Hauraki PHO Quality Plan

1st July 2018 – 30th June 2019

HAURAKI PHO HAURAKI PRIMARY HEALTH ORGANISATION NETWORK

Matua Rōpu Hauora

Quality Plan 2018-2019 CONTENTS

Quality Plan 2018-2019 INTRODUCTION

Kia koutou katoa e nga rōpu o hauora

Welcome to the Hauraki Primary Health Organisation (HPHO) Quality Plan 2018-19

This year's plan has been structured to align with the national System Level Measures (SLM) Framework, Waikato district SLM plan and Hauraki PHO's strategic and service implementation plans.

With the commitment to improving health outcomes across the whole of system through the Systems Levels Measures Framework (SLMF), a key objective for 2018-19 is to strengthen our focus on the very highest needs individuals and communities to boost wellness, reduce indicators of illness (e.g. hospital admissions, ED consultations) and address inequities in health status for Māori and high needs populations. Both practice partner and HPHO-supported services will be directed to this end. Building our capacity and capability to achieve the PHO contributory measures and pro-actively support people to achieve and maintain wellness, is the key philosophical approach in all HPHO activities.

Through the plan our four founding foci remain:

- 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.

During 2018-19 we will continue to measure the standard indicators of population health but also start to look at the broader activity that general practice undertakes to manage long term conditions, keep people well and out of hospital when possible and promote health and well-being through a preventative approach. Primary care has a critical part to play in the future of an effective and sustainable New Zealand health system and this year we have a unique opportunity to demonstrate how our model of care, our services and programmes can collectively achieve the health gains we all strive for.

I look forward to continuing to work 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 2018-2019
QUALITY IN GENERAL PRACTICE

High quality primary health care remains a core objective for Hauraki PHO practices, we continue to support all practices to achieve RNZCGP Cornerstone accreditation which provides a basic framework for this objective. Alongside this we monitor progress and achievement of Ministry of Health targets which have now transitioned to the System Level Measures Framework (SLMF). These wider system measures are intended to encourage collaboration across the sector and support the New Zealand Health Strategy objectives that all New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.

SLMF contributory measures include many of our previous health targets as these are the basic building blocks that support the wider health targets that are focused on the most vulnerable populations. For example ensuring our tamariki are immunised on time and live in smoke free homes helps to reduce respiratory illnesses and keep them out of hospital (reducing 0-4 Ambulatory Sensitive Hospitalisation rates).

In order to mark progress against these measures we need to ensure we maintain high quality databases that we can use to extract meaningful data. This requires consistent and timely recording of activity, READ coding of significant conditions (ideally every consultation should be coded) and careful review of correspondence to update medications and conditions.

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.

Dr Wendy Carroll
Clinical Director
Hauraki PHO

Quality Plan 2018-2019 QUALITY STATEMENT

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. 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.

As part of this continuous quality programme, Hauraki PHO has provided practice partners with the LOGIQC Quality Management System. In particular the practices have access to the Cornerstone Accreditation Module which will make their Cornerstone compliance and assessment processes much easier. The College can be given permission by the practice being assessed to have access to LOGIQC to check their Cornerstone Policies and Procedures, thus making the assessment process much easier for all concerned.

As the Quality Manager I would recommend that all practices get on board with the LOGIQC practice management system. They will find the Accreditation Module very easy to manage and once completed all documentation is available for annual reviews moving forward.

Effective quality improvement ensures practices invest 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. The Accreditation module provides practices with information in regard to evidence required, access to policies and procedures and any training requirements.

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

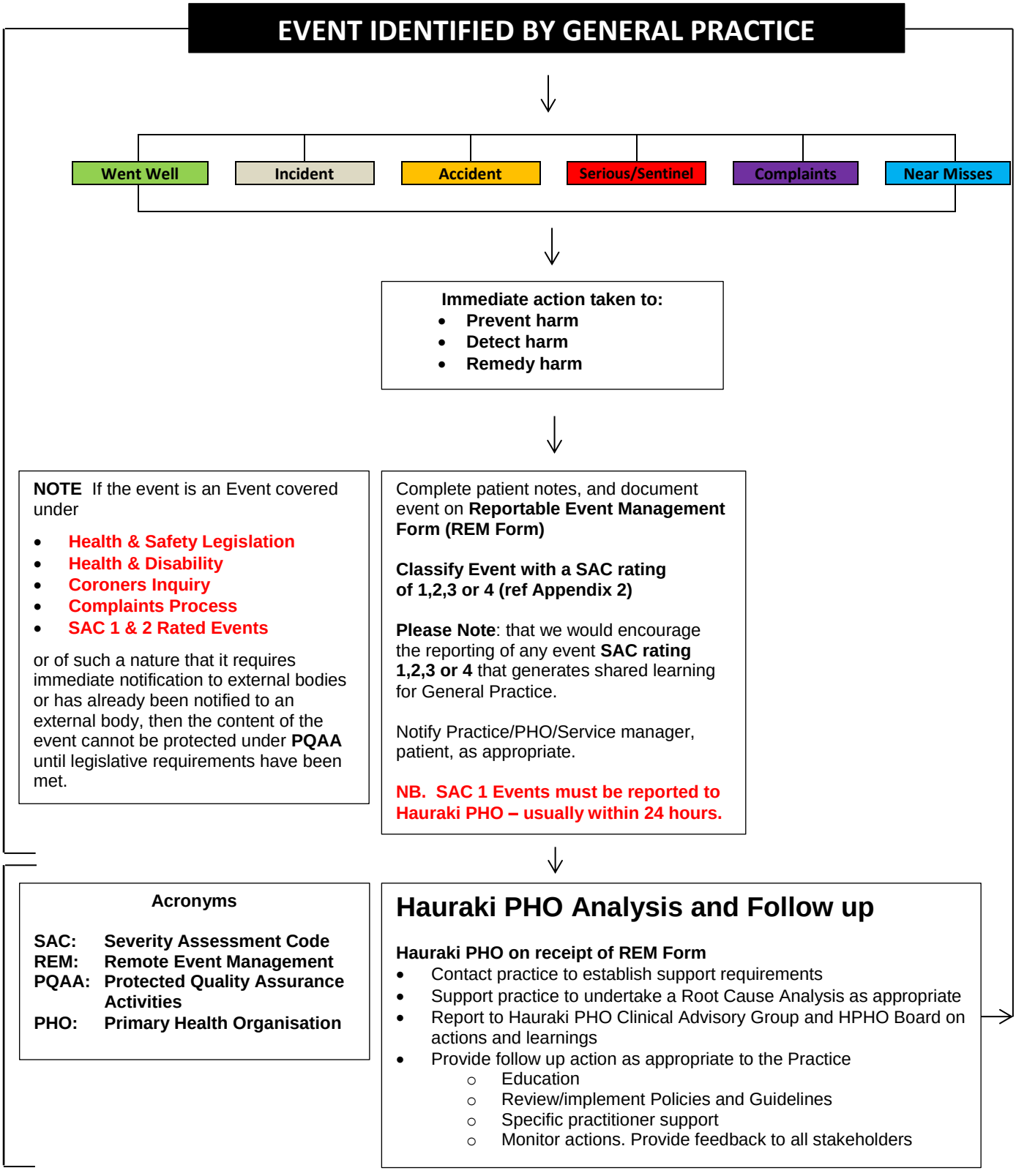
All adverse incidents, be they clinical or corporate in nature, need to be managed carefully to ensure appropriate reporting, investigation and follow up occurs in a timely and logical way. Hauraki PHO practices have well established policies and processes for reporting and managing events at practice 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 Hauraki PHO on a three monthly basis using the LOGIQC Risk Register. The Risk management module is also available from LOGIQC for practices to utilise. This provides Practices with a tool for reporting adverse and sentinel events, based on the National Incident Management Framework. Contact the HPHO Practice Support Team for further information.

The Severity Assessment Code (SAC) flowchart is included for your information.

Lynne Courtney
Quality Manager
Hauraki PHO

General Practice
Reportable Event Management Flow Chart



Appendix 1

REPORTABLE EVENT FORM

Date of Event		**Date Reported**	
Time Event Occurred		**Reported By**	
Type of Event (Please circle) **Went Well Incident Accident Serious/Sentinel Complaint Near Misses**		**Severity Assessment Code** **1 2 3 4**	
Description of the event and condition of any injured person			
Immediate action taken to minimise harm/loss			
Is the Patient/Individual aware of the event *(Record to this point prior to meeting)*?		**Yes**	**No**
Analysis			
Action/Outcome			

External Reporting	**Yes**	**No**	**Date Reported**	**Reported to**
Monitoring Requirements				

Please send a copy of the completed form to the Quality Manager, Hauraki PHO. Lynne.courtney@haurakipho.org.nz

Date received at CH:	By:	Event Number:	SAC Rating:

Appendix: 2

Severity Assessment Code (SAC) matrix

Reproduced from the *National Policy for the Management of Healthcare Incidents*
http://www.moh.govt.nz/moh.nsf/indexmh/improvingquality-reportableevents-resources.

The Severity Assessment Code (SAC) matrix is used to numerically score incidents resulting in a SAC rating ranging from 1-4, based on incident consequence or outcome and likelihood that it will recur (for ease of reference this is reproduced on the following pages).

All mandatory requirements of the draft national policy relate to **actual** consequences of events. Potential consequences may also be scored as relevant, eg: near miss events.

Events characterised by their severity as SAC 1 or SAC 2, are required to be reported to the Quality Manager at Hauraki PHO **via LOGIQC** or on the **REM Form** supplied in **Appendix 1** by either
Fax 07 8689786 or sentinelevent@haurakipho.org.nz

Consequence Table

Rate all adverse events on ACTUAL OUTCOME

Rate all near misses on the most likely potential outcome

Incidents with a high POTENTIAL SAC rating can be notified to the Central Repository (HQSC) via REB at the discretion of the organisation

Severe (SAC 1)	Major (SAC 2)	Moderate (SAC 3)	Minor (SAC 4)	Minimal (SAC 4)
Generic Consequences (applicable to all health and disability services)				
Death or permanent severe loss of function that is related to the process of health care and differs from the expected outcome of that care.	Permanent major or temporary severe loss of function that is related to the process of health care and differs from the expected outcome of that care.	Permanent moderate or temporary major loss of function that is related to the process of health care and differs from the expected outcome of that care.	Permanent minor or temporary moderate loss of function that is related to the process of health care and differs from the expected outcome of that care.	Temporary minor loss of function.

