females of any other ethnicity aged 55 to 74 years.

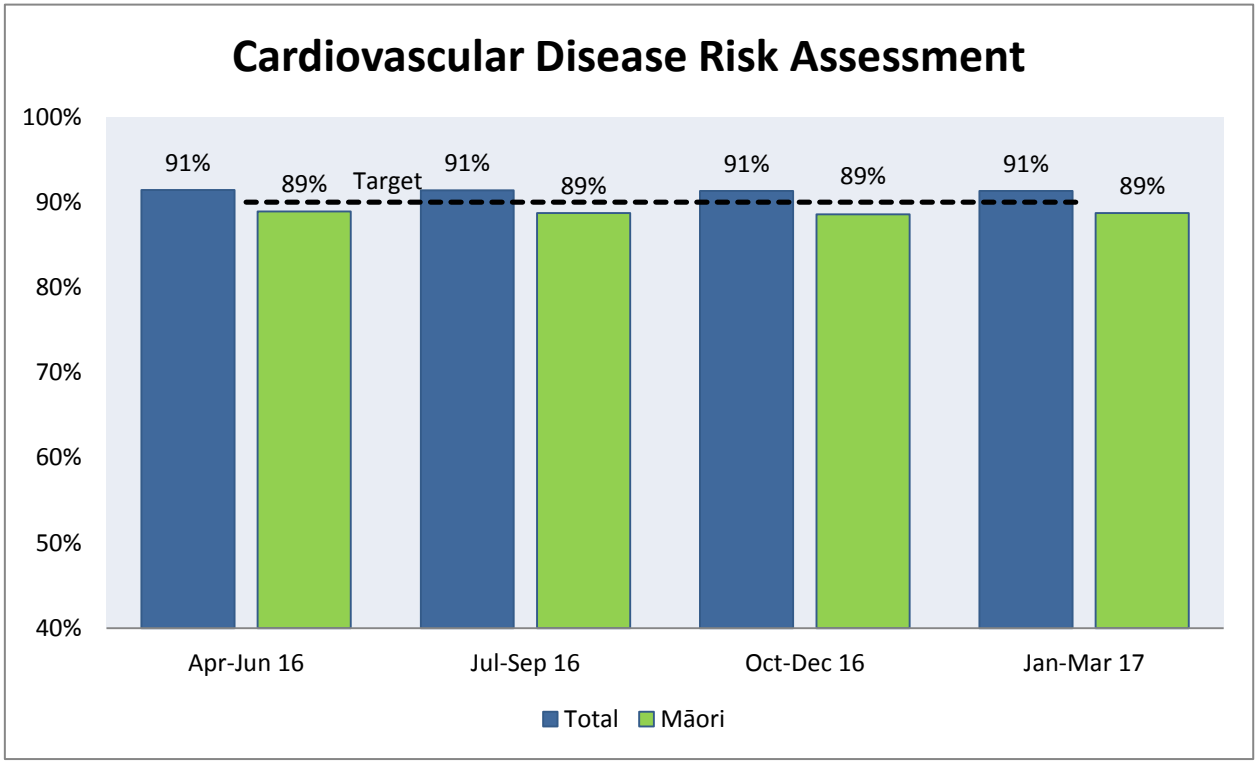
Programme Goal

90% or more of a PHO's target population have been assessed for their risk of developing cardiovascular disease.

Data Source

To measure this indicator the Programme depends on data provided through Primary Health Organisations. This is sourced from Medtech via the PHO Clinical Event Export.

PHO Performance Graph



DIABETES FOLLOW UP AFTER DETECTION

Description

Diabetes is a significant and increasing cause of disability and premature death in New Zealand. In New Zealand, it is estimated that the number of people diagnosed with diabetes exceeds 200,000 people (predominantly type 2 diabetes). There are also about 100,000 people who have diabetes but have not yet had it diagnosed. All patients with diabetes should have, as a minimum, an annual review of their disease management – this check includes laboratory testing, a clinical check, review of medications and lifestyle advice.

