**Guidance for the annual quality plan: improving population health and addressing equity**



Complete annual quality plan

**Step 5**

**Step 4**

**Step 2**

**Start here**

Choose an equity collaborative topic

Clinical gap analysis

**Step 3**

Equity and your practice

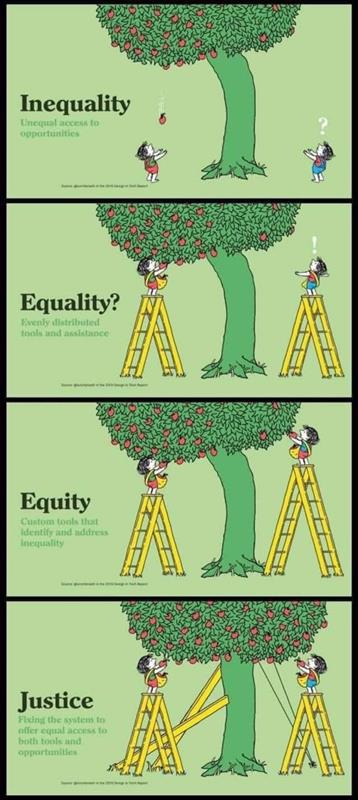
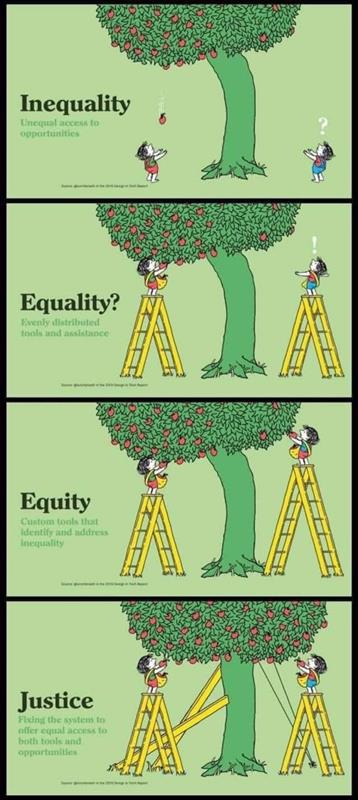
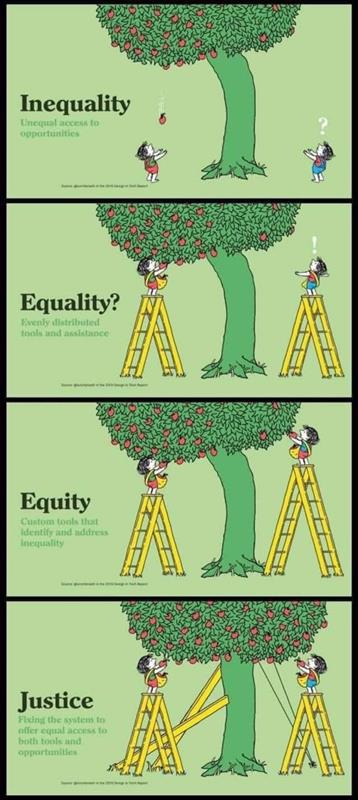
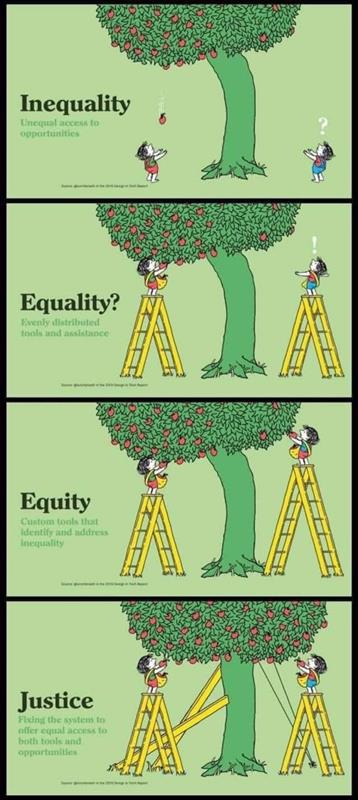
Māori health plan and your practice

**Step 1**

The annual quality plan - making it easier to meet criteria for Foundation (Māori health plan) and Cornerstone standards, (equity module, CQI module) and to accumulate CME/CNE points

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| 1. Māori health plan and your practice | |
| **Rationale** | **Guidance notes** |
| Sir Mason Durie has distinguished the Treaty as a covenant in health – on the ground, within legislation and strategy, and as a “21st century prescription” for Māori health. The Treaty forms many parts of New Zealand’s constitutional fabric and is fundamental to Māori development, health and wellbeing. But more than simply acknowledging the Treaty as a requirement or obligation, the challenge as a health provider is to implement its promise by working within a practice that can be proud of its actions toward advancing Māori health as a priority.  Thinking about and acknowledging the status of the Treaty and its obligations established under Article I (Kāwanatanga), Article II (Tino Rangatiratanga) and Article III (Ōritetanga) will help you to establish priorities for Māori health with Māori members of the community and/or Māori health providers. Article III obligation means all people, including Māori, are entitled to equitable health outcomes. During the past 30 years there have been some gains made in improving Māori health outcomes, however, current statistics and the recent Hauora Report (WAI 2575) clearly demonstrate that there is much more work to do. | Whare Tapa Wha - This is a model of health, developed by Sir Mason Durie. Understanding the importance of this holistic model will support your work and your practice to be culturally safe. The four walls of the house (whare) represent spiritual (wairua), mental (hinengaro), physical (tinana) and family (whānau). For optimal health, all four ‘walls’ must be robust and balanced. This model acknowledges the importance of family, connection and identity.  **Actions:**   1. Get the practice together. 2. Watch the [**Treaty of Waitangi**](https://procare.instructure.com/courses/463/pages/home-page-an-introduction-to-the-treaty-of-waitangi) video - if the practice team haven’t already. 3. Discuss what this means for your practice (see Appendix for ideas for change [page 14] and other resources [page 20]):  * Does our practice contribute specifically to advancing the health of Māori? If so, in what ways? If not, where could we start? * What relevance does the Treaty of Waitangi have to our practice? * What does ‘to be a good Treaty partner’ mean – for you as a New Zealand citizen; for you as a health professional; and, for this medical practice? * Describe how your practice will know if it is providing an inclusive and culturally safe environment and experience (e.g. survey results, community hui, focus groups, or face-to-face meetings with Māori patients/whānau). * How will our practice measure and monitor the goals of our Maori health plan?  1. Ask your Clinical Advisor about the [**Early Pregnancy Assessment Tool**](https://members.procare.co.nz/docs/default-source/clinical/our-picture-of-health/0-4-health-goal/epat-blurb.pdf?sfvrsn=2908c3ad_2)for Māori pregnant women. 2. Check in with the ProCare [**equity**](https://members.procare.co.nz/members-info/equity/maori-health) team about local community, regional and national linkages if required. 3. Complete the Māori health plan section in the annual quality plan template. |