Likelihood Table

LIKELIHOOD CATEGORY	DEFINITION	CONSEQUENCE				
		Severe	Major	Moderate	Minor	Minimal
Almost Certain	Almost certain to occur at least once in next three months	1	1	2	3	4
Likely	Will probably occur at least once in the next four-12 months	1	1	2	3	4
Moderate	Is expected to occur within the next one to two years	1	2	2	3	4
Unlikely	Event may occur at some time in the next two to five years	1	2	3	4	4
Rare	Unlikely to recur – may occur only in exceptional circumstances ie >five years	1	2	3	4	4

Cornerstone Status of all Hauraki PHO Practices as at June2018

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	Achieved
	Waihi Health Centre	Achieved
Waikato District	Avalon Medical	Achieved
	Cambridge Family Health	Achieved
	Drs@42 (Dr AJR Gates)	Achieved
	Five Crossroads Medical Centre	Achieved
	Grey Street Family Health Centre	Assessment in 2018
	Hamilton Lake Clinic	Achieved
	Health and Medical Clinic	Assessment in 2018
	Matamata Medical Centre	Achieved
	Ngaruawahia 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 in 2018
	Tui Medical Centres, Central, Davies Corner, Huntly, Parkwood, Rototuna, Te Rapa	Achieved
	University Student Health Services	Achieved

Waikato District Health Board

2018-19 SYSTEM LEVEL MEASURE IMPROVEMENT PLAN

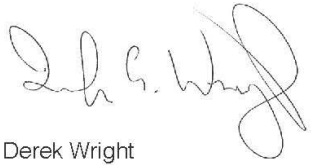
Waikato District Health Board

Contents

Introduction

The System Level Measure (SLM) Framework is a Ministry of Health led tool for integration to support District Health Boards to work in collaboration with primary, community and hospital. There is a focus on children, youth and vulnerable populations, and this work is included as part of the district's annual planning with the overall improvement targets and plans set locally while sitting within the appendix of the Annual Plan.

The 2018/19 milestones, contributory measures and activities have been decided and agreed by the below parties.



Derek Wright
Interim Chief Executive Officer
Waikato DHB

David Oldershaw
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

Development and implementation of the 17/18 SLM Improvement Plan saw the roll out of 6 SLM working groups each containing a clinical lead and project manager, the technical reference group and overall SLM Project Manager within the Waikato district. The working groups were committed to working together to achieve results.

Moving into planning for the 2018/19 year saw lessons learned undertaken with some key areas identified as working well and other areas for improvement.

Key lessons learned from 17/18:

- Include a programme approach to the current SLM structure for Waikato and tighten up terms of reference around accountability and escalation;
- Continue to utilise data and root cause analysis to systematically identify gaps and areas that warrant the most attention. This has enabled us to become very familiar with our population's data so we can see where we are doing well, and where extra effort is needed;
- Focus on a small number of key projects that the group can control and manage;
- Identify synergies across SLM's in order to work together e.g. ASH 0-4 years and acute bed days (ASH adults);
- Build on consistent communication framework across primary, secondary and community along with patient good news stories;
- Stakeholders more accountable for completing work allocated;
- Continue and tighten formal reporting framework;
- Ensure continuous quality improvement methodology is imbedded.

Development of the 2018/19 Plan

Using improvement science methodology, the process utilised by the Waikato SLM working groups for development of the 18/19 SLM Improvement Plan is below:

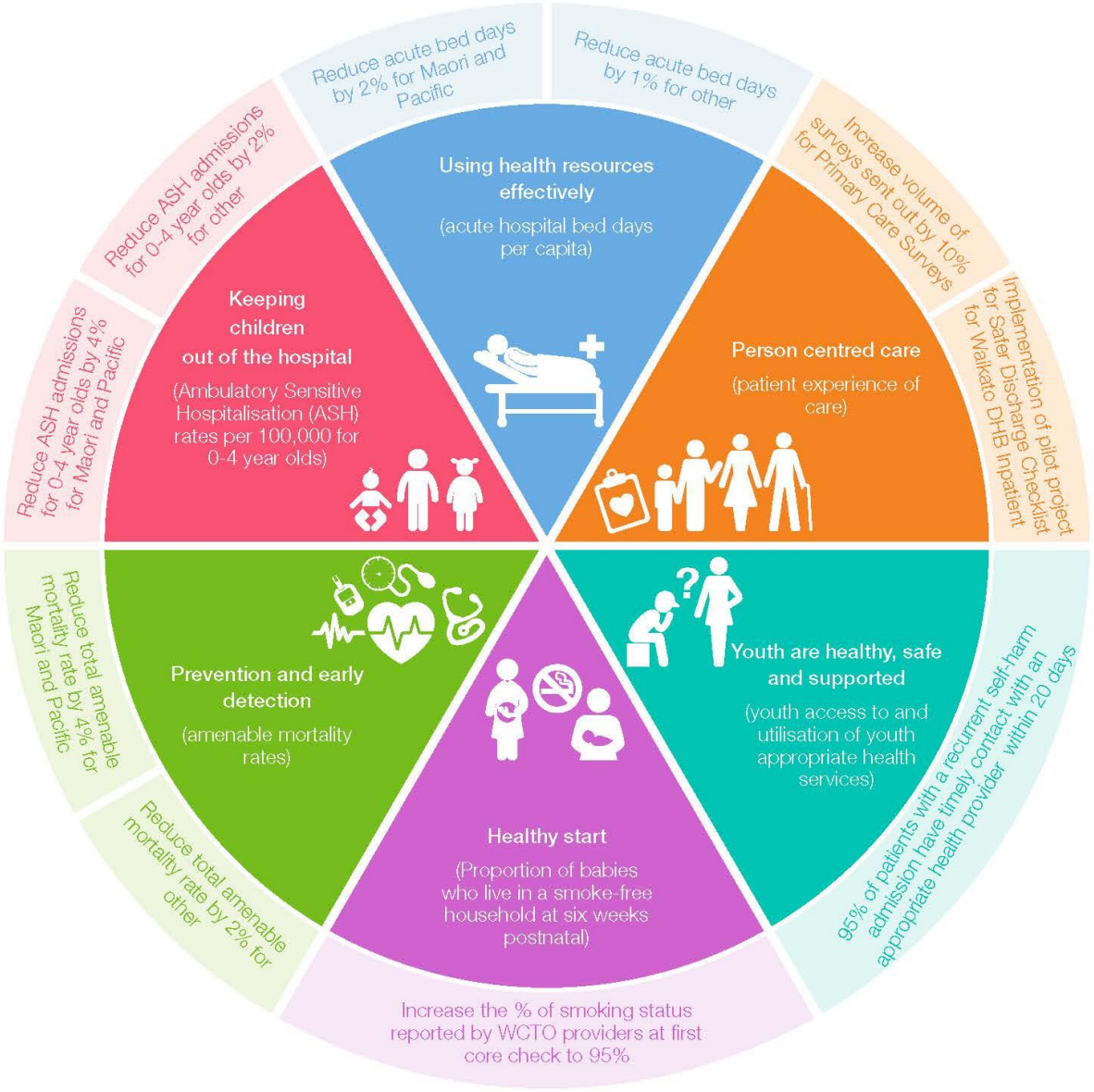
1. Continuation of the working groups for each SLM that at a minimum includes clinical, managerial and analytic expertise from across primary, secondary and community, as appropriate.
2. Examination of SLM data, both at aggregate and NHI level to understand what is driving local SLM rates to define the problem. This enabled the district alliances to: understand the health needs of our population; identify patients and population groups that experience disparity in access to healthcare and health outcomes; and target our activities to provide equitable health care and improve their health outcomes.
3. Identification of the improvement milestone/s, with all milestones focused on reducing equity gaps.
4. Identification of activities that will result in achieving the improvement milestone/s. These activities are practical, achievable in one year and targeted to the local population needs. This process was and is led by clinicians with some input from patients and local communities.
5. The selection of contributory measures that will enable the Waikato district to monitor our local progress. The contributory measures have defined numerators, denominators and data sources that enable us to report progress on activities to Inter Alliance.

Structure

The current SLM structure has been reviewed and now includes a programme approach managed by the Director of Integration. This role will provide leadership and support to the Chairs/Clinical Leads and Project Managers managing the individual SLM working groups. The Director of Integration will report progress to the Executive leads with quarterly reports to Inter Alliance.

Communication Framework

To assist with developing consistent communications across community, primary and hospital, a communication team has been developed along with a communication plan and framework. The Waikato DHB has developed an integration section on our website with the Primary Health Organisation's linking to it. 2018/19 will see regular patient good news stories added to the website along with any appropriate communications that relate to the integration work. The diagram below has been designed and will be used consistently across the organisations when communicating.


Reduce acute bed days by 2% for Maori and Pacific
Reduce acute bed days by 1% for other
Using health resources effectively
(acute hospital bed days per capita)
Increase volume of surveys sent out by 10% for Primary Care Surveys
Implementation of pilot project for Safer Discharge Checklist for Waikato DHB Inpatient
Person centred care
(patient experience of care)
Reduce ASH admissions for 0-4 year olds by 2% for other
Keeping children out of the hospital
(Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds)
Reduce ASH admissions for 0-4 year olds by 4% for Maori and Pacific
Reduce total amenable mortality rate by 4% for Maori and Pacific
Prevention and early detection
(amenable mortality rates)
Youth are healthy, safe and supported
(youth access to and utilisation of youth appropriate health services)
95% of patients with a recurrent self-harm admission have timely contact with an appropriate health provider within 20 days
Reduce total amenable mortality rate by 2% for other
Healthy start
(Proportion of babies who live in a smoke-free household at six weeks postnatal)
Increase the % of smoking status reported by WCTO providers at first core check to 95%

System level measure overview

System level measure	Baseline data	Improvement milestone 18/19 target	Contributory measures
1. ASH 0-4 years	• Māori – 9,415 per 100,000 population. • Pacific – 9,084 per 100,000 population. • "Other" –7,474 per 100,000 population. • Total –8,284 per 100,000 population. (Baseline set from 12 months, December 2017)	• Reduce ASH admissions for 0 - 4 year olds by 4% for Māori (9,038 per 100,000) • Reduce ASH admission for 0 – 4 year olds by 4% for Pacific (8,721 per 100,000) • Reduce ASH admissions for 0 - 4 year olds by 2% for other (7,325 per 100,000) across the DHB in order to reduce inequity	• A reduction in the number of 0-4 ASH respiratory presentations • A reduction in the number of 0-4 ASH gastroenteritis admissions • A reduction in the number of 0-4 ASH cellulitis/dermatitis/eczema admissions
2. Acute bed days	• Maori - 457 per 1,000 population. • Pacific - 372 per 1,000 population. • "Other" - 522 per 1,000 population. • Total - 502 per 1,000 population. (Baseline set from unstandardized data- 12 months to March 2018)	• Reduce acute bed days by 2% and maintain for Maori (448 per 1,000) by 30 June 2019 • Reduce acute bed days by 2% and maintain for Pacific (365 per 1,000) by 30 June 2019 • Reduce acute bed days by 1% and maintain for 'other' (517 per 1,000) by 30 June 2019	• ED presentation rates • Hospitalisation rates for people with COPD, cellulitis • Occupied bed days for patients 75 years and over who had two or more emergency admissions within a calendar year • Inpatient average length of stay for acute admission
3. Patient experience of care	• Number of responses sent out - 4550	• Increase volume of surveys sent out by 10% for Primary Care Surveys • Implementation of pilot project for Safer Discharge Checklist for Waikato DHB Inpatient	• Patients are offered the Patient Experience Survey in the week of their visit • Promote patients' use of general practice portals • Improved information sharing and understanding during inpatient discharge • Quality improvement project