To meet this target, information needs to be recorded in your PMS in a specific format using BPAC common form – all fields must be completed.

- **ABCs of diabetes care:**
  - **A - Awareness – empower your patients to manage their diabetes**
  - **B - BPAC Common Form –an incomplete form is not counted in target achievement**
  - **C – Care Plan - complete a patient care plan to connect the multi-disciplinary team**

Target Population

- All people aged 15 to 79 years identified as having diabetes.
- All people aged 15 to 79 years who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10) identified as having diabetes.

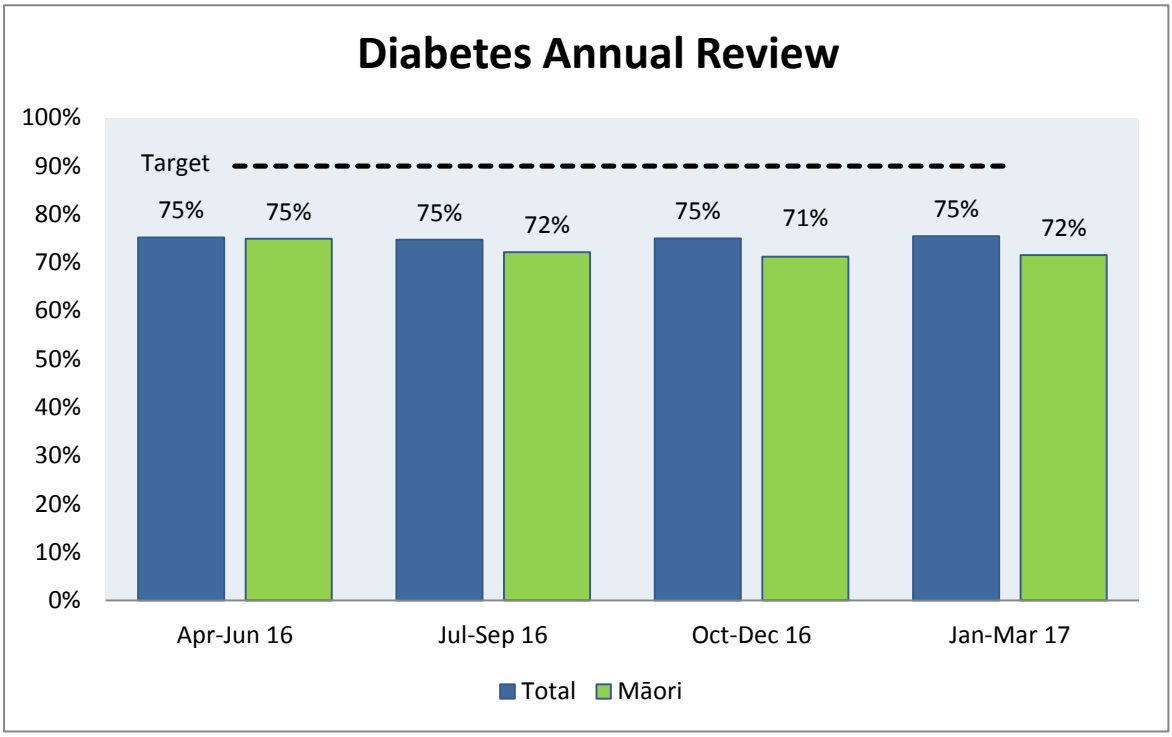
Programme Goal

90% or more of those observed to have diabetes have had a diabetes review.

Data Source

To measure this indicator the Programme depends on data that is provided through Primary Health Organisations. This is sourced from Medtech via the PHO Clinical Event Export.

PHO Performance Graph



65 YEARS + INFLUENZA VACCINATION COVERAGE

Description

Complications of influenza in the elderly can be serious or life threatening. Immunisation can reduce this disease burden. Encourage all patients over age 65 to have their annual flu vaccine before 30 June and ensure recorded in the NIR.