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| 2a. Equity and your practice | |
| **Rationale** | **Guidance notes** |
| Equity as defined by the Ministry of Health is a fundamental consideration in the Aotearoa New Zealand health care system:  In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises that different people with different levels of advantage require different approaches and resources to get equitable health outcomes.  Population groups most affected are Māori, Pacific, and people living in Q5 communities. | Equality in health care describes equivalent treatment. While each patient is given the same treatment, the factors that make patients different from one another (including but not limited to socioeconomic status, education, literacy, ethnicity, disability, access to health care, age, gender and sexual orientation) are not considered. Equity in health care accounts for those differences and focuses on delivering equivalent outcomes. This step in the annual plan encourages practices to consider the diversities within their populations and ensure they can safely care for any type of presenting patient, regardless of current enrolled patient demographics.  **Actions:**   * 1. Get the practice together.   2. Watch the [**Equity**](https://members.procare.co.nz/members-info/equity/equity-at-procare) and [**HQSC – learning and education modules on understanding bias in health care**](https://www.hqsc.govt.nz/our-programmes/patient-safety-week/publications-and-resources/publication/3866/) [module 1-3] videos (CME/CNE points).   3. Discuss what this means for your practice and what activities you will dedicate time to in order to achieve health equity (see Appendix for ideas for change [page 14] and other resources [page 20]).   4. Appoint an equity champion.   5. Complete the equity and your practice section in the annual quality plan template. |



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| 2b. Achieving equity for Pacific and your practice | |
| **Rationale** | **Guidance notes** |
| The Pacific population in New Zealand is a diverse population coming from 22 different island nations of the South Pacific. They each carry unique values and traits from their island group. They are a young population with 58% being New Zealand born. There is further diversity where Pacific people make up the biggest group of mixed ethnicity (40%) compared to non-Pacific (7%).  Pacific peoples make up 13% (109,000) of the ProCare population. ProCare cares for the biggest Pacific population in NZ. This collective group suffer poor health outcomes in comparison to non-Pacific, live in the most deprived socioeconomic neighbourhoods and have a shorter lifespan.  **Pacific concepts of holistic health and wellbeing:** The causes are multifactorial, however equity of care is a contributing factor. Achieving equity is key to ensuring this people group receive equal opportunity to excellent health care and outcomes.  Despite their struggles, Pacific peoples carry a warmth and humility, spirit of joy and celebration. These expressions come from collective core values which underpin their world view. These values bring forth “holistic health and wellbeing” for Pacific peoples, and are shared amongst the different island groups which include:   1. Family - the powerful role of the family network 2. Church, faith and spirituality 3. Community, social networks and connections - hugely influential, seen during COVID 19 pandemic 4. Generosity of giving, celebration and reciprocity.   These core values are a powerful driving force and motivating factor for how a Pacific person may think and respond to health treatment and care. It is very important to be aware of these values when trying to engage and treat a Pacific person holistically. | **Achieving equity for Pacific:** Understanding your Pacific patients and their families, learning skills to better engage them will go a long way in developing strong relationships, greater accuracy in diagnosis, improved treatment plans and greater continuity of care.  **Success:** The result for you and your team is increased confidence in working with Pacific patients, greater patient and doctor satisfaction, better health outcomes. *See ideas for change: tools for achieving equity in Pacific.*  **Actions:**   1. Intentionally take time out as a team to focus on your Pacific patient population and how they are progressing as a whole in your practice compared to other populations. Step back and take a bird’s eye view, look for patterns and compare differences in island groups if appropriate. 2. Update and review with the practice team the “big picture” epidemiology and demographics of how Pacific peoples are doing as a whole in NZ compared to other groups. This may be a motivating factor or the “why” for the need to proactively treat your individual Pacific patients. 3. Understand that Pacific peoples are a very diverse group of nations each with individual differences, generationally and ethnically. They don’t fit one mould and may have different responses to healthcare. 4. They do however share common core values which shape their concept what their definition of holistic health and wellbeing is. Begin to dialogue with your patients about these values when trying to understand and engage with them and their worldview.   **Pacific health support:** The ProCare equity team of advisors and cliniciansare a dedicated team passionate and available to support you. They can provide you with local Pacific support networks and give you guidance and support. There are also Pacific resources and a dedicated equity section on the [**members website**](https://members.procare.co.nz/members-info/equity/pacific-health) that has resources and tools to assist you. |