System level measure	Baseline data	Improvement milestone 18/19 target	Contributory measures
4. Amenable mortality	• Māori –247 per 100,000 • Pacific –204 per 100,000 • "Other" –85 per 100,000 • Total – 110 per 100,000 (Baseline data set from 5 years to Dec 14)	• Reduce total amenable mortality rate by 4% for Māori by 2022 • Reduce total amenable mortality rate by 4% for Pacific by 2022 • Reduce total amenable mortality rate by 2% for 'other' across the DHB in order to reduce inequity by 2022	• Risk reduction in those with a CVD RA score of ≥ 20% or prior CVD event • Proportion of patients assessed for risk of suicide in primary care • Number of high suspicion cancer (Scan) referrals to respiratory by GP
5. Infants who live in smokefree households (Developmental)	• The % of smoking status reported by WCTO providers at first core check - 88% (Baseline data set from 6 months to Dec17)	• Continue to increase the % of smoking status reported by WCTO providers at first core check - 95% milestone	• PHO enrolled Māori patients who smoke are referred to stop smoking services • Pregnant Māori women who smoke are referred to smoking cessation services upon registration with LMC or GP in first trimester • Māori women are enrolled in pregnancy and parenting programs • Pregnant women who smoke are issued nicotine replacement therapy (NRT) • Supporting smoke free households
6. Youth Access to Health services (Developmental)	Self-harm Patient had contact from MH following event within 20 days • 85% (Baseline data set from 3 years to Mar 18)	• 95% of patients with a recurrent self-harm admission have timely contact with an appropriate health provider within 20 days	• Youth engagement • Quality of care; utilisation and access • Data quality focusing on data improvement with poor data quality and inconsistent reporting. • Collaborative relationships

The tables below provide the following information:

- The chosen Improvement Milestones
- The rationale
- The activity agreed by the working groups

System Level Measure 1:
ASH rates in 0-4 year olds: Reduce hospital admissions rates for conditions avoidable through prevention or management in primary care

Improvement Milestones:

- Reduce by 4% for Māori and Pacific and
- Reduce by 2% for 'other' across the DHB in order to reduce inequality

Baseline data analysis:

- ASH rate remain steady throughout the year for all ethnicities measured
- By volume 0-4 year olds are the biggest age group for ASH. Respiratory infection, Dental Conditions, skin infections and Gastroenteritis/ Dehydration being the top issues for the age group.
- 'Other' show a higher rate per 1,000 of population than the other ethnicities measured with the exception of Asthma

Respiratory

	Contributory measures	Rationale	Activity
1.	A reduction in the number of 0-4 ASH respiratory presentations	Baseline rates of flu vaccines for eligible children identified in 2017/18 and show poor take up. No system in place to identify and vaccinate in primary care Unspecified upper respiratory conditions are high and are increasing. It is likely a proportion of these cases are due to inappropriate coding	Eligible children offered flu vaccine Proposal for retrospective audit (ED) coding to implement change
		Number of 0-4 ED attendees with 5+ presentations with respiratory conditions. No system in place to identify and follow up	Program in place to support repeat ED attendees
		The benefits of using this tool are increased opportunistic screening, increased interventions, increased number of referrals made to appropriate services when indicated	Harti Hauora paediatric inpatient assessment pilot implemented
		GASP has been validated as an effective tool for reducing ED admission in adults. To review as an option to support child respiratory conditions.	Explore benefits of electronic decision support tools (e.g. GASP)

Gastroenteritis			
	Contributory measures	Rationale	Activity
2.	A reduction in the number of 0-4 ASH gastroenteritis admissions	Top 5 0-4 ASH conditions with local feedback identifying need for improved access to prevention treatment and education. Aligns with acute bed days SLM work plan and PHO strategic plans	• Primary options/pathways for gastro • Community pharmacy pilot for gastroenteritis

Dermatitis			
	Contributory measures	Rationale	Activity
3.	A reduction in the number of 0-4 ASH cellulitis/dermatitis/eczema admissions	Top 5 0-4 ASH conditions with local feedback identifying need for improved access to prevention treatment and education. Aligns with acute bed days SLM work plan and PHO strategic plans	• Primary options/pathways for skin infections • Community pharmacy pilot for skin infections

System Level Measure 2:
Acute Bed Days: Improved management of demand for acute care

Improvement Milestones:
- Reduce acute bed days by 2% and maintain for Māori and Pacific by 30 June 2019
- Reduce acute bed days by 1% and maintain for 'other' by 30 June 2019

Baseline data analysis:
- The overall top issues by bed duration are Stroke, Respiratory , Hip fractures and heart failure.
- Each ethnicity show a different duration per visit
- Top issues for each ethnicity vary from the total and includes Cellulitis of lower limbs for Maori and Chronic obstructive pulmonary disease.

	Cellulitis (excluding under 13 year olds)		
	Contributory measure	Rationale	Activity
1.	Reduce ED presentation and hospitalisation rates for cellulitis	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• Publicise the community pathway • All departments to use the community pathway for self-presenting patients as the primary process • Evaluate of primary options cellulitis framework • HOT Clinic (within 24 hours)
	COPD		
	Contributory measure	Rationale	Activity
2.	Reduce ED presentations and hospitalisation rates for COPD	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• COPD Homebased Support Team new care model initiative in the community
	Asthma		
	Contributory measure	Rationale	Activity
3.	Reduce ED presentations and hospitalisation rates for people with asthma	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• GASP Programme (Hauraki PHO)
	75 years		
	Contributory measure	Rationale	Activity
4.	Reduce ED presentations and hospitalisation rates for falls* Occupied bed days for patients 75 years and over	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• Advance Care Plan implemented between DHB, Hospice and MHN • START phase two expansion • Waikato Falls and Fragility Fracture Prevention Programme

Inpatient Length of Stay			
	Contributory measure	Rationale	Activity
5.	Inpatient average length of stay	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• Reduce the length of stay for identified frail patients attending the Emergency Departments. • Disability navigator: To reduce the delays for patients with Disability in the secondary journey and improve the connections with primary and community care • Admission avoidance or complex patients identified within the following groups: o Mental Health o Health of Older People o Chronic Health

System Level Measure 3:
Patient Experience of Care: Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care

Improvement Milestone:

- Increase volume of surveys sent out by 10% for Primary Care Surveys
- Implementation of pilot project for Safer Discharge Checklist for Waikato DHB Inpatient

Baseline data analysis:

- Waikato inpatient patient experience survey has now been running for four years. The response rate Q3 17/18 was 40%.
- Primary care survey has now been running for two quarters. Available data is growing but is still limited.
- The key themes from feedback are not being told about medication side effects to look out for at home, not being given the choice of different medication options and not receiving enough information about how to manage conditions after discharge.

Increasing volumes of GP surveys			
	Contributory measures	Rationale	Activity
1.	Patients are offered the Patient Experience Survey in the week of their visit	Provides the ability for practices to understand and improve the patient experience	• Encouraging awareness • Increasing volume of surveys sent out through up to date email addresses • Training and support for general practice in use of primary care patient survey • Monitoring of uptake • Communication and training plan with general practices, hospital, patients and community Notes from 17/18 planning: In 17/18 the Primary Care Survey was rolled out to practices throughout the Waikato. In 18/19 the hopes is that PHOs will continue to support and train practices in the use of the survey. The national governance group will also continue to work on improving the survey to increase coverage.
2.	Promote patients' use of general practice portals	Provides practices with up to date contact details and email addresses this will improve response rates. This will also increase patient's access to their health information and increase transparency.	• Training and support for practices about patient portals • Monitoring of uptake • Communication and training plan with general practices, hospital, patients and community

Pilot project for Safer Discharge Checklist for Waikato DHB Inpatient			
	Contributory measures	Rationale	Activity
3.	Improved information sharing and understanding during inpatient discharge	This has consistently been a key theme from inpatient surveys	• Improve discharge planning to include safe medication transfer • Improvement of health literacy • Working group developing Safer discharge checklist • Improve communication and co-ordination of transfer of care from inpatient to primary care. • Pilot of Safer Discharge Checklist to be implemented in 18/19 in Waikato DHB Inpatient
Quality Improvement Project with PHO and Waikato DHB			
	Contributory measures	Rationale	Activity
4.	Quality improvement project	This is a quality focused SLM and so the working group would like to develop a quality improvement initiative together across the whole system	• 29 June 2018 the final weighted report from Q4 17/18 will be available for PHO patient surveys. This will provide the third quarter of results from the PHO surveys. We would like to then develop a quality improvement initiative as a working group that will involve both of the PHOs and the Waikato DHB in a project across the system. The working group will update Inter-alliance on this project in July 2018.