- **ABCs of Flu Immunisation:**
  - **A – Always ask, don't assume – keep having the conversation**
  - **B – Be safe not sorry. Immunisation protects lives**
  - **C -- Current – annual vaccination before winter**

Target Population

- All people aged 65 years and over
- All people aged 65 years and over who are within the high need population (identified as Māori, Pacific Island and/or Quintile 5)
- The funded influenza vaccine will be available until **31 December** each year from now for those aged 65 years and over who were not vaccinated before or during winter.

Programme Goal

75% or more of a PHO's target population have had a flu vaccination by 30 June of any year.

Data Source

All PHOs are measured using data from the National Immunisation Register.

PHO Performance Graph

Data not available

AGE APPROPRIATE VACCINATIONS FOR 2 YEAR OLDS

Description

Focus on immunising on time - 2 years are due at 15 months

Immunisation is the most effective way to protect children from vaccine preventable diseases and achieving high immunisation rates also provides population protection for other vulnerable groups.

To meet this programme requirement a child must have completed their primary course of immunisations as outlined in NZ National Immunisation Schedule, on time, and this must be recorded in NIR.

- **ABCs of Immunisation:**
  - **A – Always ask, don't assume – keep having the conversation with parents and carers**
  - **B – Be safe not sorry. Immunisation protects lives**
  - **C – Complete immunisation schedule on time**

Target Population

- All children who had their second birthday during the reporting period.
- All children who had their second birthday during the reporting period and who were within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10).