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| 3a. Clinical gap analysis: review your clinical targets | |
| **Rationale** | **Guidance notes** |
| The general practice team aims to be working throughout the year to meet all of the clinical targets, system level measures and Ministry of Health performance measures.  Equity in health care focuses on delivering equivalent outcomes. | **Actions:**   1. Review how your practice is doing against each of the clinical targets by population subgroups and complete the g*ap analysis* section in your annual quality plan. 2. Use the table below as a *draft* before transferring the information to your annual quality plan.   You can find your reports (OPoH) on the[**members website**](https://members.procare.co.nz/reports/your-populations-health)**.** |

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| --- | --- | --- | --- | --- | --- | --- |
| Clinical targets | Goal % | Māori % | Pacific % | Non-Māori , Non-Pacific,  Q5 % | Others  % | Equity gap |
| CVD risk assessment | 90% |  |  |  |  | Yes / No |
| CVD secondary prevention | 70% |  |  |  |  | Yes / No |
| CVD primary prevention | 70% |  |  |  |  | Yes / No |
| Diabetes management of microalbuminuria and macroalbuminuria | 90% |  |  |  |  | Yes / No |
| Diabetes HbA1c | 80% |  |  |  |  | Yes / No |
| Diabetes blood pressure | 80% |  |  |  |  | Yes / No |
| Brief advice to stop smoking | 90% |  |  |  |  | Yes / No |
| 8 month immunisations | 95% |  |  |  |  | Yes / No |
| 2 year immunisations | 95% |  |  |  |  | Yes / No |
| Flu 65+ | 75% |  |  |  |  | Yes / No |
| Cervical screening | 80% |  |  |  |  | Yes / No |

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| 3b. Clinical gap analysis: review your population health report | |
| **Rationale** | **Guidance notes** |
| As part of ProCare's population health strategy, we have developed unique reports showing the health of each practice's enrolled population.  The reports use all available data sources and are centred around our strategy's five clinical health goals; children 0-4 years, youth 15-24 years, older people’s health, wellbeing and preventive care and long term conditions.  The report provides a snapshot into current health gaps, and will allow you to focus on how to make the biggest difference to the health of your enrolled population. You will then be able to update your annual quality plan to address practice specific health and equity gaps over the next 12 months.  Equity in health care focuses on delivering equivalent outcomes.   |  |  |  | | --- | --- | --- | | **This work will assist in completion of the following Foundation Standard/Cornerstone Criteria** | **Foundation** | **Cornerstone Equity** | | **Practice uses population & ethnicity data to promote equity outcomes** | √ | √ | | * Describe data used | √ | √ | | * Ethnicity audits less than 6 months old | √ | √ | | A gap analysis is a process that compares actual performance and/or results with expectations of performance and/or results. A gaps analysis is a way to identify missing or weak skills, capabilities, processes, practices, technologies, etc. The comparison between actual and desired performance/results highlights what elements need to be added or worked on within the practice.  It can be worth considering to choose an equity collaborative that matches your clinical priority areas for maximum improvement.  **Actions:**   1. Have a look at your population health report and review how your practice is doing against some other clinical measures. 2. Discuss with your practice key equity gaps and identify areas of change (see Appendix for ideas for change [page 14] and other resources [page 20]) that you might wish to focus on. 3. Use the table below as a *draft* before transferring the information to your annual quality plan.   **You can find your reports on the** [**members website**](https://members.procare.co.nz/reports/your-populations-health)**.** |

| Population health measures | Māori % | Pacific % | Non-Māori , Non-Pacific,  Q5 % | Others  % | Equity gap |
| --- | --- | --- | --- | --- | --- |
| Healthy start to life: patients enrolled in practice who had ambulatory-sensitive hospital admission for respiratory conditions |  |  |  |  | Yes / No |
| Healthy start to life (0-4): patients enrolled in the practice who had 3+ emergency department visits in the last year |  |  |  |  | Yes / No |
| Increased youth engagement with primary care (15-24): youth visits over the next 12 months |  |  |  |  | Yes / No |
| Engaged to improve wellbeing (15+): increase the number of current smokers given cessation support |  |  |  |  | Yes / No |
| Engaged to improve wellbeing (15+): alcohol status recorded and brief advice given to those who are above the drinking guidelines |  |  |  |  | Yes / No |
| Engaged to improve wellbeing: (15+): improve BMI recording |  |  |  |  | Yes / No |
| Engaged to improve wellbeing (15+): patients classified as having high grade smears and are overdue for annual testing |  |  |  |  | Yes / No |
| Improved quality of life for people living with long term conditions (15+): patients who are recorded smokers and have COPD, CVD, diabetes or renal failure and have not been offered smoking cessation support |  |  |  |  | Yes / No |
| Improved quality of life for older people (65+): multimorbidity – monitoring and improved clinical management of older patients with 2 or more conditions |  |  |  |  | Yes / No |
| Improved quality of life for older people (65+): polypharmacy 10+ - Identify and review patients receiving polypharmacy and high risk medications |  |  |  |  | Yes / No |
| Improved quality of life for older people (65+): improve coverage of Herpes Zoster vaccination for older population |  |  |  |  | Yes / No |
| Frequent visitors (13+ visits in last 12 months) |  |  |  |  | Yes / No |