System Level Measure 4:
Amenable mortality: Reduction in the number of avoidable deaths and reduced variation for population groups

Improvement Milestones:
- For Māori and Pacific reduce total amenable mortality rates by 4% and sustain by 30 June 2022
- For other reduce total amenable mortality rates by 2% and sustain by 30 June 2022

Baseline data analysis:
- The most common causes of premature death are coronary and cerebrovascular disease, COPD, suicide, diabetes and cancers. Injuries (unintentional and self-harm are also important causes
- Overall the highest number of preventable deaths is from Coronary disease
- Lung cancer has been identified as having a significant equity gap within the Waikato

Coronary/CVD			
	Contributory measures	Rationale	Activity
1.	Risk reduction in those with a CVD RA score of ≥ 20% or prior CVD event	Modification of risk factors through self-management, lifestyle and pharmaceutical interventions has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD and diabetes.	• Carry out chart audit of all patients at a NHI level who have had a CVD event and not prescribed triple therapy • Identification of PHO and feedback to PHOs • Scope and implement a Health Action in the Workplace pilot– Aim to partner with workplaces with a screening, risk reduction and prevention of diabetes/CVD focus.
Suicide			
	Contributory measures	Rationale	Activity
2.	Proportion of patients assessed for risk of suicide in primary care	Suicide is a leading cause of amenable mortality	• Investigate an 'Early Detection of Suicide Risk in Primary Care' pilot within Hauraki PHO
Lung Cancers			
	Contributory measures	Rationale	Activity
3.	Number of high suspicion cancer (HSCan) referrals to respiratory by GP	Lung cancer remains the leading cause of cancer death in New Zealand. It is recognised that the single most important prognostic factor for lung cancer is stage at diagnosis.	• Implement a public awareness campaign for high risk populations highlighting the symptoms that may lead to early diagnosis of lung cancer • Develop and deliver education and training for early detection of lung cancer to GP and pharmacy in the community • Streamline patient access to diagnostics • Formalise early detection of lung cancer clinical pathway that links to high suspicion of cancer referral pathway • Develop monitoring and evaluation framework

System Level Measure 5:
Babies living in smoke free homes (developmental 2017/18): Reduction in the number of maternal smoking as well as the home and whānau/family environment

Improvement Milestone:

- Continue to increase in the percentage of smoking status reported by WCTO providers at first core check - 95%milestone

Baseline data analysis:

- Placing the spot-light on particular data sets has resulted in data quality improvement in the past and it is anticipated this will occur for these datasets as well. Locally we have limited across sector access to regular robust data and the focus for 2018/19 activity is on data quality and monitoring. This includes our improvement milestone for 2018/19 being focused on maintaining our data quality to capture our denominator data accurately and consistently across providers.
- This SLM is important because it focuses attention on maternal smoking as well as the home and whānau/family environment. For these to be a success, stop smoking support and services need to be available across the lifespan and therefore our contributory measures are focused across the different stages of the pregnancy pathway

Pre pregnancy and household contacts

	Contributory measures	Rationale	Activity
1.	Māori patients who smoke are referred to stop smoking services. (denominator PHO enrolled)	*Whānau engagement* Population measure to capture the wider household population *Equity* Significant equity gap between Māori and NZ European. This measure targets Māori results to enhance equity focus for monitoring and activity. *Utilisation and access* Low numbers referred to stop smoking services *Data quality improvement* Data reports only the number of smoking given brief advice and does not report the number referred and does not provide ethnicity breakdown.	• System in place to report on referral data by ethnicity and equity gap • Utilise the local dashboard • Communication plan

Early pregnancy			
	Contributory measures	Rationale	Activity
2.	Pregnant Māori women who smoke are referred to stop smoking services at first contact (upon registration with a LMC or when seen by a GP in first trimester)	*Provider relationships* Early pathway intervention measure focused on provision of high quality care by LMCs and general practice *Data quality improvement* Data comes from two sources, MMPO and from DHB employed midwives. Due to issues with data collection, available data is not complete *Equity* Significant equity gap between Māori and NZ European. This measure targets Māori results to enhance equity focus for monitoring and activity. *Utilisation and access* Low numbers accepting referrals to smoking services	• Report on referral data by ethnicity and equity gap • Continue to communicate incentive scheme for pregnant women to the midwifery community and general practice. • Clinical pathway for GP first trimester visit promoted
Pregnant			
3.	Contributory measures	Rationale	Activity
	Māori women enrolled in pregnancy and parenting programmes	*Whānau engagement* Opportunity to focus on total wellbeing. Local pregnancy and parenting workshops include wider whānau *Data quality improvement* No baseline data *Equity* Anecdote evidence suggests low enrolment of Māori women in pregnancy and parenting programmes.	• Pregnancy and Parenting Programmes data collected including ethnicity and smoking status • Stop smoking services promoted in pregnancy and parenting programmes
4.	Pregnant women who smoke are issued NRT	NRT has been shown to be effective in supporting pregnant women to stop smoking. It is best used in conjunction with other measures including biofeedback/CO monitoring, counselling and incentives.	• NRT baseline established for primary and secondary care • NRT information is updated
Lifespan			
5.	Contributory measures	Rationale	Activity
	Supporting smoke free households	Focusing attention on maternal smoking as well as home and family/ whānau environment. Promoting opportunistic screening and follow up by existing providers/ services working with families and pregnant women	• Work with WCTO providers to improve data quality • Roll out Tupeka Kore Framework • Smoke free household information promoted

System Level Measure 6:
Youth: Intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year olds'.

Improvement Milestone:

- 95% of patients with a recurrent self-harm admission have timely contact with an appropriate health provider within 20 days

Baseline data analysis:

- For 2017/18 an improvement milestone was chosen to improve the understanding of the systems in place for management of recurrent self-harm presentation across the sector. That milestone was 90% of patients with a recurrent self-harm admission have contact with a health provider. To date we have captured the number of recurrent self-harm admissions that had contact with DHB mental health services.
- For the 36 month period to March 2018, 96% of recurrent intentional self-harm admissions had contact from DHB mental health services following an event and 93% had a face to face appointment. Although we have met our 90% target for 2017/18, capturing the complete data for our improvement milestone is ongoing with further engagement and data analysis outside of the DHB mental health services

Youth Engagement

	Contributory measures	Rationale	Activity
1.	Youth engagement	Youth voice represented in health service development. Evidence shows that young people who do not have positive interactions with health care services/providers do not return and have poorer outcomes.	• School based health services focus groups - including feedback on HEEADSS assessment tool with a specific focus on cultural appropriateness and effectiveness • Work with Youth Intact youth reference groups to develop Harti Hauora Rangatahi • Work with existing youth reference groups to develop a youth mental wellness programme for the University of Waikato health service, and community
2.	Quality of care; utilisation and access	Poor understanding of current youth services availability. To achieve health equity for youth, primary to tertiary services need to be accessible, appropriate and effective	• Map secondary school based health services to explore gaps and opportunities • Develop comprehensive youth wellbeing tool Harti Hauora Rangatahi • Improve ED self-harm discharge information sharing with primary care • Pilot Harti Hauora Rangatahi with priority population - consider NEET population target • Deliver youth mental wellness programme for the University of Waikato Health service and community • Promote and attend Safe Hands Safe Plan training

3.	Data quality	Focus is on data improvement with poor data quality and inconsistent reporting. Clear and consistent measure of outcome data is required to achieve equity	• Continue to map patient journey for recurrent self-harm ED admissions • Waikato Youth wellbeing profile developed and disseminated • Review ED self-harm data including demographic, presentation characteristics and pathway of care for 10 to 24 year old self-harm population admissions • Collect and report on self-harm school based health services data • This activity is subject to an agreed process on data sharing.
4.	Collaborative relationships	Focus is on increased collaboration, enhanced understanding of youth needs and youth service provision, and increasing opportunities for alignment.	• Explore opportunities for a youth focus for new community psychologists role and current Brief Intervention Clinicians role • Improved pathway of care between ED and DHB mental health services • Collaboration between community psychologist, ED and mental health providers

Appendix

2018/19 SYSTEM LEVEL MEASURES (SLM) WORKING GROUP
TERMS OF REFERENCE AND MEMBERSHIP

Purpose

The purpose of the SLM working group is to bring together local experts across the sector to collaborate and recommend the following for their 2018/19 measure

- An improvement milestone
- contributory measures and milestones;
- Quality improvement activities to achieve contributory measures and therefore SLM.

Specific Responsibilities

- Review analysis of local data supplied by the TRG to identify main contributors

(Where we are now)

- Identifying improvement milestone

(Where we want to be)

- Selecting the most relevant contributory measures
- Identifying wider supporting measures which assist the delivery of the system level measure but are not the nominated contributory measures
- Identifying activity and provider that will impact the contributory milestones and supporting measures. This could be current, planned i.e. listed in annual plan or new activities ideas

(How will we get there?)

- Oversee activity agreed that will impact the milestones
- Report on activity progress to the identified governance group (this will be alongside the technical reference group who will report on performance)

Outside of Scope

- Waikato's System Level Measure Plan sign off
- Funding related decisions

Linkages

The improvement milestones chosen should take into consideration the strategic priorities across the region, particularly reducing inequity and should aim to:

- Align to current strategic priorities
- Align to current alliance work programmes and activities
- Information that is already collected and readily available; and where possible aligned across the region
- Relevant to family and whānau, clinicians and managers
- Relevant to vulnerable population including but not limited to older people and children
- Impacting on a reasonable sized population
- Desirable with regard to a return on input investment

Formation Details
The working group were established in May 2017

Terms of Membership
The length of term for each member (designated role) will be 13 months until end of June 2019. Each PHOs operating in the Waikato District have been asked to provide a representative. DHB representatives and wider providers are included as appropriate. Appendix one has a list of members for each working group. Membership may change dependent on each organisations desired attendee. A delegate may represent members on the proviso that the delegate has the ability to report to their own services/organisations and can make informed contribution to discussions.

Meetings.
Working groups meeting will vary and the frequency is led by the Chair.
Working groups to report to their governance groups at a minimum quarterly.

Accountability
The working group are an expert advisory group and will make recommendations to either the Waikato Child Health Network, Demand Management Advisory Group or Inter-Alliance as determined below.

Waikato Child Health Network and DMG make final recommendations to Inter-Alliance

Governance
Waikato DHB's executive leads for SLM are

- Damian Tomic - Clinical Director Primary and Integrated Care and
- Tanya Maloney, Executive Director Strategy and Funding.

The Waikato Inter-alliance will have oversight for Waikato system level measures.

The working group will all report to one of the two following groups or straight to Inter-Alliance

1. Waikato Child and Youth Health Network
   - Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds;
   - Proportion of babies who live in a smoke-free household at six weeks post-natal
   - Youth access to and utilisation of youth-appropriate health services

2. Demand Management Advisory
   - Acute hospital bed days per capita;
   - Amenable mortality

3. Inter-Alliance
   - Patient Experience of Care

Midlands Regional Linkages will be in the form of information sharing.
There may also be linkage with the Ministry team around data sources and SLM reporting

Decision Making
The working group are chaired by the DHB clinical lead for each SLM (see appendix one). If the Chair resigns from the working group during this period another member of working group will be appointed by the DHB SLM executives.

A quorum for the group will be at least the chair or delegated chair and 50% of permanent members.
Due to tight timeframes, engagement and agreement may be made via email as appropriate

The working group role is to put forward recommendation to the group they report to as above. The working group Chair will strive to seek consensus from the group on recommendations put forward. Final decisions on recommendations put forward to the Waikato Inter Alliance group will be decided by the Waikato Child health Network or DMG as appropriate. Please note Patient experience of care reports to Waikato Inter-Alliance.