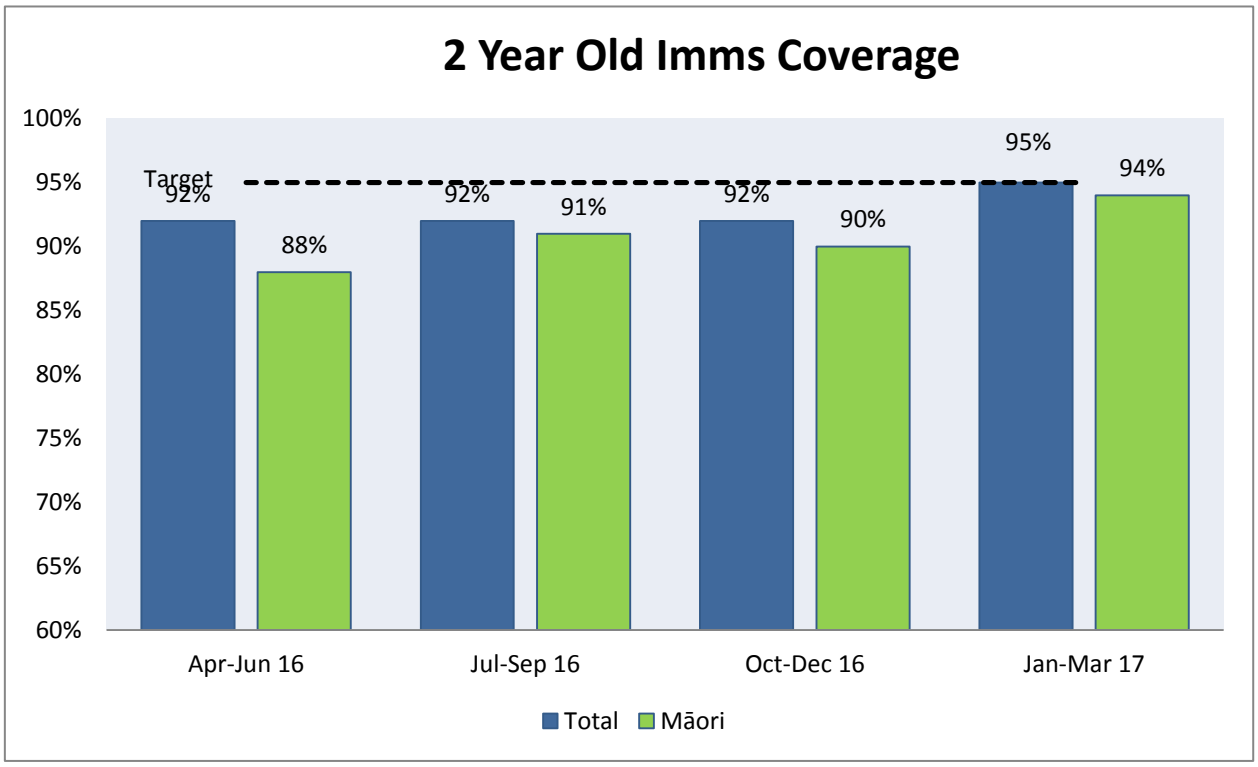
Programme Goal

95% or more of a PHO's target population have received their complete set of age appropriate vaccinations on time.

Data Source

All PHOs are measured using data from the National Immunisation Register.

PHO Performance Graph



AGE APPROPRIATE VACCINATIONS FOR 8 MTH OLDS

Description

Focus on immunising on time - 8 months are due at 5 months

Immunisation is the most effective way to protect children from vaccine preventable diseases and achieving high immunisation rates also provides population protection for other vulnerable groups.

To meet this programme requirement a child must have completed their primary course of immunisations, as outlined in NZ National Immunisation Schedule, on time and this must be recorded in NIR.

- **ABCs of Immunisation:**
  - **A – Always ask, don't assume – keep having the conversation with parents and carers**
  - **B – Be safe not sorry. Immunisation protects lives**
  - **C - Complete immunisation schedule on time**

Target Population

- All children who are within the 8 month old cohort during the reporting period.
- All children who are within the 8 month old cohort during the reporting period who are within the high need population (identified as Māori, Pacific Island and/or Quintile 5).