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| 1. Choose an equity collaborative topic | | |
| **Rationale** | | **Guidance notes** |
| The practice team have identified an area for improvement and have chosen to be a part of a virtual collaborative to improve one aspect of the quality of the service. The practice will share improvement methods, ideas and data on service performance.   |  |  |  |  | | --- | --- | --- | --- | | **This work will assist in the completion of the following Foundation Standard /Cornerstone Criteria** | **Foundation** | **Cornerstone Equity** | **Cornerstone CQI** | | **Data and audit findings are displayed, monitored with practice team** |  | √ |  | | * Audit activity using PDSA |  | √ |  | | * Progress charts displayed in staff-only spaces |  | √ |  | | **Activity for CQI Cornerstone Module** |  |  | √ | | | To achieve a consistent, systematic, sustainable and equitable outcome it is highly recommended your chosen equity collaborative matches one of your clinical priority areas for maximum effect.  The ProCare equity collaboratives are looking to automatically provide monthly data tracking so this will lessen practice burden.  Practice interest will determine whether a collaborative topic will be offered e.g. a minimum number of practices is needed for sharing of ideas and support.  Practices may choose to continue or take part with the Safety in Practice collaboratives instead of the ProCare equity collaboratives.  **Action:**   1. Choose **one** equity collaborative from the list provided and include it in your annual quality plan. |
| **Health goal** | **Equity collaborative topics (*choose one*)** | **Benefits of joining the collaborative** |
| Healthy start to life (0-4) | Use of the Early Pregnancy Assessment Tool (EPAT) collaborative | Practices can now use EPAT in their care provision of pregnant women. EPAT is incorporated in the practice PMS system and enables a systematic assessment with prompts to support you in providing evidence-based care.  Through this collaborative, you will receive coaching and support on proven health care improvement methods to integrate EPAT into your practice impactfully and sustainably. You can be shown ways of measuring how successfully you’ve implemented EPAT and its contribution to improving the care provision to your patients. There will be organised collaborative learning sessions which are also a platform to share your knowledge, processes and outcomes with other practices. |

| **Health goal** | **Equity collaborative topics (*choose one*)** | **Benefits of joining the collaborative** |
| --- | --- | --- |
| Healthy start to life (0-4) | The development of midwives or social worker hubs collaborative | Virtual midwives and social worker hubs are a virtual space within which practices can make real time handovers with midwives and social workers during the pregnant woman’s practice visit. This can be done either by video call, phone call or with the midwife of social worker physically present in the practice. ProCare will provide practices with a continually updated list of midwives and social workers, put together in collaboration with NGOs such as Awhi Ora and government organisations.  Through this quality Improvement collaborative, you will receive coaching and support on proven health care improvement methods to cater the virtual midwives and social worker hubs to your practice impactfully and sustainably. You can be shown ways of measuring how successfully you’ve implemented the hubs and their contribution to improving the care provision to your patients. There will be organised collaborative learning sessions which are also a platform to share your knowledge, processes and outcomes with other practices. |
| Increased youth engagement with primary care (15-24) | Youth friendly practice collaborative | ProCare has adopted a youth health toolbox to assist practices in catering for the needs of youths and providing more youth friendly clinical services. The [**toolbox**](https://members.procare.co.nz/members-info/clinical/our-picture-of-health/youth-engagement)contains resources to practically and pragmatically achieve improved working relationships with youth in general practices and provide the needed care.  Through this quality Improvement collaborative, you will receive coaching and support on proven health care improvement methods to incorporate changes into your practice for increased youth engagement impactfully and sustainably. You can be shown ways of measuring how successfully you’ve implemented youth friendly changes and its contribution to improving the care provision to your patients. There will be organised collaborative learning sessions which are also a platform to share your knowledge, processes and outcomes with other practices. |
| Engaged to improve wellbeing | Alcohol screening and brief advice | The Alcohol ABC (A= Ask B= Brief advice C= Counselling) approach is a simple and effective evidence-based tool to record alcohol intake and provide brief advice and counselling for patients whose alcohol behaviours may be harmful. The approach is systematic, integrated into everyday practice. On average for every 8 people who receive an alcohol brief intervention, one will reduce their intake to safer levels. This approach is highly recommended as an intervention tool by the RNZCGP to help uncover areas not usually considered in general practice quality improvement activity.  Through this equity collaborative, you will receive coaching and support on proven health care improvement methods to incorporate Alcohol ABC into your practice impactfully and sustainably. You can be shown ways of measuring how successfully you’ve implemented Alcohol ABC and its contribution to improving the care provision to your patients. There will be organised collaborative learning sessions which are also a platform to share your knowledge, processes and outcomes with other practices. |
| Improved quality of life for people living with long term conditions (15+) | Shared medical appointments for the management of long term conditions | Shared medical appointments (SMAs) is an initiative of the National Health Care Home (HCH) model of care. It is a new way of working, requiring a shift from traditional models of general practice care. It is important to integrate SMAs into practices in a way that is fit for the future and sustainable.  Through this collaborative, you will receive coaching on proven health care improvement methods to help you incorporate SMAs into your practice impactfully and sustainably. You can be shown ways of measuring how successfully you’ve implemented SMAs and its contribution to improving the care provision to your patients. There will be organised collaborative learning sessions which are also a platform to share your knowledge, processes and outcomes with other practices. |
| Improved quality of life for people living with long term conditions (15+) | Choose **one** of the long term condition bundles from the list below:   * BPAC: encouraging smoking cessation * RNZCGP: heart failure with LV systolic dysfunction – non-pharma management *(practices must have access to Dr Info)* * Microalbuminuria and ACEi/ARB (audit tool developed and approved for MOPS points) * CMH: management of gout *(practices must have access to Dr Info)* | These long term condition (LTC) bundles are available on the members website under the [**LTC health goal**](https://members.procare.co.nz/members-info/clinical/our-picture-of-health/long-term-conditions). They have all been approved for CME/CNE points as well as meeting annual audit requirements.  Through this equity collaborative, you will receive coaching on proven health care improvement methods to help you in address any of these topics in your practice impactfully and sustainably. There will be organised collaborative learning sessions which are also a platform to share your knowledge, processes and outcomes with other practices. For Counties Manukau practices, there is some funding available for screening. |
| Improved quality of life for older people (65+) | Polypharmacy/medicines review | ProCare will remotely install the module in your practice management system. The Quality Improvement collaborative will support you in making this review process fit for purpose for your practice.  Through this collaborative, you will receive coaching on proven health care improvement methods to help you incorporate Polypharmacy review into your practice impactfully and sustainably. You can be shown ways of measuring how successfully you’ve implemented polypharmacy reviews and its contribution to improving the care provision to your patients. There will be organised collaborative learning sessions which are also a platform to share your knowledge, processes and outcomes with other practices. |
| Improved quality of life for older people (65+) | Falls prevention | ProCare will remotely install the module in your practice management system. The quality Improvement collaborative will support you in making the falls screening process fit for purpose for your practice.  Through this collaborative, you will receive coaching on proven health care improvement methods to help you incorporate falls screening into your practice impactfully and sustainably. You can be shown ways of measuring how successfully you’ve implemented falls screening and its contribution to improving the care provision to your patients. There will be organised collaborative learning sessions which are also a platform to share your knowledge, processes and outcomes with other practices. For Counties Manukau practices, there is some funding available for screening. |