Issues with recommendation to be escalated through each organisations management structure

Membership

Acute hospital bed days per capita (i.e. using health resources effectively) *Reports to Demand Management Advisory Group*		
Damian Tomic (Waikato DHB) –lead	Puamiria Maaka (MHN)	Graham Guy (Waikato DHB)
Jo-Anne Deane (Project Manager)	Lorraine Hetaraka-Stevens (NHC)	Cath Knapton (Midland Pharmacy Group)
Stephen Ayliffe (Hauraki)	Andrea Coxhead (Waikato DHB)	Nina Scott (Waikato DHB)
Katpaham Kasipillai (Attend as required, Waikato DHB)		

Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (i.e. keeping children out of hospital) *Reports to Waikato Child and Youth Health Network*		
Dave Graham (Waikato DHB) lead	Cath Knapton (Midland Pharmacy Group)	Jo-Anne Deane (Waikato DHB)
Kath Yuill Proctor (Project Manager)	Kui White (Raukura – Well Child Tamariki Ora representative)	Geraldine Tennent (Waikato DHB Child Health GP liaison)
Stephen Ayliffe (Hauraki)	Felicity Dumble (Waikato DHB)	Katpaham Kasipillai (Attend as required, Waikato DHB)
Katie Ayers (Oral health)	Tracey Jackson (MHN)	
Karina Elkington (Waikato DHB)		
Lorraine Hetaraka-Stevens (NHC)		

Patient experience of care (i.e. person-centred care) *Reports to Inter-Alliance*		
Mo Neville (Waikato DHB) lead	Stephen Ayliffe (Hauraki)	Michelle Bayley (MHN)
Cait Cresswell (Project Manager)	Cath Knapton (Midland Pharmacy Group)	Lorraine Hetaraka-Stevens (NHC)
Trish Anderson (Hauraki)	Janet Ball (Waikato DHB)	Jo-Anne Deane (Waikato DHB)
Reuben Kendall (Hauraki)	Katpaham Kasipillai (Attend as required, Waikato DHB)	
Amenable mortality rates (i.e. prevention and early detection) *Reports to Inter-Alliance*		
Doug Stephenson (Waikato DHB) lead	Ross Lawrenson (Waikato DHB)	Shona Haggart (Waikato DHB)
Cara Dibble (Project Manager)	Nina Scott (Waikato DHB)	Loraine Elliot (Waikato DHB)
Stephen Ayliffe (Hauraki)	Lorraine Hetaraka-Stevens (NHC)	Jo-Anne Deane (Waikato DHB)
Clare Simcock (Waikato DHB)	Justina Wu (Waikato DHB)	Puamiria Maaka (MHN)
Grant Parkinson (Waikato DHB)	Katpaham Kasipillai (Attend as required, Waikato DHB)	
Proportion of babies who live in a smoke-free household at six weeks post natal (i.e. healthy start) *Reports to Waikato Child and Youth Health Network*		
Nina Scott (Waikato DHB) –lead	Ruth Galvin – Women's Health (Waikato DHB)	LMC provider tbc
Dallas Honey (Project Manager)	Kelly Spriggs – TPO (Waikato DHB)	Kate Dallas (Waikato DHB)
Michelle Rohleder (Hauraki)	Karina Elkington – Strategy and Funding (Waikato DHB)	Cath Knapton (MCPG)
Dallas Honey – Strategy and Funding (Waikato DHB)	Kym Tipene (Well child provider)	Jo-Anne Deane (Waikato DHB)
Dave Graham (Waikato DHB)	Plunket provider	Selena Batt (MHN)
Katpaham Kasipillai (Attend as required, Waikato DHB)		
Youth System Level Measure (i.e. youth are healthy, safe and supported) *Reports to Waikato Child and Youth Health Network*		

Polly Atatoa Carr (Waikato DHB Women and Children's) clinical lead/chair

Kath Yuill Proctor (Waikato DHB Women's and Children's) project manager

Lorraine Hetaraka-Stevens (National Hauora Coalition)

Tracy Jackson (Pinnacle Midlands Health Network)

Amanda Bradley (Pinnacle Midlands Health Network)

Stephen Ayliffe (Hauraki PHO)

Rachel Haswell (Youth INTact)

Jolene Profitt (Hauora Waikato)

Bronwyn Campbell (Pinnacle Midlands Health Network school based health service)

Cath Knapton (Midland Community Pharmacy Group)

Frances Robbins (General Practitioner – youth special interest)

Jo-Anne Deane (Waikato DHB Integrated Care)

Rachael Aitchison (Waikato DHB Mental Health and Addictions)

Clare Simcock (Waikato DHB Quality and Patient Safety – Suicide Prevention and Postvention Coordinator)

Larry Clarke (Waikato DHB Strategy and Funding portfolio manager)

Hayley Colmore-Williams (Waikato DHB Emergency Hospital Services)

Katpaham Kasipillai (Attend as required, Waikato DHB)

For the Practices 2018-2019

THIS PAGE IS RESERVED FOR THE ACHIEVEMENT VS SLMs DIAGRAM THAT IS CURRENTLY BEING COMPILED

Quality Plan 2018-2019 Business as Usual
Activity that supports achievement of System Level Measures

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

Breast Screening Coverage

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 a validated 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 Coverage

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 National Cervical Screening Programme (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.

NB.

- Please remember children 0-4 years who have had a hospital admission, within the last 4 years, for a respiratory illness are eligible for a subsidised influenza vaccination.
- Hauraki PHO allows use of Service to Improve Access (SIA) funding for non-subsidised patients.

Smoking

Continued efforts have seen smoking rates in New Zealand Aotearoa continue to reduce, with 17% of adults currently smoking; 15% smoke daily. This has decreased 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 their whanau, as well as future health benefits for 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

ACP

Advance Care Planning is a way to help you think about, talk about and share your thoughts and wishes about your future health care.

It is focused on and involves both you and your health care professionals responsible for your care. It may also involve your whanau/family and/or carers if that is your wish.

Now is the best time to consider taking part in an advance care planning conversation before you become seriously ill. Planning will help you and those around you understand what is important to you and what treatment and care you would like.

It gives you the chance to think about and share your preference for end of life care based on:

- Your personal views and values
- A better understanding of your current and likely future health, and
- The treatment and care options available to you.

You can set out what you want or hope for in an advance care plan. You should keep your advance care plan up to date, especially if things change.

The value of an advance care plan is in the conversations and shared understanding.

Recording your choices or wishes is voluntary. It is a good idea and will make it easier for those important to you and your healthcare providers to use this information to decide on what treatment and care you would want if you could not tell them yourself.

Practices need to ensure they have:

- A nominated Practice ACP Champion in place
- Relevant staff have completed ACP training – minimum level 1
- ACPs are recorded electronically via the MMH™ Dynamic Form
- Quarterly reporting of number of plans are completed

GASP

Giving Asthma Support to Patients (GASP) is a unique training programme for nurses and online tool developed to provide asthma education at point of care, and to provide health care professionals in primary care with skills and knowledge to undertake a structured asthma assessment and care plan.

GASP aims to:

- Support achievement of System Level Measures (SLM) targets
- Improve patient outcomes demonstrated through achievement of best practice
    - A reduction in avoidable hospital admissions
    - A reduction in avoidable ED presentations
    - Reduction in steroid and pharmacological usage by patients
    - Decrease in referrals for FSA in respiratory OPD.
    - Increased understanding by CNS/respiratory physicians
    - Reduction in winter demand on hospital services
- Empower individuals and whanau to improve and sustain wellness
- Improve continuity of care across the primary, secondary care continuum for patients with asthma and respiratory illness
- Enhance opportunities for Practice Nurses to play an advanced role in the assessment and treatment of Respiratory disease
- Reduce variation of care for conditions including Asthma and associated respiratory disease.

Practices need to ensure:

- A nominated Practice GASP Champion in place
- Relevant staff have completed GASP training
- Monthly Nurse led clinic is established
- Asthma plans for all GASP assessed patients are in place
- Quarterly reporting of number of plans are completed

Now that the SLMF has been established, we need to measure wider practice activity and this includes management of long term conditions and other health parameters. Hauraki PHO will audit activity against the following measures:

B4SC (Payment to practice on completion of check & achievement of target)

Practices need to ensure they have:

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

Patient Portal (Payment to practice on achievement)

Patient Portal is fully funded by Hauraki PHO and Practices need to ensure they:

- Are offering the Manage My Health Patient Portal
- Are achieving an increase of 10% per quarter of eligible enrolled patients having **activated** accounts

LOGIQC (Fully funded by HPHO)

Practices need to ensure they have:

- Implemented and are utilising LOGIQC Quality Management System
- A nominated Practice LOGIQC champion in place
- At least one clinical staff member competent in the use of LOGIQC
- At least one administration staff member competent in the use of LOGIQC
- A process to record incidents and sentinel events in the Risk Register of LOGIQC
- A process to record and report SAC1 and SAC2 level events to Hauraki PHO

Immunisations

Early enrolment at primary care enables **"on time"** childhood schedule immunisation which is shown to reduce hospital admissions.

We need to work on improvements to close the gap reducing inequities of service access and outcomes.