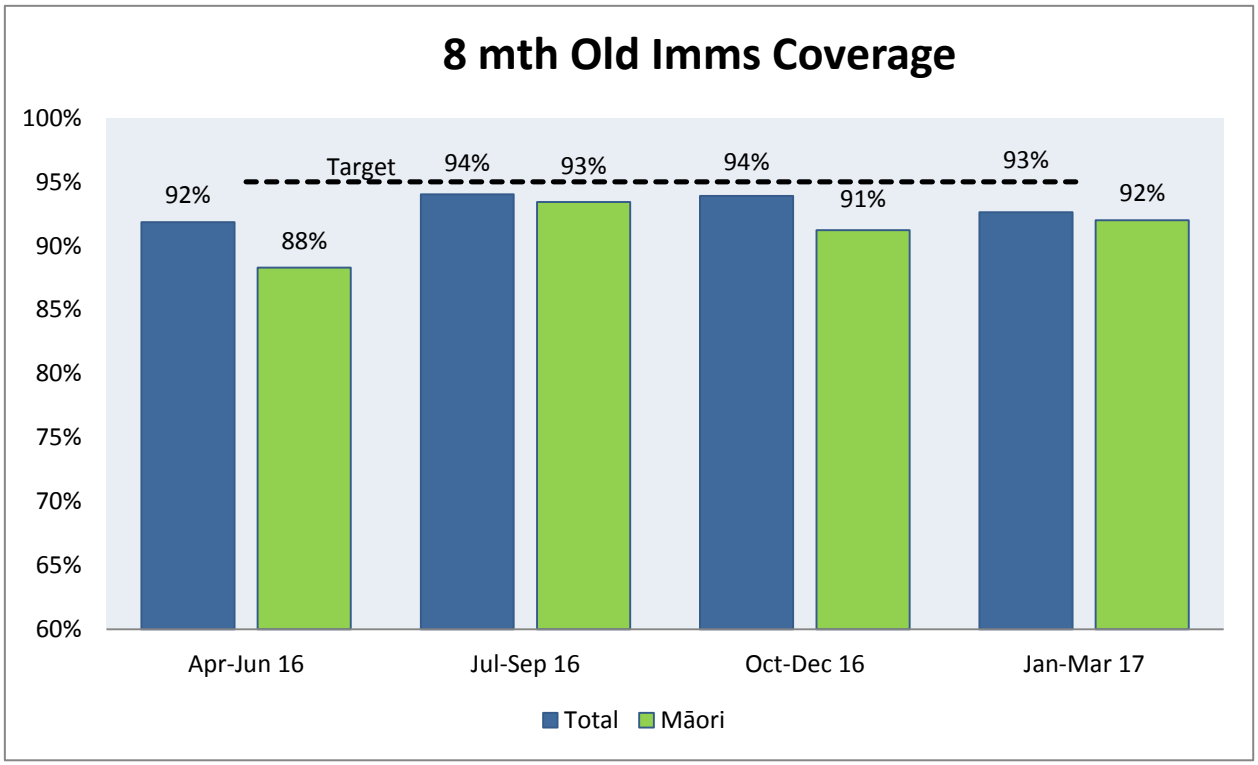
Programme Goal

95% or more of the target population have received their complete set of age appropriate vaccinations on time.

Data Source

All PHOs are measured using data from the National Immunisation Register.

PHO Performance Graph



SMOKING BRIEF ADVICE AND CESSATION SUPPORT

Description

Stopping smoking confers immediate benefit on those with smoking related diseases and future health benefits on all smokers. Helping smokers to quit is a leading national health goal.

To meet this target, smoking status of all eligible patients must be recorded in your PMS using recognised Read codes. All current (and quitting) smokers must be offered brief advice and cessation support and this must be recorded in your PMS using recognised Zcodes as provided via Patient Dashboard.

- **ABCs:**
  - **A - Ask regularly**
  - **B – Give Brief Advice**
  - **C – Celebrate support to be offered**

Target Population

- All people aged 15 to 74 years who are within the high need population (identified as Māori, Pacific Island and/or Quintile 5) whose most recent smoking status is recorded as current smoker.
- All people aged 15 to 74 years who are within the other population whose most recent smoking status is recorded as current smoker.