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| **Health goal** | **Other collaborative topics (*choose one*)** | **Action** |
| Safety in Practice collaboratives  *ADHB/WDHB practices only* | Select one:   1. GP medicines reconciliation 2. GP results handling module 3. Kidneys prescribing module 4. NSAIDs prescribing module 5. High risk medicines prescribing module 6. GP warfarin module | Submit an expression of interest to take part. |

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| 5. Complete your annual plan | | |
| **Priority areas** | **Checklist** | **Tick when complete** |
| Māori health plan | Did you get the practice together? |  |
| Did the practice watch the video? |  |
| Did you discuss what this means for your practice and include change ideas for Māori health plan? |  |
| Did you check in with the ProCare equity team about local community, regional and national linkages? |  |
| Equity | Did you get the practice together? |  |
| Did the practice watch the video(s) on equity? |  |
| Did you have a discussion around what this means for your practice, identified population sub-groups and health care areas to achieve equity? |  |
| Have you appointed an equity champion? |  |
| Clinical targets | Did you review how your practice is doing against each of the clinical targets (OPoH) by population subgroups? |  |
| Did you agree and include change ideas for your clinical target areas (OPoH)? |  |
| Population health measures | Did you review your population health report and how your practice is doing against the clinical measures? |  |
| Did you discuss with your practice key equity gaps and identify areas of change that you might wish to focus on? |  |
| Did you agree and include change ideas for your *other* clinical measures from your population health report? |  |
| Equity collaboratives | Did you choose one collaborative from the list provided? |  |
| Other | If you have other areas you would like to include in your quality plan, did you add them to the “other quality initiatives” section? *e.g. Te Tumu Waiora, environmental sustainability, workforce/management, practice environment and infrastructure, and patient experience* |  |