This needs to involve all partnerships with a shared responsibility to

- Enrol
- Engage
- Monitor
- Promote

Opportunistic immunisation should be offered at every contact including after-hours clinics. Examples of this are:

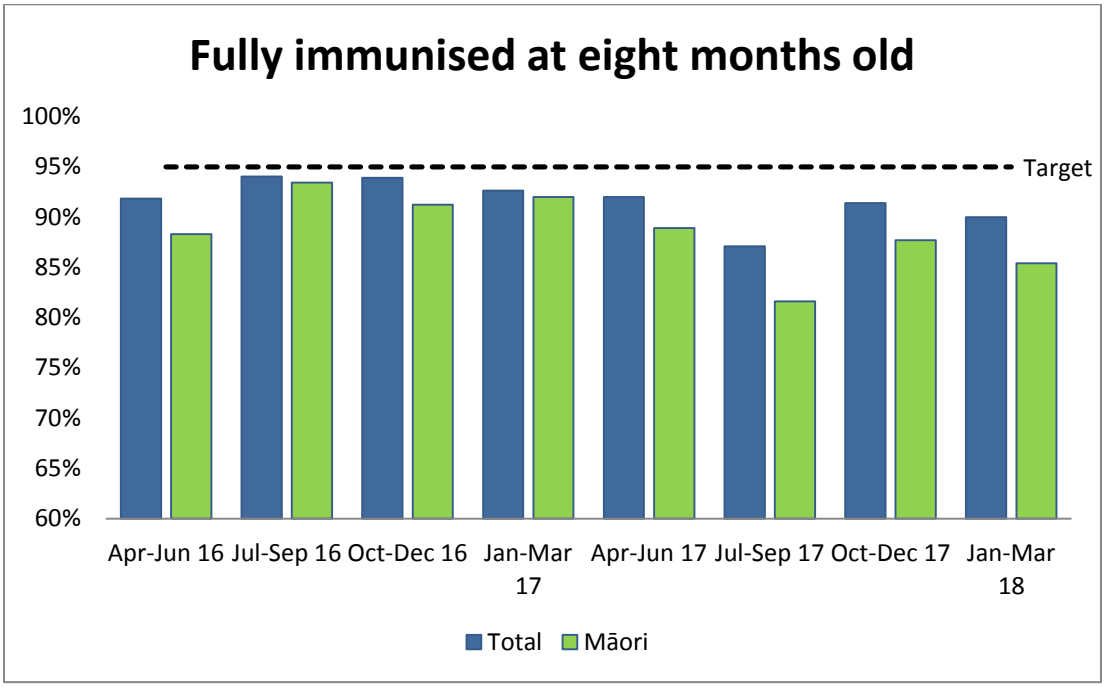
- A Grandmother may be in clinic with her mokopuna that are overdue immunisations. A verbal consent or text is all that is required from the mother to complete overdue immunisations.
- Whilst we acknowledge that a baby/child should be immunised at the Practice they are enrolled with, there can be extenuating circumstances where they may need to be immunised in another area. OIS will

sometimes recommend a baby visiting out of area and close to being overdue, go to the local medical centre for immunisations.

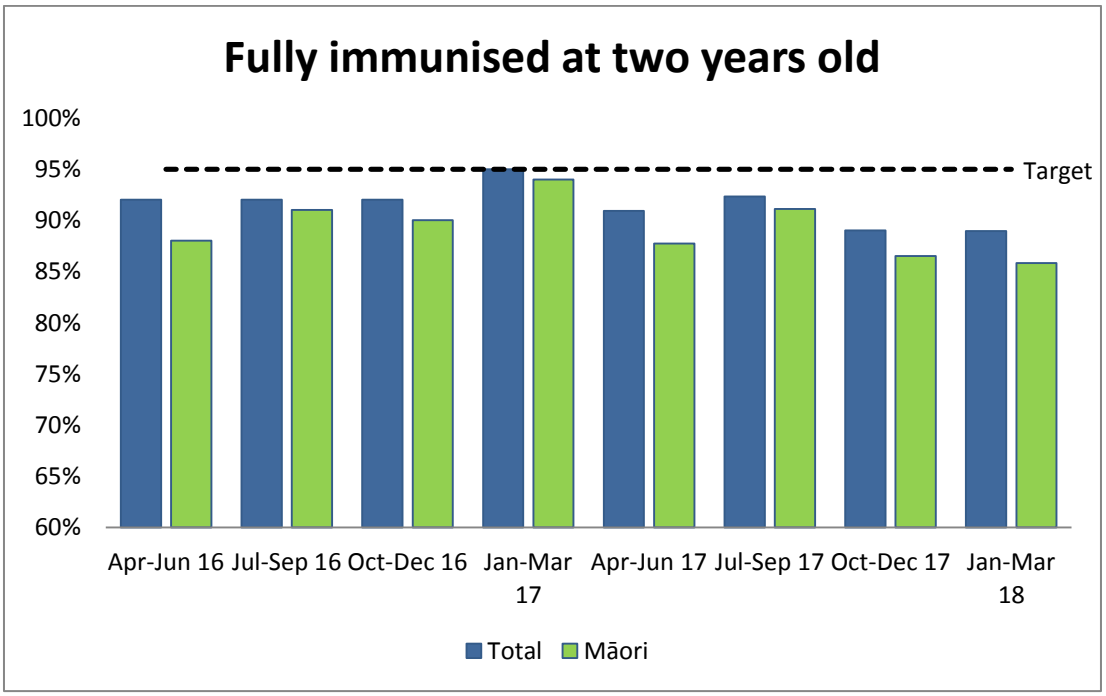
Take every opportunity to promote and provide education in a respectful, inclusive and non-judgemental way for parents to make an informed choice.

Use cross sector agency engagement with families/whanau who are not engaging with health services. E.g. Family Start & Oranga Tamarki.

Appropriate Vaccinations for Hauraki PHO Children Aged 8 Months



Appropriate Vaccinations for Hauraki PHO Children Aged 2 Years



Smoking Brief Advice and Cessation Support

Quitting smoking is one of the best things one can do to improve one's health. Primary Health Care Professionals play an important role in prompting quit attempts and offering support to quit.

There are numerous tools available to assist with giving smoking brief advice and cessation and the ABC approach is the most effective method. Smoking ABC can be provided by phone calls, text message, letter or face to face.

Following the ABC approach:

- ***A***sk about and document smoking status for all patients 15 years and older
  - Use Patient Dashboard in Medtech 32/Evolution
  - Use Appointment Scanner in Medtech 32/Evolution
  - Check for any recalls that may have been set
- ***B***rief advice is given to all patients who smoke – this can be done in a 30 second conversation
- ***C***essation is offered by:
  - Referral to Quitline
  - Referral (via Advanced Form in Medtech 32/Evolution) to Regional Once & For All Stop Smoking Service http://www.onceandforall.co.nz/
  - Referral to a Smoking Cessation provider

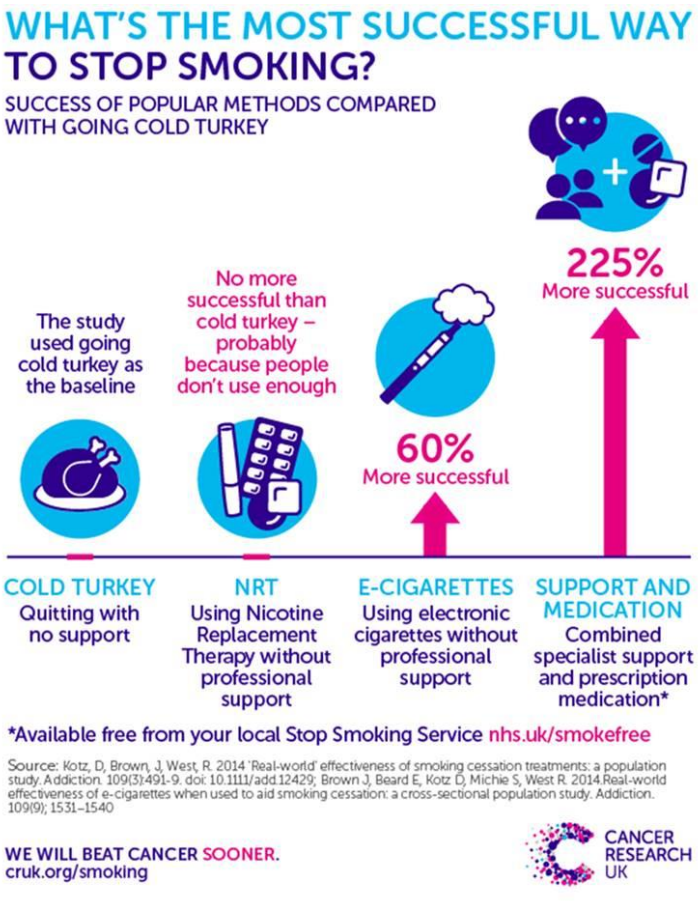
Vaping – recent changes

Vaping – known as "heat not burn" can now be legally imported, sold and distributed in New Zealand.

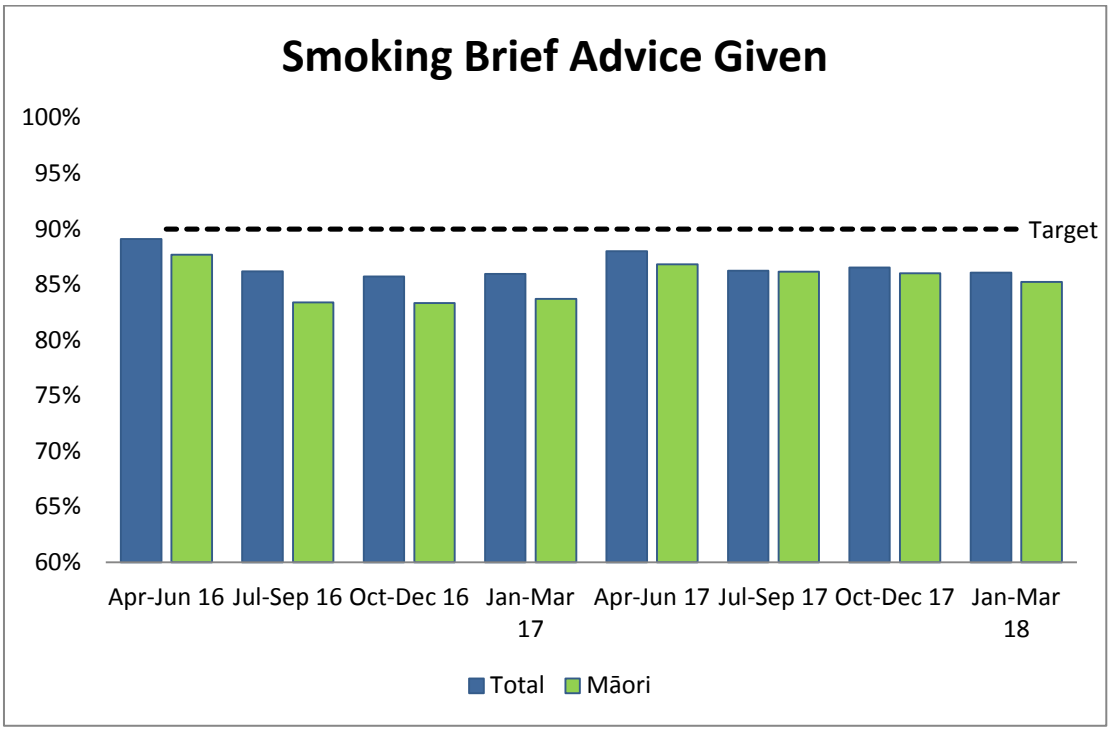
Please note that the ban on smoking in indoor workplaces, early childhood centres and schools only applies to smoking and not to vaping or products that are not smoked. It will be the decision of employers and business owners to decide whether or not to include vaping in their smoke-free policies.