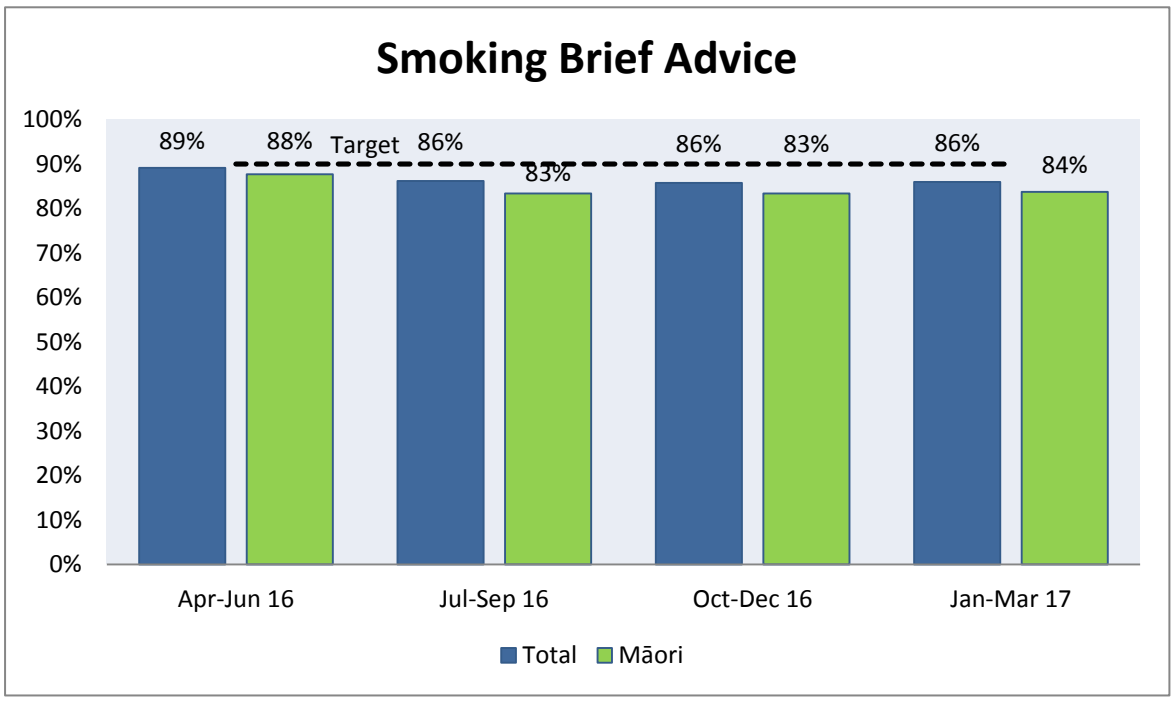
Programme Goal

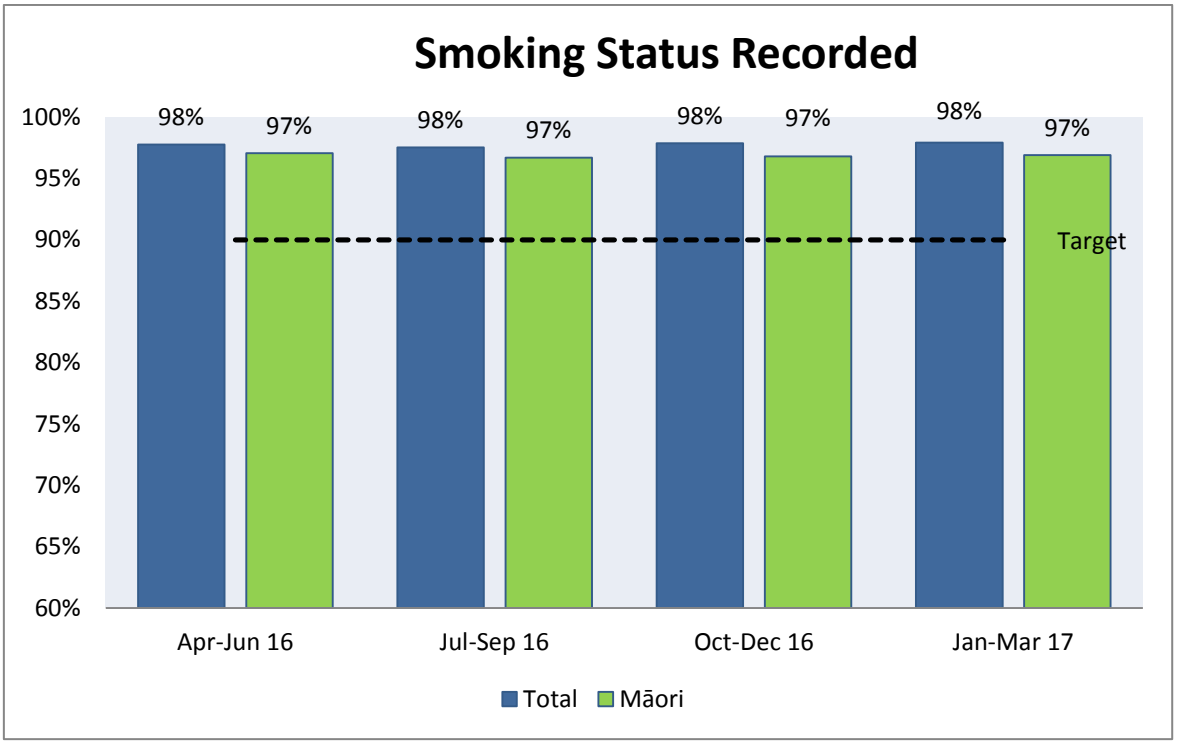
90% or more of a PHO's target population enrolled with general practice whose most recent smoking status is recorded as current smoker, will have been offered brief advice and/or cessation support services within the last 12 months.

Data Source

To measure this indicator (both high need population and other population) the Programme depends on data that is provided through Primary Health Organisations. This is sourced from Medtech via the PHO Clinical Event Export.