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| Appendix: ideas for change | | |
| **Rationale** | | **Guidance notes** |
| Sometimes it’s hard to know where to start. Here are some ideas for change.   |  |  |  | | --- | --- | --- | | **This work will assist in completion of the following Foundation Standard /Cornerstone Criteria** | **Foundation** | **Cornerstone Equity** | | **Practice uses population & ethnicity data to promote equity outcomes** |  | √ | | * Describe data used |  | √ | | * Ethnicity audits less than 6 months old |  | √ | | **Data and audit findings are displayed, monitored with practice team** |  | √ | | * Audit activity using PDSA |  | √ | | * Progress charts displayed in staff-only spaces |  | √ | | | **Action:**   1. Use the i*deas for change* and o*ther* r*esources* below when completing the Māori health plan, equity in your practice, clinical targets and other clinical areas possibly highlighted by your practice’s population health report located on the [**members website**](https://members.procare.co.nz/reports/your-populations-health)**.** |
| **Topic** | **Ideas for change** | |
| Māori health plan | 1. **Plan to improve Māori health** - complete the *Māori health plan and your practice* section in the annual quality template; read ProCare’s Māori health strategy and if required contact ProCare’s [**equity**](https://members.procare.co.nz/members-info/equity/maori-health) team to facilitate the development of your own Māori health plan. 2. **Set realistic goals for your practice** - you cannot change everything at once. The first step may be to implement workforce development so all practice staff know the importance of the changes to be made. Simple initial goals may include: Treaty of Waitangi training; cultural safety training; staff awareness of the significance of institutional racism and unconscious bias and how these contribute to inequitable Māori health outcomes; staff attempt to pronounce Māori names and words correctly; our practice welcomes whānau participation in consultations; our practice provides signage, pamphlets and information in Te Reo Māori; ethnicity data are regularly checked and recorded correctly; we have a list of local and national Māori providers and practitioners. 3. **Build trusting therapeutic relationships** - understanding and engaging with Māori patients and their whānau will go a long way to developing trusting therapeutic relationships. The values, beliefs and previous experiences of Māori patients play a key role in how your relationship with them will develop, and therefore how effective you are as their physician. Effective communication with Māori, the kind that enhances the patient/physician relationship, needs to be based on an approach that validates the patient’s experience within his or her own life or cultural context. Take time for introductions, interpersonal connections and links (people, place or activities in common); let the patient tell their story; understand the unique illness experience of each Māori patient you see; use open questions to check understanding and agreement; consider printing out notes for Māori patients to take home with them; consider your use of language and how you impart knowledge (avoid the use medical jargon). 4. **Engage Māori patients in their health issues** – it is important to regard each encounter with a Māori patient as an opportunity to engage them in their own health care and to address wider issues. Some examples may be: CVD risk assessment for patients presenting with gout; smoking cessation advice; blood pressure check, adopting the [**Early Pregnancy Assessment Tool**](https://members.procare.co.nz/docs/default-source/clinical/our-picture-of-health/0-4-health-goal/epat-blurb.pdf?sfvrsn=2908c3ad_2) which will ensure all whānau receive a thorough assessment and referrals to services, improve health outcomes for Māori babies and improve the quality, quantity and consistency of Māori pregnancy assessments. 5. **Agree on realistic patient health goals** – discuss a health plan with Māori patients/whānau that can be implemented incrementally and that sets patient-centred goals (find out what is important to them – it may be more meaningful to a person with asthma to set a goal of playing a rugby game without breathlessness, rather than improving their peak expiratory flow rate); make the goals achievable and measureable. 6. **Make it easy for patients to come back** – give Māori patients a reason to return; validate their reason for attendance and follow this up with them; use recall reminders; consider barriers to access (financial barriers may be an issue – offer solutions to this by setting up regular small payments or accessing targeted funding, consider flexible clinic times and child friendly facilities if getting time off work or child care are issues). 7. **Form partnerships** – consider the role of whānau in the healthcare of Māori patients; where appropriate, involve whānau in consultations and treatment decisions; form partnerships with local Māori communities and Māori health providers; consider investing time and resource in the wider community in which you practice – attend Māori and community events, and establish initiatives with local community groups, kura, schools, or businesses. | |
| Equity in your practice | 1. Watch ‘*Keep calm and carry on during COVID and beyond’* webinar on [**equity in your practice**](https://members.procare.co.nz/members-info/equity/equity-at-procare), where Dr Wiki Gillespie (Māori) and Dr Justine Mesui (Pacific) outlines a series of ideas. 2. Contact [**ProCare’s equity team**](https://members.procare.co.nz/members-info/equity/equity-at-procare) of Māori and Pacific advisors, and clinicians for further ideas, resources and support. | |
| Tools for achieving equity in Pacific | Understanding your Pacific patients and their families, learning skills to better engage them will go a long way in developing strong relationships, greater accuracy in diagnosis, improved treatment plans and greater continuity of care. The result for you and your team is increased confidence in working with Pacific patients, greater patient and doctor satisfaction, better health outcomes.   1. Discuss this with your practice or clinic peer group and decide how you can individually and as a team begin to achieve some of them. 2. Focus on equal health outcomes. 3. Take the lead in developing a relationship with your Pacific patient and their family as their primary health care provider. 4. Show an active interest in what is important to them. Be intentional yet polite in asking about what their world is like. 5. Be mindful that Pacific patients are assessing you as much as you are assessing them. 6. Ensure all general practice staff are developing culturally competence. 7. Create a physical environment of cultural competence at the general practice that accommodates the cultural values and preferences of your patients. 8. Collect and maintain accurate ethnicity data. 9. Pronounce your patients’ names correctly. For Pacific peoples their names are significant reflecting generational blessing and identity, it can represent a family member, the village or clan they are from, for some their name can represent a noble or chiefly title that has been passed down through the generations. 10. Consider involving the family. 11. Teach and learn. 12. Be flexible in your approach to delivering clinical information. Be aware of the speed and tone of your speech, your body language and the language that you use, such as medical jargon.   For a more detailed explanation and ideas click [**here**](https://members.procare.co.nz/members-info/equity/pacific-health). | |