Vaping/smoking can be recorded in smoking status as:

- If smoke a "burn product" – smoker
- If smoke and vape – smoker
- If vape – ex smoker
- If vape never smoked – non smoker



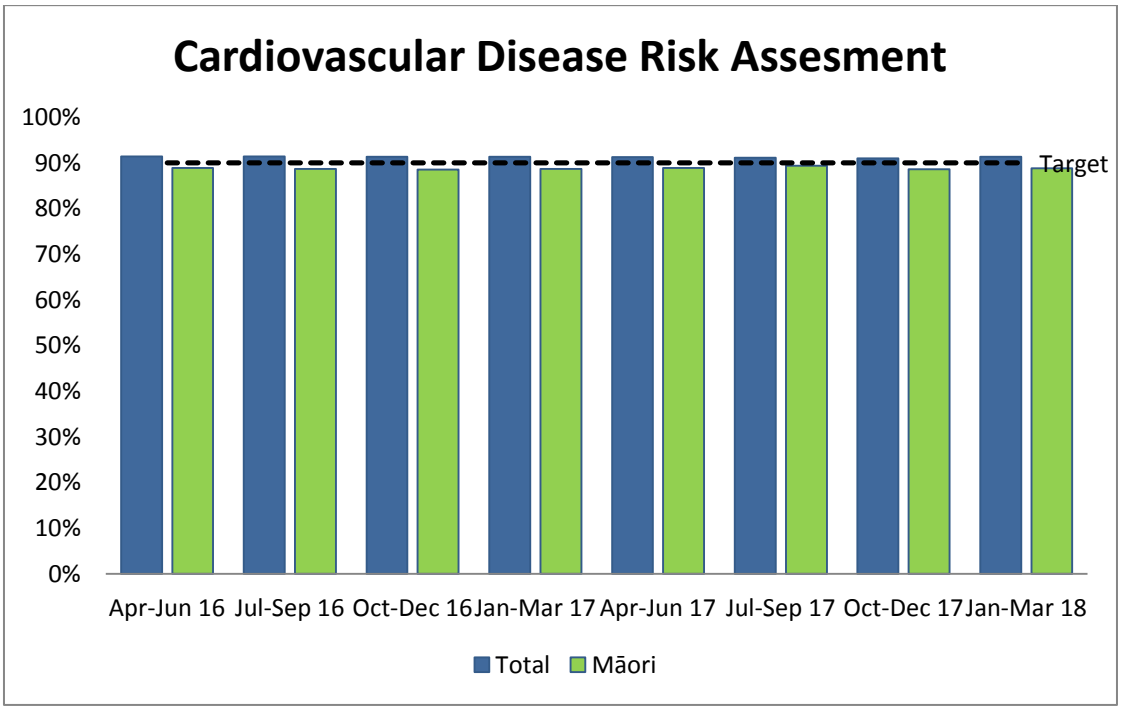
Smoking ABCs Completed for Hauraki PHO Eligible Population



Cardiovascular Disease Risk Assessment (CVRA)

Re CVRA – new guidelines published this year – **Cardiovascular Disease Risk Assessment and Management for Primary Care** (Ministry of Health, 2018). All practices should be familiar with these guidelines; amendments to our risk assessment tools are underway to reflect these guidelines and should be available later this year. In the meantime we recommend practices continue to focus on risk assessment for Māori males age 35-44.

CVRAs Completed for Hauraki PHO Eligible Population



Diabetes Management

There has been bourgeoning numbers of people diagnosed with diabetes over the last 2 decades, and a health care system that focuses on secondary care rather than prevention and early intervention. Because of this, Type 2 diabetes now lies exclusively in the realm of primary health care in the Waikato region.

Type 2 diabetes is strongly linked to social, environmental and economic indicators of health. The challenge for primary care is to focus on management and education for whanau with diabetes, while we also find opportunities to reduce inequalities.

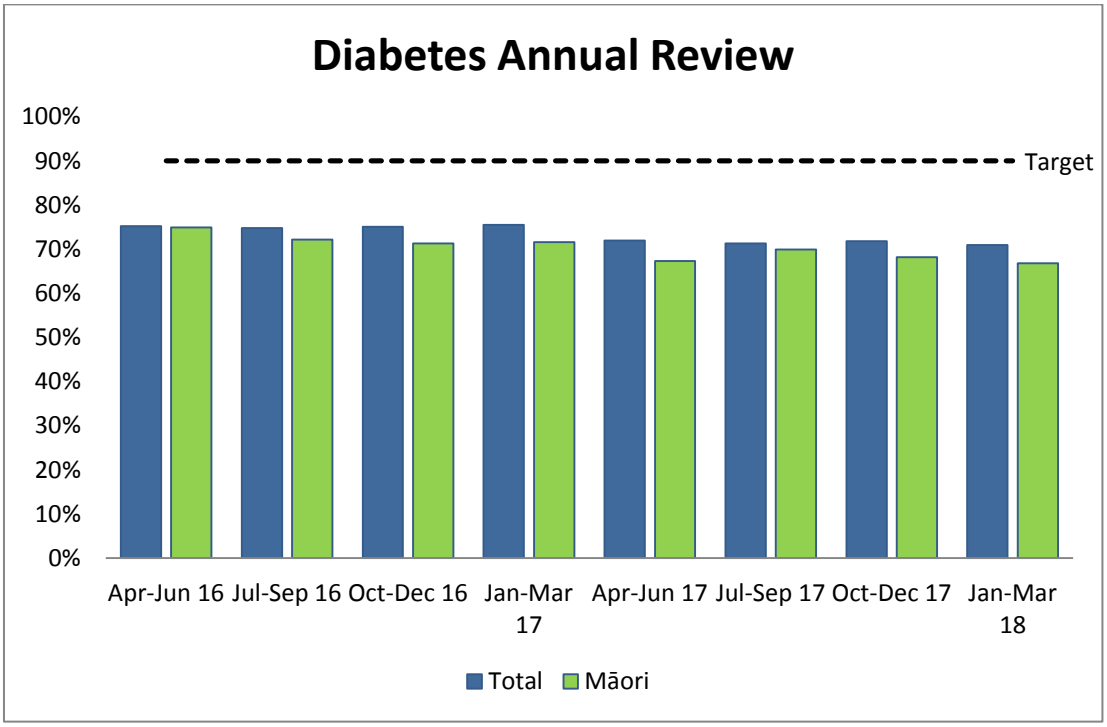
Type 2 diabetes is a progressive condition that may start with pre diabetes or gestational diabetes and can, over years, lead to multiple co morbidities and ill health. This is why an annual review is important - to pick up these changes early and look at strategies that minimises further deterioration. In Hauraki PHO we have 7500 people who have diabetes. While we can congratulate ourselves that 72 % did receive a review, this leaves more than 2000 people who missed out on their opportunity to sit with a health professional and have a robust conversation and update on their progressive, chronic condition.

Young people with type 2 diabetes, Māori, Pacific, and Indian people are more likely to develop complications from diabetes and our attention needs to clearly sit on preventing this from happening. In Hauraki PHO we have 53% of people with an HbA1c under 65 (note that this HbA1c is 'adequate' control and not suitable for all.) while the other 47% of people have above adequate glucose results, and 350 whanau have an HbA1c over 100. These whanau will almost certainly experience complications from their diabetes.

Type 2 diabetes is a condition that is closely aligned with cardiac factors including BP, smoking, weight and lipids. We tend to focus on glucose control as this is simple to measure, and HbA1c is an indicator of lifetime risk of complications. A well educated workforce is necessary for us to keep our perspective wide and ensure consistent high quality care for whanau with diabetes. Wintec offers two courses for nurses in diabetes – level 700 a basic diabetes programme that all practices nurses would benefit from. Level 800 paper which is a post graduate focus on diabetes which would benefit all diabetes nurse champions in general practice.

The diabetes programme goal for Hauraki PHO is to provide consistent high quality care that is targeted where need is highest and is sustainable.

Diabetes Annual Reviews Recorded for Hauraki PHO Eligible Population



Breast & Cervical Screening

From July 2017 – March 2018, 16712 Waikato women attended a breast screen appointment (2917 Māori and 342 PI). Breast screening numbers for the Waikato DHB are currently below target.

HPHO is exploring new and innovative ways to assist women to be screened. Our Support to Breast and Cervical Screening Service programme works in partnership with Breast Screen Midland and our Practice Partners to support women to screen.

If an enrolled HPHO woman does not book an appointment directly with Breast Screen Midland, we will then try contacting her. At least three contact attempts are made. Once we have made contact, we offer an appointment and transport if needed.

Recommendations for achieving quality targets:

- As a woman approaches her 45th birthday, remind her that she is now eligible to enrol into the free national breast screening programme. Women can self-enrol via www.timetoscreen.nz . If she is in the practice, enrolment forms can be found in Medtech 32/Evolution. It is helpful to record the woman's place of birth.
- Practices who enrol eligible women are able to claim $5 from Breast Screen Midland (BSM)
- The HPHO Support to Service team is available to assist with enrolling and following up appointments for priority group women
- From time to time we support practice initiatives by contacting unenrolled women or women who are no longer being contacted by BSM. This is done in conjunction with the BSM GP Liaison

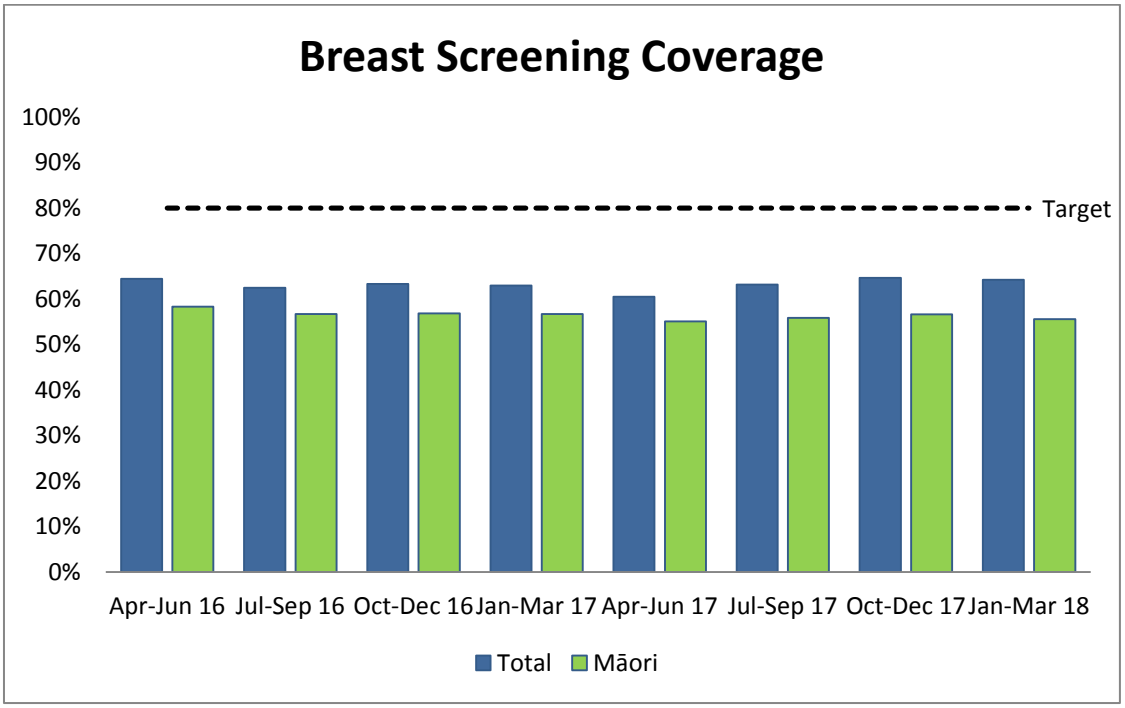
Examples of success:

- First time screener, who was transported to her mammogram appointment (aged 59, Māori) "They've been trying to get me here for 2 years." Following mammogram "That was nothing!"
- 49 year old first time screener had been told by other whanau members not to screen as it is too painful. She phoned to say the mammogram went really well and wanted to know how to enrol her daughter. This is a great example of breaking the cycle and having women who can become whanau advocates

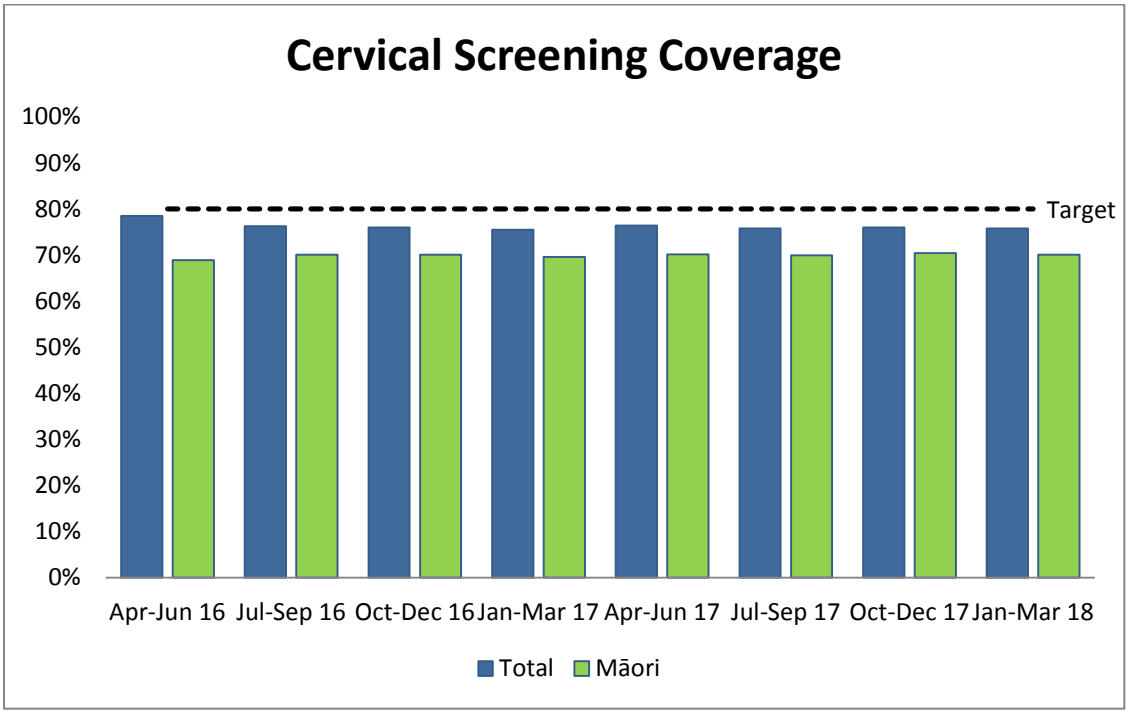
When discussing a breast screen mammogram with women, some of the barriers to screening are:

- Work or family commitments:
    - Appointments are available from 7.30am – 5.30pm and Saturday mornings are also available at fixed sites
- Fear of pain:
    - A mammogram maybe uncomfortable, but should not be painful. Occasionally a woman may take paracetamol prior to her screening appointment. If she feels pain during the screening, she should tell the radiographer
- Fear of results:
    - The smallest change found by having regular mammograms is 2mm. The average size of a lump found by a woman self-checking from time to time is 15.6cm. Survival rates increase if detected early.
- Previous negative experiences:
    - BSM are consistently working with their staff for quality improvements

Breast Screening Recorded for Hauraki PHO Eligible Women



Cervical Screening Recorded for Hauraki PHO Eligible Women



Patient Experience Survey (PES)

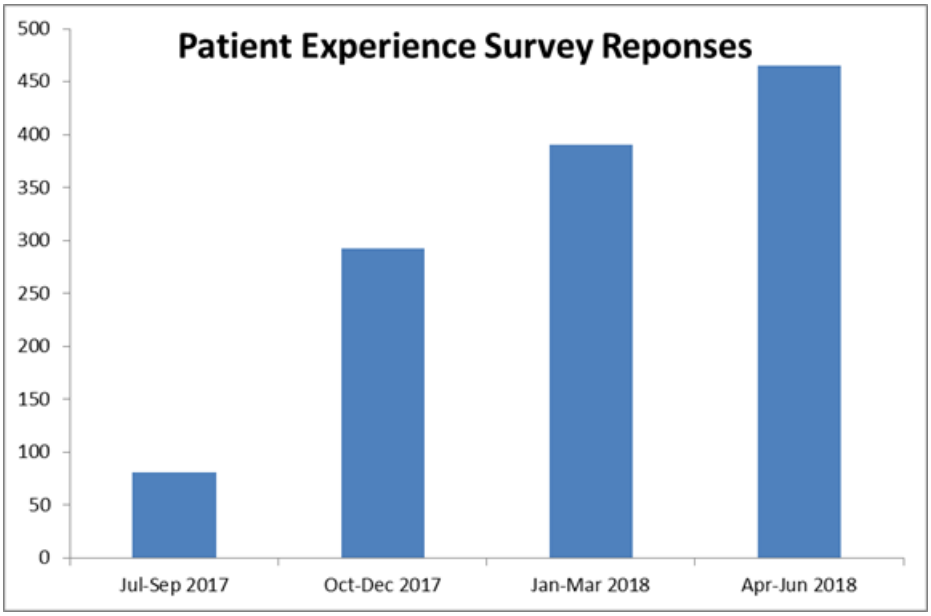
The PES survey is recognised as evidence contributing towards Indicator 9 of the Cornerstone Aiming for Excellence Standard which requires patients' input into service planning. The College has confirmed that the use of the Patient Experience Survey (PES) is recognised as a source of evidence towards meeting this indicator. For quality improvement processes, the use of this tool will need to be accompanied by a quality improvement activity undertaken on the basis of the survey results received.

There are 2 parts – one is the PES and getting people to complete it (and enough completed for them to be useful) and the second is to use the information provided as an opportunity for a quality improvement.

Hauraki PHO requests that two areas of feedback from the PES be utilised for a quality improvement opportunity.

Quarterly Reporting timelines:

Jan – June – Reporting to Hauraki PHO by 15 July
July – Dec – reporting to Hauraki PHO by 15 January



Hauraki PHO practice partners began participating in the Patient Experience Survey following the rollout of the National Enrolment Service in mid-2017. Of 24 practices, 22 practices (92%) are now taking part in the survey on a quarterly basis, exceeding the Waikato DHB's target of 80% of practices participating.

Survey response volumes have increased significantly each quarter, with levels now reaching a point where there is the ability to identify potential issues. This allows practices and the PHO alike to implement changes to improve the experience of the health system for our enrolled population.

Please ensure as many of your patients as possible have their email addresses updated in Medtech 32/Evolution.

For the 2018/19 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 2018-19 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%)
    - Cervical screening (80%)
    - Smoking Cessation (90%)
    - CVRA (90%) for Māori males aged 35-44 years
    - Diabetes Annual Reviews (90%)
    - B4 School checks (80%)
    - Activated patient portal 10% increase per quarter for eligible population

- $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)

* Please note that from the 1st January 2019, as has been previously indicated, the funding pool will increase as we move funds from the Activity funding to Achievement funding.
* Over the next 6 months, we will be consulting with Practice owner/directors regarding the preferred methodology for calculating Quality Payments.

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 the 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.

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

Preferred READ Codes for General Practice Guide to achieve 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

RESPONSIBILITIES

Practice Responsibilities

On behalf of their enrolled population, Hauraki PHO Practices are required to do the following:

- Sign and return their Back to Back Agreement by 31st July 2018
- Adhere to the Back to Back Agreement and HPHO Quality Plan
- Quality payments are dependent on practices participating in ALL of the identified Quality and System Level Measure (SLM) activities detailed in this plan
- Have designated champions identified in the practice for each of the following; Immunisation, Cervical screening, Cardiovascular Disease, Diabetes , Smoking Cessation, B4SC, Patient Portal, Advance Care Planning, GASP and LOGIQC
- Ensure the Communication person disseminates relevant information from HPHO to the whole Practice Team
- Ensure the Practice Manager has a trained Deputy to cover when the Practice Manager is on leave or unavailable
- Provide Practice Registers, Clinical Event Exports, Provider Lists and quarterly reporting on time. **Payment for target achievement relies on this**
- Maintain Cornerstone Accreditation, utilising LOGIQC Quality Management System and
- Provide high quality, accessible patient services
- Provide on-going training and professional development support for all practice staff
- 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 of these audits are to be made available to HPHO on request
- Risk Management – advise Serious and Sentinel events are to be reported to HPHO within one working day or sooner
- Provide at least one practice representative at the Hauraki PHO Annual General Meeting
- Provide 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
- Utilise HPHO funded Clinical Decision Support tools and applications
- Provide evidence to Hauraki PHO of 24/7 coverage arrangements

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
- Continue to invest in innovative solutions to meet changing health needs and support General Practice in today's challenging environment
- Work with the Waikato DHB to develop and implement the DHB's Ten Year 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, equitable, 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
- Ensure fair and equitable distribution of Flexible Funding Pool to support the wellness of our enrolled population

QUALITY OUTCOMES : TIPS, TRICKS & HELPFUL HINTS

Use all the Electronic Decision Support Tools, Champions 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
- TeleHealth
- Clinical Pathways (Map of Medicine is to be replaced with HealthPathways)
- LOGIQC Quality Management System