PHO Performance Graphs




Smoking Status Recorded
100%
95%
90%
85%
80%
75%
70%
65%
60%
98%
97%
98%
97%
98%
97%
98%
97%
Target
Apr-Jun 16
Jul-Sep 16
Oct-Dec 16
Jan-Mar 17
Total
Māori

RESPONSIBILITIES

Practice Responsibilities

Hauraki PHO Practices will do the following for their enrolled population

Contractual

- Sign and adhere to the Back to Back Contractual Agreement and HPHO Quality Plan which includes but is not limited to the following inclusions
- Designate champions in the practice for each of the following areas :
  - Programme goals: Immunisation, cervical screening, cardiovascular disease, diabetes and smoking cessation
  - Communication: Contact person responsible for ensuring the whole Practice Team receives relevant information from HPHO
  - Practice Management: Nominated manager and 2IC
- Provide Practice Registers, Clinical Event Exports and Provider Lists on time. Payment for target achievement relies on this

Practice Accreditation

- Maintain Cornerstone Accreditation and
  - Provide high quality, accessible patient services
  - Provide on-going training and professional development support for all practice staff

Quality and Partnership

- Risk Management – advise Serious and Sentinel events to HPHO within one working day or sooner.
- Complete two clinical audits or audit cycles per annum. Use BPAC or RNZCGP resources – ask HPHO Clinical Director, Dr Wendy Carroll if you need help with this. Results to be reported to HPHO
- Encourage attendance by at least one practice representative at the Hauraki PHO Annual General Meeting
- Mandatory attendance by at least one practice representative at the annual Education Day
- Encourage attendance by appropriate staff at HPHO training opportunities
- Ensure a minimum of one Level 7 trained Diabetes Nurse per 5000 enrolled patients
- Ensure dedicated staff time for quality achievement as per your FFP allocation
- Utilise HPHO funded software tools and applications

PHO Responsibilities

Hauraki PHO must abide by the Ministry of Health mandatory stipulations within the PHO Services Agreement we have signed on your behalf with Waikato DHB. Together with HPHO practice partners, on behalf of our enrolled population we will

- Ensure the quality provision of services for which capitation based funding is provided
- Continually develop co-ordinated and integrated services in response to changing health needs
- Work with the Waikato DHB to develop and implement the DHB's Annual Plan and achieve the Government's policy objectives for health care
- Support our Enrolled Population and other Eligible Persons to stay well and ensure they receive accessible quality, co-ordinated care delivered by multi-disciplinary teams
- Ensure access to, and sustainability of, equitable healthcare delivery
- Support all population groups to achieve optimum health outcomes and reduce disparities
- Achieve outcomes determined by the Hauraki Hauora Alliance Leadership Team (HHALT)
- Promote and support workforce development and sustainability
- Flexible Funding Pool allocation to ensure fair and equitable distribution of funds to support the wellness of our enrolled population

QUALITY OUTCOMES : TIPS, TRICKS & HELPFUL HINTS

Use all the electronic decision support tools and clinical services available to your practice:

- HPHO Champions
- BPAC and BPI Reports
- Dr Info
- Patient Dashboard
- Appointment Scanner
- Outreach Immunisation Service
- Manawanui Whai Ora Kaitiaki (MWOK) Team
- HPHO Primary Mental Health Team
- HPHO Practice Support Team
- Patient Portal and Shared Electronic Health Record
- SmartHealth
- Map of Medicine
- LOGIQC

IDEAS FOR PRACTICES AND PRACTICE CHAMPIONS

CVRA Checks

- Use BPI (or Dr Info) Virtual CVRA report re Non F2F checks
- Check BPAC "Incomplete Common Forms"
- Run clinics – use Cobas machine (ask MWOK team)

Immunisations

- Check (ALL) Provider Inbox Daily for NIR messages – respond promptly to error messages and phone NIR for any technical difficulties.
- Respond to NCHIP nominations promptly
- At 4 weeks of age book the 6 week immunisation appointment.
- At the 6 week and each subsequent one book the next appointment before leaving the surgery. Send a reminder.
- Ask reception staff to identify children booked into GP who are due/overdue immunisations (utilise Appointment Scanner)
- Do a status query on new patients and/or patients who have transferred but are still included in your target population.
- Ask doctors to get involved in the immunisation conversation especially regarding declines.