| **Clinical target areas** | **Ideas for change (consider population sub-groups that you might want to focus on)** | |
| CVD risk assessments | All eligible patients to have a CVD risk assessment every five years or more frequently if clinically appropriate. Note the earlier eligibility 15 years earlier for Māori, Pacific and Indian subcontinent (South Asian) people men at 30 years, women at 40 years. | |
| CVD secondary prevention | Recall and review patient’s medication as required. Check triple therapy for patients with peripheral vascular procedures (e.g. Femoral-popliteal bypass). These people often miss out. | |
| CVD primary prevention | Recall and review patient’s medication as required. | |
| Diabetes management of microalbuminuria and macroalbuminuria | Undertake clinical audit on management of micoalbuminuria: patients are on an ACE inhibitor or ARB using data from our practice’s population health analysis (LTC goal website for RNZCGP approved audit). | |
| **Clinical target areas [cont’d]** | **Ideas for change [cont’d] (consider population sub-groups that you might want to focus on)** | |
| Diabetes HbA1c | Recall patients with HbA1c above 64mmol for medication, diet and lifestyle review. | |
| Diabetes blood pressure | Recall patients with systolic <140mmHg for medication review. | |
| Brief advice to stop smoking | Smoking status of all eligible patients is recorded with the aim to provide brief advice for all smokers and quitters. Record all offers for smoking cessation referral or treatment even if patient declines. | |
| 8 month immunisations | Ensure appropriate recall system for immunisations of 8 month children. | |
| 2 year immunisations | Ensure appropriate recall system for immunisations of 2 year old children. | |
| Flu 65+ | Check the list of 65+ who are eligible for flu vaccine. | |
| Cervical screening | Review patients not on the cervical register and who haven’t had a cervical smear screening in the last 3 years in PMS.  Provide space for WONS nurse to carry out free cervical screening for enrolled patients with a focus on Māori and Pacific women. | |
| **Other clinical measures from** [**your population health report**](https://members.procare.co.nz/reports/your-populations-health) | **Ideas for change  (consider population sub-groups that you might want to focus on)** | |
| Healthy start to life (0-4): **patients enrolled in the practice who had ambulatory-sensitive hospital admission for respiratory conditions** | * Review quarterly NHI lists to identify any interventions that may be required such as flu vaccine. | |
| Healthy start to life (0-4): **patients enrolled in the practice who had 3+ emergency department visits in the last year** | * Review monthly NHI lists to identify any interventions that may be required to support the family/whānau. | |
| **Other clinical measures from** [**your population health report**](https://members.procare.co.nz/reports/your-populations-health)[cont’d] | **Ideas for change [cont’d] (consider population sub-groups that you might want to focus on)** | |
| Increased youth engagement with primary care (15-24): **youth visits over the next 12 months** | * Review monthly NHI lists. * Complete youth friendly audit to see if practice is “friendly”. * Utilise the youth health toolbox to improve youth engagement within the practice. | |
| Engaged to improve wellbeing (15+):increase the number of current smokers given cessation support | * Review monthly NHI lists. * Use appropriate tools to remind staff to provide cessation support or referral for cessation support. * Use appointment scanner to identify patients among the list of daily appointments who need to be offered cessation support. * Use referral pathways to the appropriate cessation programmes (Ready Steady Quit and Smokefree). | |
| Engaged to improve wellbeing (15+):alcohol status recorded and brief advice given to those who are above the drinking guidelines | * Review monthly NHI lists. * Set up a reminder system to discuss and record individual patients’ alcohol status (patient dashboard). * Use tool to identify alcohol consumption, provide brief advice as appropriate. * Or access alcohol counselling. | |
| Engaged to improve wellbeing (15+):improve BMI recording | * Review monthly NHI lists. * Use or set up appropriate tools to remind clinicians to record patient’s BMI. | |
| Engaged to improve wellbeing (15+):patients classified as having high grade smears and are overdue for annual testing | * Review NHI list of women with high grade smears who are overdue for follow up. | |
| Improved quality of life for people living with long term conditions: patients who are recorded smokers and have COPD, CVD, Diabetes or renal failure and have not been offered smoking cessation support | * Review monthly NHI lists. * Set up a recall of these patients and offer smoking cessation support. | |
| **Other clinical measures from** [**your population health report**](https://members.procare.co.nz/reports/your-populations-health)[cont’d] | **Ideas for change [cont’d] (consider population sub-groups that you might want to focus on)** | |
| Improved quality of life for older people (65+):multimorbidity – monitoring and improved clinical management of older patients with 2 or more conditions | * Review annual NHI List. * Review Māori and Pacific and high needs patients first. * Setup recalls and review medication and identify any outstanding actions e.g. bloods, referrals e.g. to health coach. | |
| Improved quality of life for older people (65+): polypharmacy 10+ - Identify and review patients receiving polypharmacy and high risk medications | * Review monthly NHI lists, plan and implement patient recalls. * Use patient dashboard prompts. * Identify variations in use of high risk medications. * Review of prescribing patterns. | |
| Improved quality of life for older people (65+): improve coverage of Herpes Zoster vaccination for older population | * Run query builds for those eligible. * Improve follow-up and communications supporting free zoster vaccination. * Invite in for vaccination. | |
| Frequent visitors (13+ visits in last 12 months) | * Review plan of care, social and other needs. | |
| Whānau unmet health needs | * Consider shared medical appointment. | |