B4 School Checks

- Appoint a B4SC champion. Monthly Exception reports go to them for action.
- Apply the same rule as Immunisations, particularly for children in families who don't engage or are high deprivation: three attempts to contact, refer to Cay-C Team for address/contact details check. No new info – Refer to Outreach service for a home visit if 4years 6 months.
- Advice for parents who want to wait till child is nearly five years before having check: if the child needs to be referred they run the risk of having to take their child out of school, and time off work, to take them for appointments.

Smoking Brief Advice

- Consider sending a txt message to your smokers offering brief advice (utilise Vensa smoking campaign).
- Consider online Smoke Free Course – All staff
- Check Dr Info report re "Given nicotine replacement and no smoking advice recorded"
- Update smoking status and brief advice for your smokers every time they visit the practice to keep this up to date.

Breast Screening

- Take any available opportunity to discuss Breast Screening with your enrolled women aged 45-69 years. Have an auto recall set up in Medtech to capture women turning 45 years so they can be invited to enrol with Breast Screen Midland (BSM).
- If there is the opportunity to enrol a women with Breast Screen Midland (BSM) before they turn 45 years take it, BSM will hold onto the enrolment and contact the women once she turns 45 years.
- Use the BSM Enrolment & Booking Form when enrolling a woman with the programme, this will enable an appointment date/time to be sent with the invite letter from BSM.
- BSM will pay you $5 for every woman you enrol with the programme.
- Run a query of all your enrolled women aged 45-69 years to check enrolment status. Shona Gibbons at BSM can run this query through the BSM Database and give you a report of who is not enrolled with BSM.

Diabetes Annual Review

- Personal approach works best, letter, phone calls or personalised text messages to invite for annual diabetes review.
- Remind person with diabetes, this is a free service for a complete health assessment and medication review. It provides an opportunity to work with the nurse to improve health outcomes. HPHO funding allows for several visits with nurse at no cost if needed.
- Use positive language, celebrate small victories.
- Understand where your patients sit, catch at the right time. Be opportunistic; check patient coming into practise each day. Highlight Doctors/nurses on dashboard that DARS is due. Prompts to order lab tests or do baseline checks.
- Utilize MWOK team to work with hard to reach patients to assist with assessment and home visits.

Cervical Screening

- Offer free CX via Priority Smear and SIA free CX (for those that are eligible)
- Consider Outreach and After Hours clinics
- Monitor Dr Info report re "CX Inbox Document no Screening".
- Request screening history from NCSP for new patients
- Use the Karo reports to update screening status for women
- During this year look out for new screening outcome terms which will ensure consistent recording nationally. Support will be provided to practices to complete this change.

Recalls

- Recall is a clinical process and should be the responsibility of a clinical staff member.
- We recommend you use the Medtech recall tool.
- An appropriately trained admin staff member or health care assistant can manage the practice recall process under the supervision of a clinical staff member.

Enrolling new patients

- Consider offering new patients an enrolment appointment to complete baseline recordings and check medications and past medical history.
- Request past medical records in GP2GP format as first preference.
- GP2GP records should be imported by a clinician who should ensure that screening terms are mapped correctly and should review medical records to ensure all appropriate recalls are set.
- Transcribing medical records received in non GP2GP format must be done by a clinician who should ensure all necessary classifications, immunisations, recall and screening are recorded. Remember only an authorised prescriber can transcribe medications.

Patient Portal

- Appoint a designated practice champion
- Encourage patients to sign up to Patient Portal
- Utilise the iPad provided by Hauraki PHO to make the sign up process easier for patients
- Utilise posters and promotional material provided by Hauraki PHO to promote Patient Portal in the practice
- Ensure all staff are aware of benefits of using Patient Portal

READ Codes and Classifications

- Remember to keep classifications up to date from hospital discharge summaries and clinical correspondence. This ensures an accurate disease register in your practice.