| Appendix: other resources | |
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| **Priority areas** | **Resources** |
| **Māori health** | Links relating to Māori health:  [Guidance] [Medical Council of New Zealand: Best health outcomes for Māori: practice implications](https://www.mcnz.org.nz/assets/standards/ed659af389/Best-health-outcomes-for-Maori-Practice-implications.pdf)  [Guidance] [Medical Council of New Zealand: He Ara Hauora Māori: A pathway to Māori health equity](https://www.mcnz.org.nz/assets/standards/6c2ece58e8/He-Ara-Hauora-Maori-A-Pathway-to-Maori-Health-Equity.pdf)  [Guidance] [Medical Council of New Zealand: statement on cultural safety](https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/)  [Guidance] [Ministry of Health: Equity of health care for Māori: a framework](https://www.health.govt.nz/publication/equity-health-care-maori-framework)  [Guidance] [ProCare's population health strategy, our picture of health](https://members.procare.co.nz/members-info/clinical/our-picture-of-health)  [Guidance] [RNZCGP Māori health strategy: he ihu waka, he ihu whenua, he ihu tangata](https://www.rnzcgp.org.nz/RNZCGP/Advocacy/M%C4%81ori_health_strategy.aspx)  [Guidance] [RNZCGP Māori health plan and indicators](https://www.rnzcgp.org.nz/Quality/Indicators/3.aspx?WebsiteKey=7623fc84-8f36-4d86-b0c2-150be9e8f9d9&hkey=eccb9831-d6a4-4594-850e-7079fd5a07ee&indicatorcontent=1#indicatorcontent)  [Guidance] [Whānau ora health impact assessment 2007](https://www.health.govt.nz/system/files/documents/publications/whanau-ora-hia-2007.pdf) |
| **Equity** | RNZCGP change idea in equity module: conduct a gaps analysis on your practice workforce to support Māori and Pacific patients:   1. Identify the area needed to be analysed (e.g. recruiting a workforce who supports Māori and Pacific patients). 2. Identify the current state of the organisation in this area (e.g. does the practice have a strategic plan for recruiting a workforce to support Māori and Pacific patients?). 3. Identify the ideal (e.g. the practice has a clinician fluent in Te Reo Māori). 4. Compare the current state with the ideal to identify gaps (e.g. the practice currently has one nurse who knows some Te Reo Māori). 5. Analyse the gap (e.g. why does the practice only have one person who knows Te Reo Māori? Will having access to a language interpreter improve patient outcomes, or is there another, better way using the current resources? What have patients said regarding lack of language interpreters in the current staff?). 6. Plan to address and fix gap (e.g. support current staff to learn Te Reo Māori, start recruitment drive seeking candidates with language skills). 7. Consider timelines, cost, and priorities.   [Guidance] [Achieving health equity by eliminating health inequities RNZCGP position statements](https://rnzcgp.org.nz/gpdocs/Intranet/2012-Health-inequities-position-statement.pdf)  [Guidance] [Clarke, Amanda R., et al. A roadmap to reduce racial and ethnic disparities in health care. Published by *Finding Answers: Disparities Research for Change,* Robert Wood Johnson Foundation](https://www.solvingdisparities.org/sites/default/files/Roadmap_StrategyOverview_final_MSLrevisions_11-3-14%20%284%29.pdf)  [Guidance] [Dr Camara Jones social determinants of equity Youtube](https://www.youtube.com/watch?v=G3KOs7hg9Bs)  [Guidance] [Dr Camara Jones explains cliff of good health Youtube](https://www.youtube.com/watch?v=to7Yrl50iHI)  [Guidance] [Gap analysis - how to conduct](https://searchcio.techtarget.com/definition/gap-analysis)  [Guidance] [Gap analysis - four step guide](https://www.clearpointstrategy.com/gap-analysis-template/)  [Guidance] [Gap analysis - complete guide](https://www.smartsheet.com/gap-analysis-method-examples)  [Guidance] [HQSC: quality improvement: no quality without equity?](https://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf)  [Guidance] International Journal for equity in health: [why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition](https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3)  [Guidance] [International Journal for equity in health: closing the health equity gap: evidence-based strategies for primary health care organizations](https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-11-59)  [Guidance] [Medical Council of New Zealand: He Ara Hauora Māori A pathway to Māori health equity](https://www.mcnz.org.nz/assets/standards/6c2ece58e8/He-Ara-Hauora-Maori-A-Pathway-to-Maori-Health-Equity.pdf)  [Guidance] Medical Council of New Zealand: [best health outcomes for Māori](https://www.mcnz.org.nz/assets/MediaReleases/a4c0bf345a/2.-MCNZ-Achieving-Best-Health-Outcomes-for-Maori-a-Resource-consultation-May-2019.pdf)  [Guidance] [Medical Council of New Zealand: best health outcomes for Māori: practice Implications](https://www.mcnz.org.nz/assets/standards/ed659af389/Best-health-outcomes-for-Maori-Practice-implications.pdf)  [Guidance] [Medical Council of New Zealand: statement on cultural safety](https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/)  [Guidance] [Ministry of Health: achieving equity](https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity)  [Guidance] [Ministry of Health: equity of health care for Māori: a framework](https://www.health.govt.nz/publication/equity-health-care-maori-framework)  [Guidance] [Ministry of Health: Māori health](https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga)  [Guidance] [Ministry of Health: He Korowai Oranga: Māori health strategy](https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga)  [Guidance] [New Zealand Medical Association: health equity position statement](http://www.closingthegap.org.nz/site-map/opinion-articles/nz-medical-assn-health-equity-positionn-statement/)  [Guidance] [New Zealand Nurses Organisation: closing the gap: how nurses can help achieve health access and equity](https://www.nzno.org.nz/LinkClick.aspx?fileticket=ZiCD_i0fsfY%3D&portalid=0)  [Tool] Dr [Suzanne Pitama: The Meihana model: utilising a Māori health framework within your clinical practice](https://www.youtube.com/watch?v=rJxLMF7UTak)  [Tool] [The health equity assessment tool (HEAT)](https://www.health.govt.nz/publication/health-equity-assessment-tool-users-guide)  [Tool] [Primary care ethnicity data audit toolkit](https://www.health.govt.nz/system/files/documents/publications/primary-care-ethnicity-data-audit-toolkit-jun13-v2.pdf)  [[Tool] Project Implicit: Harvard implicit bias test](https://implicit.harvard.edu/implicit/takeatest.html)  [Training] [Diversity Works New Z](https://diversityworks.org.nz/events-training)ealand  [Training] [HQSC: learning and education modules on understanding bias in health care](https://www.hqsc.govt.nz/our-programmes/patient-safety-week/publications-and-resources/publication/3866/)  [Training] LearnOnline - [learning resources for health practitioners](https://learnonline.health.nz/) search for ‘*cultural competency’*  [Training] [Mauriora health education research: foundation course in cultural competency](https://members.mauriora.co.nz/course/foundation-course-in-cultural-competency-maori/) (Māori) |
| **Pacific health** | Links relating to Pacific health:  [Guidance] [Excerpted from New Zealand Guidelines Group 2003: Management of type 2 diabetes by Dr Justine Mesui](https://aus01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmembers.procare.co.nz%2Fdocs%2Fdefault-source%2Fquality%2Fannual-quality-plan%2Fnzggmanagement-of-type-2-diabetes_pacific-perspectives.pdf&amp;data=02%7C01%7CBelindaS%40procare.co.nz%7C4197e4d5e9c64a8a7ac108d821236869%7Ca164ca1632994ce38cea2b8c4fcd3257%7C0%7C0%7C637295783243439778&amp;sdata=aTxsRWDdaA1XSZSpJHAArhOporgp800tPnop7n%2FYyR8%3D&amp;reserved=0)  [Guidance] [Ministry of Health: Ola manuia, Pacific health and wellbeing plan 2020 – 2025](https://www.health.govt.nz/system/files/documents/publications/ola-manuia-pacific-health-wellbeing-action-plan-10june2020.pdf)  [Guidance] [Medical Council of New Zealand: Best outcomes for Pacific peoples](https://www.mcnz.org.nz/assets/standards/349b83865b/Best-health-outcomes-for-Pacific-Peoples.pdf)  [Guidance] [RNZCGP: cultural competency in general practice](https://rnzcgp.org.nz/GPdocs/New-website/Cultural-competence-framework-and-guidelines-1.pdf)  [Guidance] [Tofa Saili: A review of evidence about health equity for Pacific, 2019](https://nzdoctor.co.nz/sites/default/files/2019-09/Tofa%20Saili-%20A%20review%20of%20evidence%20about%20health%20equity%20for%20Pacific%20Peoples%20in%20New%20Zealand.pdf)  [Training] [Le Va: cultural competency training for Pacific](https://www.leva.co.nz/training-education/engaging-pasifika) |
| **Annual quality plan template** | We have developed a [**blank annual quality plan**](https://members.procare.co.nz/members-info/quality/quality-plan). You may already have a plan, and are welcome to use that, but please do check whether you have all the ingredients from our guidance document. |

Please email your completed annual quality plan to your ProCare clinical advisor.